



**Community Health Workers in
Rhode Island:**
Growing a public health workforce for a
healthier state

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Dear Rhode Islanders,

Health happens in our homes, schools, jobs, and communities. It begins with the services available in our neighborhoods, the quality of our housing, the safety of our communities, the food we have access to, and our employment opportunities. Community Health Workers play an essential role in addressing factors like these that contribute to the health of individuals, families, and communities. They serve as a link between individuals or communities and needed health or social services. They also bridge cultural differences between communities and health and social services by providing culturally appropriate health education.

I am pleased to present this study of Rhode Island's Community Health Worker workforce. The goal of this study is to present information gathered from employers of Community Health Workers across Rhode Island, and to share diverse perspectives about how we can sustain and expand this important part of our healthcare workforce.

The Rhode Island Department of Health (RIDOH) understands that health is about more than just medical care. The use of Community Health Workers is a proven best practice in addressing preventable differences in health outcomes among socio-demographic groups. In 2016, RIDOH was proud to lead efforts, in partnership with Rhode Island College, to establish formal certification credentialing opportunities for these professionals through the Rhode Island Certification Board. We look forward to partnering with employers and partners across the state to support this vital segment of our healthcare workforce and help ensure that every Rhode Islander has access to high-quality health and wellness 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 of Health

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Executive Summary

Introduction

Community Health Workers in Rhode Island go where health begins: where we live, learn, work and play. Community Health Workers (CHWs) have a long track record in Rhode Island as frontline public health professionals who often have similar cultural beliefs, chronic health conditions, disability, or life experiences as other people in the same community. As trusted leaders, they serve as a link between their community and needed health or social services. Community health workers help to improve access to, quality of, and cultural responsiveness of service providers.

In Rhode Island, statewide efforts to build healthier communities have created new opportunities to expand Community Health Workers' scale and impact. New CHW certification opportunities, fully implemented in 2017, bring a new level of formality to the community health workforce. Moves to tie healthcare payments to improving health outcomes and quality of care at lower cost incentivize healthcare organizations to address prevention and the socioeconomic and environmental determinants of health, where CHWs excel. Initiatives like the Rhode Island Department of Health (RIDOH)'s Health Equity Zones, and Community Health Teams supported by payers and the State Innovation Model Test Grant, work to build links between community and clinical settings using CHWs. Training aligned to CHW certification is available from several providers, and the Community Health Worker Association of RI (CHWARI) is newly active with support from Governor Gina M. Raimondo's Real Jobs RI initiative. There is a sense of momentum.

About this report

This study presents a snapshot of CHW employers in the state, gathers collective wisdom and stakeholders' perspectives about how to pay for a community health workforce, and highlights promising opportunities to grow and sustain the field.

Methods

During 2017, Brady Dunklee, an MPH Candidate at Boston University School of Public Health, partnered with the Rhode Island Department of Health to conduct 25 interviews of employers and stakeholders. Findings from this process are organized in the report thematically in the first section, and as case studies in the second. We also present perspectives from the following individuals.

- Nicole Alexander-Scott, MD, MPH – Director, Rhode Island Department of Health
- Carrie Bridges Feliz, MPH – Director, Lifespan Community Health Institute
- Dannie Ritchie, MD, MPH – Founder, Community Health Innovations of RI
- Marti Rosenberg – Director, State Innovation Model Test Grant, Rhode Island Office of the Health Insurance Commissioner
- James Rajotte, MS – Chief Health Program Evaluator, State Innovation Model Test Grant, Rhode Island Department of Health
- Charlotte Crist, RN-BC, CCM, CPHQ – Managing Director of Clinical Programs, Blue Cross & Blue Shield of Rhode Island
- Marie Ganim, PhD – Rhode Island Health Insurance Commissioner
- Rick Brooks –Director, Healthcare Workforce Transformation, Rhode Island Executive Office of Health & Human Services
- Marianne Raimondo – Executive Director, Institute for Education in Healthcare, Rhode Island College
- Larry Warner, MPH – Grants Program Officer, Rhode Island Foundation

Key Findings

Our findings are organized in five sections, organized around key questions:

Where do CHWs work? What do they do? Rhode Island CHWs are already working in settings from the smallest grassroots organizations to the largest health systems. In Rhode Island, some work in medical settings including Federally Qualified Health Centers (FQHCs), hospitals, health systems, and clinics. Some are employed directly by payers. A Community Health Team model integrating CHWs on interdisciplinary teams is expanding with support from a variety of initiatives focused on health system transformation, including the State Innovation Model Test Grant and the Care Transformation Collaborative of Rhode Island. Many CHWs also work in organizations that combine social and health services, and community-based organizations. Several Community Action Programs (CAPs) employ CHWs. Some CHW programs are geographically focused, while others target particular populations or health conditions. The Rhode Island Parent Information Network (RIPIN) employs the most CHWs of any organization in the state, and Lifespan is the largest employer that employs CHWs.

Who gets CHW services? Most CHWs work with people with high levels of social need and health risk. Employers and payers use several tools to assess need and risk, including proprietary systems. HIV/AIDS organizations use a comprehensive acuity assessment. Two population-focused programs provide CHW services to all clients of specific prevention and education programs.

How are CHWs funded? No one has found the “silver bullet” solution yet. CHWs in Rhode Island are funded through a broad array of sources and methods. The majority of the funding comes through time-limited philanthropic or categorical public grant funding (“soft money”), rather than payments that are built into health plans or core operating funds. Such “soft” money includes significant investments in health system

transformation, and public grants and contracts for health and social services, in addition to philanthropic support. Community Action Programs (CAPs) employ CHWs with social services funding. Some grant funding targets specific health conditions or populations. Payers support CHWs on a fee-for-service basis only in extremely limited settings and situations, but support through alternative payment mechanisms like capitation is gaining ground. Several larger organizations fund CHWs through core operating funds. Funding for CHW workforce development is also supporting trainers and employers.

How are CHWs trained and sustained? CHWs and their employers need more than financial resources to sustain them. Interviewed employers identified key factors including certification and continuing education, administrative infrastructure, hiring procedures, integration onto teams, workplace supports, a career ladder, a professional community building a clear CHW role and identity, and evaluation as important resources for a sustainable workforce.

How can the CHW workforce grow? Key themes emerged from interviews with employers and stakeholders, indicating a growing consensus in the field. There is momentum building among employers, payers and government for expanding the CHW workforce. Employers are using innovative strategies to support CHWs. Pay-for-value approaches hold more promise than fee for service models. Training and workforce development resources are available now. And employers and CHWs may learn from each other's practices related to workplace supports and evaluation.

Rhode Island has the opportunity to be a national leader in the implementation, growth and sustainability of Community Health Worker models. We hope that this report will provide a useful resource to employers, payers and stakeholders working with CHWs to improve public health.

Methods and Purpose

The purpose of this study was to answer a series of essential questions about Community Health Workers (CHWs) in Rhode Island in 2017, in order to share know-how and promising practices, and help drive action in supporting the CHW workforce. We wanted to know 1) Where do CHWs work? What do they do? 2) Who gets CHW services? 3) How are CHWs funded? 4) How are CHWs trained and sustained? 5) How can the CHW workforce grow?

To answer these questions, study author Brady Dunklee conducted 25 employer and stakeholder interviews, from May to November 2017. Interviewees were identified and recruited first by Rhode Island Department of Health (RIDOH) managers' working knowledge of the field, then by asking participants to identify other candidates to interview. **The sample aims to be representative and diverse, but not exhaustive.** Interviews began with prepared questions, but took the form of open-ended conversations, focused on CHW roles, funding, and sustainability. Participants defined "CHW" for their own context, but were prompted with the American Public Health Association (APHA) definition and a list of job titles commonly listed under the umbrella term "Community Health Worker." Findings are limited to the individuals and organizations who agreed to participate, and to self-report in interviews and follow-ups. Findings were not independently verified. This was a qualitative study, and does not provide substantial quantitative information on Rhode Island's CHW landscape.

This report is structured in two sections: a report on findings organized by the study's essential questions, followed by a series of case studies profiling organizations and programs with CHWs, and stakeholders.

1. Where do CHWs work? What do they do?

The short answer:

Rhode Island CHWs are already working in settings from the smallest grassroots organizations to the largest health systems. In Rhode Island, some work in medical settings including FQHCs, hospitals, and clinics. Some are employed directly by payers. A Community Health Team model integrating CHWs on interdisciplinary teams is expanding with support from a variety of initiatives focused on health system transformation, including the State Innovation Model Test Grant and the Care Transformation Collaborative of Rhode Island. Many CHWs also work in organizations that combine social and health services, and community-based organizations. Several Community Action Programs (CAPs) employ CHWs. Some CHW programs are geographically focused, while others target particular populations or health conditions. The Rhode Island Parent Information Network (RIPIN) employs the most CHWs of any organization in the state, and Lifespan is the largest employer that employs CHWs.

“In this pay-for-value world that we’re entering, I think to be successful it takes a CHW.”

-Carrie Bridges Feliz, Lifespan Community Health Institute

At a glance: Where do CHWs work? What do they do?

How this section is organized

What is a Community Health Worker?

Settings and Roles

Clinical

- Primary Care Providers
 - CTC-RI Community Health Teams
- Federally Qualified Health Centers
 - Blackstone Valley Community Health Center
 - Providence Community Health Centers
 - Thundermist Health Center
- Health Systems & Hospitals
 - Lifespan
 - South County Health
 - CareNE / Integra (*not current CHW employer*)
- *Perspective: Carrie Bridges Feliz, Lifespan Community Health Institute*
- Free Clinics
 - Clínica Esperanza Hope Clinic

Combined Clinical and Social Service Organizations

- RI Parent Information Network (RIPIN)
- East Bay Community Action Program (EBCAP)
- Family Service of RI

Social Service Organizations

- Community Action Partnership of Providence

Payers

- Blue Cross & Blue Shield of Rhode Island (*not direct employer*)
- Neighborhood Health Plan of Rhode Island

Government

- Various, detailed in other sections

Community-Based Organizations

- Project Weber/RENEW
- Dorcas International Institute of Rhode Island
 - *Perspective: Dannie Ritchie, Community Health Innovations of Rhode Island*

Owner-Operator

- Our Journ3i

Health Promotion Programs

- Geographic-focused
 - Community Health Teams
 - Health Equity Zones
- Population-focused
 - Center for Prisoner Health & Human Rights, Rhode Island Department of Corrections
 - Dorcas International Institute of Rhode Island
 - Project Weber/RENEW
- Health Condition-focused
 - HIV/AIDS programs
 - Lifespan Cancer Institute and asthma programs
 - RIDOH health promotion programs
 - Home Asthma Response Program (HARP)

What is a Community Health Worker?

For the Rhode Island Department of Health, Community Health Workers are **frontline, public health professionals who often have similar cultural beliefs, chronic health conditions, disability, or life experiences as other people in the same community**. As trusted leaders, they often serve as a link between their community and needed health or social services. Community Health Workers help to improve access to, quality of, and cultural responsiveness of service providers. The Rhode Island Department of Health understands that health is about more than just medical care and supports the formal certification of these individuals. Health begins where we live, learn, work, and play.

For the American Public Health Association, “[a] community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”¹

An Umbrella Term

Community Health Worker, or CHW, is an umbrella term that may include a number of job titles:

- Community Health Educator
- Outreach Educator
- Outreach Worker
- Enrollment Worker
- Health Advocate
- Peer Advocate
- Peer Leader
- Street Worker
- Youth Outreach Worker
- Family Advocate
- Family Planning Counselor
- Family Support Worker
- Doula
- Patient Navigator
- Promotor(a) de Salud

Source: Wilkinson, G., 2017.

Not all employers or workers with these titles consider themselves CHWs, and not all CHWs have one of these titles.

In the same way, “physician” is an umbrella term that includes professions of many titles: surgeon, pediatrician, and cardiologist, for example.

Settings and roles

Rhode Island CHWs work in settings ranging from clinical to community-based, in institutions occupying church basements and skyscrapers. This section reviews CHW employers in the state who were interviewed for the project, and is intended to provide

¹ APHA, 2017. Available at <https://www.apha.org/apha-communities/member-sections/community-health-workers>

a representative cross-section, but not an exhaustive list. The organization employing the greatest number of CHWs in the state is the Rhode Island Parent Information Network. The largest organization that employs CHWs is Lifespan. Employers and programs are grouped by category, some of which overlap.

Clinical

Primary Care Providers

There have been some attempts to employ CHWs in smaller-scale primary care practices, but the bulk of CHWs supporting primary care are working at Federally Qualified Health Centers (FQHCs), and/or employed on Community Health Teams that serve multiple primary care providers in a given region. Community Health Teams, or CHTs, are the CHW employment model most favored by state health system transformation efforts. The Care Transformation Collaborative of Rhode Island (CTC-RI) has funded two CHTs with health plan resources for several years, and the State Innovation Model Test Grant (SIM) has recently funded and/or fostered alignment to expand CHTs in the state. SIM's CHT Consolidated Operations Model is being implemented by vendor CTC-RI, working with subcontractors, to provide centralized administrative support. Six teams are participating in the Consolidated Operations Model. A CHT in this model includes at least two CHWs, and a Community-Based Licensed Health Professional (typically a behavioral health clinician).

“When [primary care providers] get used to CHWs, they love them. [...] In the past you felt like, ‘how will you help this person?’ [...] They go from feeling they are under water, to feeling like this is a team effort.”

-Susanne Campbell, CTC-RI.

Community Health Teams employing CHWs are supported by SIM and CTC-RI, payers, and other leveraged funds. Community Health Teams (CHTs) in Rhode Island are interdisciplinary outreach teams focused on high-risk/high-cost patients. CHTs in this model include at least two Community Health Workers, and a Community-Based Licensed Health Professional (CBLHP) such as a behavioral health specialist, a nurse care manager, and in some cases a social worker. CHTs use care management processes to address patients' physical and behavioral health needs, health education, and social determinants of health.

CHTs were piloted beginning in 2014, drawing on models from Vermont Blueprint for Health and Maine Quality Counts. The Care Transformation Collaborative of Rhode Island (CTC-RI) organized pilot teams at South County Health and Blackstone Valley Community Health Center. Health plans funded these pilots through CTC-RI for a total budget of \$600K. The target population

is high-risk, high-utilization patients who are frequently in the Emergency Department, or admitted as inpatients, have behavioral health conditions, and are disengaged from primary care. The intended focus is the top 5% of utilizers, including patients with advanced illness, episodic or persistent high spending patterns. Nurse Care Managers at CTC-RI practices can refer patients to a CHT in their geographic area if they meet a threshold of current risk, or exhibit rising risk. Non-CTC practices can also refer patients, as long as an agreement is in place. Referrals are geographically-based and payer-agnostic. All CHTs serve specific geographic areas and are co-located in Rhode Island Department of Health (RIDOH) Health Equity Zones.

Rhode Island's State Innovation Model Test Grant (SIM) is an initiative to transform healthcare delivery and financing by combining integrated population health and payment reform, which is supporting CHTs. SIM's vision is "to create one integrated and comprehensive health system that extends into the community setting to provide sequenced care and follow-up for Rhode Island's highest-risk patients (including those with physical and behavioral health conditions)." The project works to enable a transition to "value-based care that addresses social and environmental determinants of health," achieving the triple aim of better health, better care, and lower costs. Supporting the expansion of Community Health Teams is one major SIM project activity. SIM has also braided funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement SBIRT as part of the CHT expansion project. SBIRT stands for Screening, Brief Intervention, and Referral to Treatment, and is an evidence-based approach to identifying and addressing problematic substance use among patients. The Care Transformation Collaborative of Rhode Island (CTC-RI) is funded by SIM and health plans to expand and support CHTs. CHTs currently operating or newly established:

- **South County Health** – Currently operating. Serves Washington County. CTC-RI Health Plan funding and SBIRT funding. 2 FTE CHWs, 1 SBIRT worker, 1 Behavioral Health Care Manager.
- **Blackstone Valley Community Health Center** – Currently operating. Serves Pawtucket/Central Falls. CTC-RI Health Plan funding and SBIRT funding. 2 FTE CHWs, 1 SBIRT worker, 1 Behavioral Health Care Manager.
- **Thundermist Health Center** – One new CTC-RI CHT split between West Warwick, Woonsocket., SBIRT and SIM funding. 2 Community Health Access Teams (CHATs) leverage Fee For Service arrangement with Neighborhood Health Plan of Rhode Island (NHPR), and philanthropic support. 2 FTE CHWs split between teams, 2 SBIRT workers, 1 Behavioral Health Care Manager.
- **Family Service of RI** – New CHT forming. Serving Providence. SIM and SBIRT funding. 2 FTE CHWs, 1 SBIRT worker, 1 Behavioral Health Care Manager.
- **East Bay Community Action Program (EBCAP)** – New CHT forming. Serving Newport. UnitedHealthcare funding via the Office of the Health Insurance Commissioner (OHIC) and SBIRT funding. 2 FTE CHWs, 2 SBIRT workers, 1 Behavioral Health Care Manager.

⇒ *For more information on CHTs, see case studies in the appendices on CTC-RI, the State Innovation Model (SIM) Test Grant, South County Health, Thundermist Health Center, Blackstone Valley Community Health Center, Family Service of RI, and East Bay Community Action Program (EBCAP).*

“We wish everyone in the system understood only 10% of health happens in the doctor’s office. Until we’re there, CHTs are the connector between the 10% and the rest. The hope is to demonstrate cost containment with our CHT model, and show providers that addressing social determinants of health is the way to go.”

–Marti Rosenberg, State Innovation Model.

Federally Qualified Health Centers (FQHCs)

At least four Community Health Centers in Rhode Island employ CHWs in addition to, and distinct from CHWs on Community Health Teams (CHTs) hosted at FQHCs. These CHWs typically focus on patients who are disengaged from primary care, those who have multiple chronic conditions and hospital use, and who are identified by payers as high-risk/high-cost. Thundermist and Blackstone Valley Community Health Centers (CHCs) have used CHTs since 2014, and CHTs are being added at EBCAP and Providence Community Health Centers’ Olneyville site, by Family Service of RI. However, CHWs employed by FQHCs also work in school and City government settings, case management, insurance enrollment, and asthma care, and help promote access to social services.

⇒ *EBCAP, a Community Action Program and FQHC, is detailed in the Combined Clinical and Social Service Organizations section.*

Blackstone Valley Community Health Center (BVCHC) employs CHWs in school-based, city government, and Community Health Team settings. Two CHWs have been employed by the health center for two years. One CHW is employed by BVCHC to work at the Central Falls City Office on Health. This CHW calls all Central Falls residents who have had Emergency Medical Services (EMS) transportation after 72 hours to connect them to primary care. She runs data on EMS transports, focuses on frequent users, does intensive case management, and connects them to resources. BVCHC has seen a reduction in ambulance transport since this intervention started. BVCHC also embedded a CHW in its school-based clinic at Central Falls High School. She focused on enrolling students as patients, and reducing teen pregnancy. BVCHC has reported strong increases in enrollment and reductions in pregnancy as a result. A CTC-RI Community Health Team is also based at BVCHC, employing two CHWs since 2014.

BVCHC uses a multi-stakeholder approach to address the socioeconomic and environmental determinants of health among high-risk patients in Central Falls. This approach includes CHWs. Central Falls is an unusual community: a densely populated small city, with little private transportation and more than 70% of residents speaking a language other than English. A multidisciplinary team meets weekly at BVCHC to discuss high-risk patients. The meetings typically include representatives from housing agencies, EMS, a recovery organization, the police department, and others, and BVCHC CHWs participate. Anyone can bring a patient to the meeting's attention, and the goal is "to figure out how to take care of everybody." This may mean sending a CHW to knock on someone's door, often to help with mental health and substance use disorder referrals. In working with homeless people, the group takes a Housing First approach, working to address housing needs as prerequisites to solving medical problems. The meeting relies on personal communication, rather than data sharing that would create a heavy privacy burden.

“CHWs really are the glue in how you make the theory of prevention practical to real people.”

-Michael Fine, MD, Blackstone Valley Community Health Center.

Providence Community Health Centers (PCHC) employs Community Health Advocates (CHAs) in their Case Management department, who work with high-risk patients. CHAs connect patients to community resources and support English-Spanish translation. Sixty percent of PCHC patients are bilingual. CHAs must be bilingual as well, and pass a language test. Their primary role is to provide case management including culturally sensitive translation, and connections to social and community resources identified by the nurse case manager through assessment and plan of care interventions. CHAs may work on socioeconomic and environmental determinants of health that are identified as barriers, as well as help patients fill out forms, understand written materials, or speak with medical or service providers. CHAs frequently help patients access transportation and food resources. They identify and help overcome obstacles to keeping medical appointments.

PCHC also employs patient navigators to promote and support cancer screenings through grant funding. Navigators have a different scope of practice than case management CHAs, and work in the clinical practice. They are funded by a RIDOH grant to support screenings for cancer among women, and colorectal cancer.

Thundermist Health Center uses Community Health Access Teams (CHATs) with CHWs to target high-risk patients. Thundermist has employed two CHATs since 2014 that include two CHWs, an LICSW, and behavioral health specialists. CHATs were originally proposed to the health center by Neighborhood Health Plan of RI (NHPRI) as a way to address socioeconomic

and environmental determinants of health outside of the clinic walls among high-risk Medicaid patients. In addition to CHWs working with CHATs, Thundermist also employs a CHW focused on asthma, funded by RIDOH.

⇒ *Thundermist has a unique payment arrangement for CHATs. See “How are CHWs funded?”*

Health Systems and Hospitals

Lifespan, the state’s largest health system and largest private employer, has recently formalized Community Health Worker job descriptions, and posted positions for CHWs in adult primary care, cancer and pediatric asthma. The Lifespan Community Health Institute (LCHI) views CHWs as a key strategy to address population health by addressing the socioeconomic and environmental determinants of health.

⇒ *See also the Center for Prisoner Health & Human Rights, and LCHI Director Carrie Bridges Feliz’ perspective on CHWs.*

South County Health (SCH), a health system and a member of the Integra Community Care Network Accountable Care Organization (ACO), has had a Community Health Team through CTC-RI since 2014. Elizabeth Fortin of South County Health is the Program Director for CTC-RI’s expansion to six Community Health Teams statewide. Two CHWs on South County’s own CHT benefit from having South County Hospital in the health system: they make hospital visits to patients, and integrate with SCH’s Case Management Department. Each CHW on the South County Health CHT has a caseload of roughly 50 patients at a time, and sees 200-300 in a given year.

Integra Community Care Network is an ACO and Medicaid Accountable Entity, including health system **Care New England**, that has not employed CHWs to date, but is beginning to engage in population health. Integra and Care New England leaders interviewed for this project believe population health efforts and resources may drive interest in a CHW workforce.

Perspective

From an interview with

Carrie Bridges Feliz, MPH

Director, Lifespan Community Health Institute

“I was a biology major in college. The instructor had this refrain when he was describing biological pathways: ‘it takes a protein.’ That has stuck with me. I feel that way about Community Health Workers. **In this pay-for-value world that we’re all entering, I think to be successful it takes a CHW.** That has to be a part of the team. [...] There is overlap between Community Health Workers and Nurse Care Managers. The bend has been towards more clinical management. But we still really lack that CHW function in all these permutations at the adult and pediatric side of Patient-Centered Medical Homes. I know there’s desire, but there are some hurdles in the payment structure that are still preventing us from doing what everybody wants to do. We don’t have CHWs in [primary care practices]. We want them, but fundamental money mechanisms are preventing it. We want to get to that state of affairs. I think it will really make a difference in patient outcomes and in costs in the value equation. What will get us to the point that we are willing to test that I’m not exactly sure. I can speculate. I’m optimistic that we will get there, probably just in a piecemeal fashion. I think it is an essential function in this value-based world we are all leaning into.”

“It goes without saying that part of the limitations of social work in the hospital setting is that it is not reimbursed. We have invested in social workers because we see their value, but it’s expensive. But I think it’s the cost of doing business. It would be great to have that role reimbursed by insurers. Until we reach that day I want to help my employer see this as just the cost of doing business, but a worthwhile cost. We are working to build the evidence and we are at the beginning of that process.”

[Interviewer asks “if you had three wishes.”] “I’d wish for the money to pay for CHWs. I’d wish for evaluation supports to evaluate them. When you think of sustainability, you think of people, training, the cultivation of a pathway. You think about job opportunities. [...] Not just training to create CHWs, but training to help maintain and grow them. I would wish for an institute [...] to provide support to employers and CHWs themselves.”

“I also hope we do this in a way that doesn’t distort the original intent of CHWs. The intent is they’re from the community, they don’t need advanced degrees, they don’t need credentials because they bring instead the credibility of lived experience, networks. I don’t want us to get so fancy we forget what their real value is, and that we value it. There should be opportunities for folks with the expertise we need to be gainfully employed and be contributing members of public health and healthcare landscapes. Sometimes we get in our own way.”

Free Clinics

CHWs called Navegantes have long worked and been trained at **Clínica Esperanza / Hope Clinic (CEHC)**, a free clinic providing care to uninsured, predominantly Spanish-speaking patients in the Olneyville neighborhood of Providence. Navegantes (navigators) at CEHC conduct culturally-attuned health education, outreach and screenings to clinic patients, including diabetes prevention and promotion of medication adherence. They are also trained

medical interpreters, and help connect patients to medical services beyond the clinic as needed.

⇒ *CEHC is developing an innovative pay-for-success model called Bridging the Gap – more in “How are CHWs funded?”*

Combined Clinical and Social Service Organizations

RIPIN, EBCAP and Family Service of RI (FSRI) are larger organizations with a broad array of health and social services. EBCAP is a Community Action Program with an integrated FQHC, FSRI is a human services agency with extensive programming in behavioral health and HIV/AIDS, and RIPIN began as a community organization that grew into a number of health and social service arenas. Together these three represent roughly two thirds of the CHWs employed by organizations interviewed for this study.

The **Rhode Island Parent Information Network (RIPIN)** employs 61 active certified CHWs as of this writing, making it the largest CHW employer in the state. 76 RIPIN CHWs completed the grandfathering process in which in-service CHWs could be certified in 2017. RIPIN has maintained a core focus on children with special needs, while expanding to provide peer navigation, coaching and advocacy in a number of health and social service arenas. RIPIN has a strong belief in centering shared experience: all frontline staff are peers of their programs’ target populations, or have experience navigating the systems the programs engage.

Within RIPIN’s in-house programs, CHWs support systems navigation, coaching and advocacy for parents of children with special needs. Parents of children who have completed Early Intervention provide peer support to parents beginning the process. The Family Voices program provides healthcare information, leadership development and support for children and youth with special healthcare needs or disabilities. One role RIPIN CHWs play is to train families and providers to use the Family Voices national website to access vetted health information and resources, and access the Medical Home Portal. RIPIN is also the federal designee to operate a parent information and training center, supported with a grant administered by the Rhode Island Department of Education (RIDE).

RIPIN CHWs are also embedded in healthcare and health promotion settings. Patient Navigators work with RIDOH to operate the Community Health Network, a centralized system to provide telephone-based referrals to patient education and prevention programs, including diabetes prevention and chronic disease self-management, and the WISEWOMAN cancer screening program. Four RIPIN CHWs act as technical assistance liaisons to Health Equity Zone programs. CHWs also support programs in fall reduction for older adults, WIC referrals, immunization, birth defect prevention, and emergency preparedness.

RIPIN is building CHW apprenticeship. In registered apprenticeship, an employer provides integrated on-the-job and classroom skills training to entry-level employees. Apprentices receive a wage progression as their skills and experience grow, progressing to become fully qualified employees over the course of one or more years. Apprenticeship RI promotes

apprenticeship in the health sector and other industries, by providing in-kind technical assistance.

RIPIN plans to **pilot a CHW apprenticeship with two new hires in 2017**. They have worked with Apprenticeship RI to compile and adapt in-house training activities, and build and register standards for a Peer Navigator program. Peer Navigators will work in school-based settings while completing their training and certification over the course of a year.

⇒ *For more on the apprenticeship model in the health sector, see the case study in the appendices on Apprenticeship RI.*

East Bay Community Action Program (EBCAP) is a CAP with an integrated FQHC providing health and human services in Rhode Island's East Bay communities. Community Health Workers in the Integrated Health program focus on outreach, health insurance enrollment, and connecting patients to social services. CHWs work under three job titles, each with two full-time employees:

- *Health Advocates* – join patients in exam rooms at the Community Health Center, to do social service assessments as part of intake, intervene in social crises, and work to prevent homelessness and food insecurity.
- *Patient Engagement Specialists* – find, and work to engage patients in the community who have not been in contact with EBCAP, but are attributed to the primary care practice by Medicaid through HealthSource RI. They target high-risk patients with Emergency Department use but little or no connection to primary care.
- *Outreach and Enrollment Navigators* – provide health insurance enrollment navigation and support to community members under contract with the RI Health Center Association.

Along with other program staff, CHWs perform social needs “get-to-knows” for everyone new to the practice, to identify socioeconomic and environmental determinants of health. “If someone comes in with a specific need, there’s probably something else that’s attached to it,” says Carla Wahnon, Integrated Health Manager. CHWs coordinate with Nurse Care Managers to engage people in primary care, increase levels of screenings, and connect them to other available services.

Family Service of Rhode Island (FSRI) is a large social service organization that operates and supports a variety of health programs. The majority of clients served are under 18, but there are adult services in several program areas, including HIV/AIDS service provider AIDS Project RI. Twelve CHWs at FSRI are Case Managers working in at least four programs. Case Managers are primarily existing FSRI employees who are being grandfathered in as certified CHWs.

FSRI is participating in the Community Health Team (CHT) expansion, adding a CHT in Providence that incorporates Screening, Brief Intervention and Referral to Treatment (SBIRT). At Providence Community Health Centers’ Olneyville site, two new bilingual CHWs and SBIRT workers have started integrating

with the pediatric practice, and providing SBIRT screening for adults. CHWs on the CHT will also work at Crossroads RI doing SBIRT among the homeless population and referring to a new program to work on Medically Assisted Treatment for opioid use disorder. At St. Joseph's Health Center a CHW will assist with screenings and assessments, and the CHT is working out the details of a relationship with a primary care provider in East Providence.

Mental health services at FSRI use CHWs in home-based and outpatient programs. The In-Home Services Department uses Case Manager CHWs to conduct Trauma Systems Therapy with minors and their families, under contract with the Rhode Island Department of Children, Youth and Families. In Outpatient and Enhanced Outpatient Services, the case management team supports functional family therapy. Using a CHW as part of the team is a strategic way to integrate all the systems a child has contact with, so that no matter the system, there is coordination and consistency.

AIDS Project Rhode Island also uses CHW case managers who will be trained in SBIRT. The CHW will also screen for socioeconomic and environmental determinants of health.

Social Service Organizations

A number of employers interviewed for this study provide social services, and the distinction between Clinical, Combined Clinical and Social Service, Social Service, and Community-Based Organization is somewhat arbitrary. CHWs' work is largely about blending or integrating health and human services, or working within a third category. The socioeconomic and environmental determinants of health are addressed by programming that falls within traditional social services:

Community Action Partnership of Providence (CAPP) is a social services agency without an embedded FQHC. However, its activities address the socioeconomic and environmental determinants of health through heating assistance, food pantries, lead safety, weatherization, veterans' issues and economic supports. Executive Director Rilwan Feyisitan views all of these activities as interconnected with community health, and considers navigators, resident educators, benefit eligibility specialists and other staff to be CHWs.

Payers

Some health insurance carriers in the state have opted to employ Community Health Workers directly. Neighborhood Health Plan of RI (NHPRI) and Blue Cross & Blue Shield of Rhode Island (BCBSRI) were interviewed for this study. NHPRI's CHWs focus on high-risk patients in two community-based programs. BCBSRI's Health Advocates focus on case management.

⇒ *For information and perspectives about health plans' support of CHWs as payers see "How are CHWs funded?"*

Neighborhood Health Plan of Rhode Island (NHPRI) directly employs CHWs as Community Care Coordinators on interdisciplinary care teams. Understanding and addressing socioeconomic and environmental determinants of health for a patient is an integral part of the work done by CHWs. NHPRI CHWs may have different roles depending on the needs of the patient. Their

work may include completing health risk assessments or referring members to services, utilities, and food and housing supports. “Sometimes it’s amazing what the CHW uncovers in the home, [...] bringing people to a higher level of care,” says Yvonne Heredia, Manager of Case Management at NHPRI.

The NHPRI Health@Home Program employs CHWs to support home-based primary care for high-risk patients. Patients enrolled in the Health@Home Program typically have multiple chronic conditions, and frequent Emergency Department visits and inpatient hospitalizations. Nurse practitioner (NP) led teams for the Health@Home program are assigned geographically. One or two CHWs work with each NP. A comprehensive in-home assessment is conducted by the NP to identify medical, behavioral and social needs. The CHW’s role is to support the treatment plan outlined by the NP, which may include providing services such as taking vital signs, reinforcing medication adherence as directed by the NP, or facilitating transportation to provider visits using the state’s Logisticare program or cab vouchers. Health@Home CHWs go through the state’s CHW certification process.

Blue Cross & Blue Shield of Rhode Island (BCBSRI) employs Health Advocates in their Case Management department to provide telephone-based support to members, and direct and refer them to health education classes at BCBSRI retail locations. These classes are peer-taught and evidence-based, including topics such as fall prevention, diabetes education, biometrics, and Alzheimer’s support. BCBSRI also refers members to CHWs on Community Health Teams, which are supported in part by BCBSRI’s participation in the CTC-RI multipayer initiative.

Government

The Rhode Island Department of Health (RIDOH), and the Rhode Island Department of Corrections (RIDOC) employ CHWs. RIDOH contracts with RIPIN for peer support in many of its programs, and RIDOH funds RIDOC to provide an HIV/AIDS peer navigator in the Adult Correctional Institutions (ACI). In turn, RIDOC contracts with the Center for Prisoner Health and Human Rights, a center of Lifespan, to provide medical discharge planning at the ACI. At the municipal level, the City of Central Falls funds a Blackstone Valley Community Health Center CHW to work with their City Office on Health, and the Providence Public School Department works with Dorcas International Institute CHWs at their Newcomer School. RIDOH funds Health Equity Zones (HEZs), whose backbone agencies include municipal governments. Some HEZs employ CHWs, and four RIPIN CHWs act as liaisons to the HEZs.

⇒ *For more on CHWs serving justice-involved individuals, see the Center for Prisoner Health and Human Rights profile in Population-Focused Programs.*

⇒ *For more on HEZs, see Geographic-Focused Programs.*

Community-Based Organizations

Project Weber/RENEW and Dorcas International Institute of Rhode Island (DIIRI) are the two organizations interviewed for this project that best fit the profile of a

Community-Based Organization (CBO) by their size, constituencies and activities. Although Clínica Esperanza is a free clinic profiled in the clinical section, it could also be considered a CBO with deep community roots, a small operating budget and volunteer support. RIPIN started as a CBO, and keeps a strong peer-led focus, but has grown in size and scope. And Our Journ3i Works is a “perinatal community-based wellness organization” with a strong focus on communities of color, but is also the only owner-operator interviewed for this study, and deserves a separate category.

⇒ *Project Weber/RENEW and DIIRI CHWs are profiled as Population-Focused Programs below.*

Perspective

From an interview with

Dannie Ritchie, MD, MPH

Clinical Assistant Professor of Family Medicine, Brown University;
Founder, Community Health Innovations of Rhode Island

Community Health Workers aren't new. There's talk that CHWs are an emergent workforce, but they came out of the Community Health Center movement, and the community and migrant health movement in the '60s. They were also a way to try and promote entry-level employment for people in underserved communities. Efforts to expand and support the CHW workforce have been underway for many years, which include the national campaign for professional recognition. It achieved designation as a profession and occupational code by the US Department of Labor in 2009.

The Community Health Center that I practiced in during my Family Medicine Residency had Community Health Representatives (CHRs), one of the terms used for CHWs. Our community-based practice understood CHRs to be the face of the community, and to communicate that this was a welcoming place because they had people from and with community there. That's a real statement in terms of the approach that you take with serving underserved people of color. When I completed residency and did my national health service corps I worked with the Indian Health Service, (IHS), where they too have Community Health Representatives. IHS remains a federally supported CHW program.

When the Transcultural Community Health Initiative, a cross-disciplinary, cross-agency and workforce group, decided to promote and support community decision-making to address health disparities in 2003, we decided to do it through the promotion of the CHW workforce. We did a Rhode Island Foundation series on health disparities and CHWs. We found that we were asking the same questions that were being asked nationally and to some extent still. They are questions like "how many CHWs are there," and "where do they work?" There is still a need to quantify. However, studies we did with the RI Department of Labor and Training in 2009 and 2014 along with the DLT labor statistics generated counts of CHWs in the state that vary widely. So something is wrong about how we are counting, and we are not paying attention to it. It speaks to the need for better agreed-upon ways to quantify for better precision and accuracy.

The organization that I founded, Community Health Innovations of Rhode Island, currently trains CHWs, creates policy models, and does academic teaching and research in support of CHWs. It has a participatory, assets-based philosophy at the core that is community-centered and focused. I believe if you keep those things always in your mind and ask the community, get them involved, it's much different from helicoptering in. It's about equity. And it recognizes that we're all learners and teachers, understanding we can learn and develop better programs when we include the rich and diverse voices and knowledge of the community.

It's critical that CHWs maintain their community focus. It's also vital that we recognize the need to develop CHWs' skills through training, and make sure that they are paid for the work that they do, which is primarily about addressing the Social Determinants of Health (SDOH). In the move to pay-for-value, that can include CHWs as part of the Community Health Team, many still remain fixated on Fee For Service. Minnesota payment for CHWs did this and now has required a narrow, healthcare frame for CHWs' work, which limits the work they can do. That's the danger, that's the warning, that as we fashion programs with only a clinical focus, not the larger social ramifications, we will not see the value of addressing the SDOH and community needs and assets.

Since I started work here in RI on health disparities, there have been insights and discussions leading to the use of the term health equity, and the understanding that disparities are a measure of the lack of equity. One of the reasons I stayed in Rhode Island was that many measures of health disparities were the same, if not worse, than other states, even though there is some of the better access to healthcare. You can knock yourself out trying to improve access, but there are other things that are making people sick. The key is that while the more disenfranchised bear the greater burden of poor health outcomes, all are affected across socio-economic brackets. That is how inequity works. That's where you go to SDOH and start looking at changing structures. CHWs can address SDOH. They are part of the answer in creating a level playing field to create equity and better health for all.

Owner-Operator

Our Journ3i is owned and operated by maternal and child health CCHW Quatia “Q” Osorio. Our Journ3i is based in Providence, and provides doula services and breastfeeding support primarily to African American women, to combat disparities in maternal and child outcomes. She focuses in particular on trauma, anxiety, and empowerment, and sees patients regardless of ability to pay. Whereas low-income mothers often experience judgment, stigma, and distrust in interacting with medical and government institutions, Osorio provides a non-judgmental, culturally concordant approach.

“The Community Health Worker has the whole story,” says Osorio. “The employer wants data, needs to piece it together to justify services, what to include in a Medicaid package. Sometimes basic stuff like being there talking about a budget, you find out other issues like transportation and childcare.” “Community health workers are so valuable. We bring the story with the data.”

Health Promotion Programs

Geographic-Focused Programs

Community Health Teams (CHTs) are geographically focused, starting in clinical settings and extending to the community where people live, work, learn and play. CHTs are extensions of primary care, and operate in locations such as patients’ homes, senior centers, etc., to meet patients where they are. Their role is not to deliver medical care outside of the clinic walls, but to address the root causes of illness related to socioeconomic, environmental, interpersonal, and behavioral issues.

Rhode Island’s **Health Equity Zone (HEZ)** initiative is a place-based, community-driven approach to eliminating health disparities. Partnerships in 9 geographically contiguous areas in the state receive seed funding from RIDOH to carry out locally-tailored approaches to prevent chronic disease, improve birth outcomes, and improve the socioeconomic and environmental conditions of neighborhoods. Many HEZ partnerships employ CHWs, whose activities include resident education and outreach, facilitating local food access, convening breastfeeding support groups, holding lead-safe house parties, and many others. All Community Health Teams in the state are strategically located within place-based HEZs.

Population-Focused Programs

Peer CHWs are working with justice-involved, refugee, and sex worker populations. Their practice includes linkage to primary care, cultural orientation, harm reduction, HIV testing and support to persons living with HIV/AIDS (PLWHA).

The **Center for Prisoner Health and Human Rights** is based at Miriam Hospital, part of the Lifespan health system. The Center is working with the Lifespan Community Health Institute to hire two CHWs to staff a Transitions

Clinic connecting released prisoners to primary care at the Adult Center for Primary Care. This program aims to address the period immediately post-release in which formerly incarcerated populations have a window of high risk for hospitalization, Emergency Department use, overdose, and death. CHWs will meet with patients before release, provide a warm hand-off, meet patients in the clinic at regularly scheduled times, and offer long-term support. They will also assist with Medicaid enrollment.

The Center has also contracted with the Rhode Island Department of Corrections to hire a CHW to support medical discharge planning within the Adult Correctional Institutions (ACI). Staff are working to coordinate efforts between the ACI-based and community-based teams.

The Rhode Island Department of Corrections is also a grantee of RIDOH's Peer Navigator demonstration project, using a Peer Navigator to conduct HIV testing for individuals in the intake center at the ACI.

Dorcias International Institute of RI (DIIRI) uses a specialized CHW program to provide health systems orientations to newly arrived refugees in its resettlement program. DIIRI trains and contracts with CHWs with shared language and experience to meet with families within a few weeks of arrival, and provide systems navigation for the first three months. Using clients' native languages, they introduce the basics of the healthcare system, language, and cultural customs around health. They help clients understand appointments, and how to pick up prescriptions, use medical insurance, and take the bus. They introduce the US emphasis on medical specialization and preventive care, and ensure proper documentation of vaccinations. CHWs are paid a stipend per arriving family, and intensity of services varies by circumstance. A DIIRI CHW also works with unaccompanied minor immigrants, and there are CHWs working at the Providence Public School Department's Newcomer School focused on parent engagement. Eighteen CHWs are currently working with DIIRI, and the organization is pursuing RIDOH certification for them.

Project Weber/RENEW uses peer CHWs for harm reduction and health promotion among sex workers and high-risk women and men, including transgender sex workers. CHWs work under the titles Peer Outreach Worker, Drop-in Center Manager, and Transgender Peer Outreach Worker, and seven of eight have been certified as CHWs as of this writing. Project Weber/RENEW united two harm reduction programs for at-risk people in Rhode Island. RENEW had focused on the needs of female sex workers in Providence, Pawtucket and Central Falls, while Project Weber focused on male sex workers in Providence. The two organizations merged in 2016, "in order to serve the full range of sex workers and high risk women and men, including transgender sex workers²." Both programs were historically peer-led, and continue to be staffed predominantly by people with lived experience of sex work, substance use and HIV. Weber/RENEW has a positive relationship with law enforcement, who see

² weberrenew.org

the program as a resource to reduce arrests, and refer sex workers to the CHWs in the program.

Weber/RENEW CHWs focus on outreach, HIV and recovery support, trans* health, education and basic needs. CHWs at Weber/RENEW work under several titles. Peer Outreach Workers provide health education, support, HIV testing, needle exchange, and basic needs support. Drop-In Center Managers manage these services, and are CHWs themselves. A Transgender Peer Outreach Worker focuses on street outreach to at-risk trans* community members. The PrEP case manager is focused on enrolling high-risk HIV-negative male sex workers for a Brown University/Miriam Hospital study on case management and PrEP adherence, but provides referral services for others. Most staff are trained recovery coaches or peer recovery support specialists, and help deliver naloxone and fentanyl training.

Health Condition-Focused Programs

Many CHWs are employed to support patients with particular health conditions. HIV/AIDS is the leader in this field by number of CHWs and collective experience utilizing them as non-medical case managers, but CHWs also work in the cancer navigation, diabetes prevention and management, and asthma fields.

The HIV field has a great deal of experience in managing the socioeconomic and environmental determinants of health, because factors such as housing, linkage to care, nutrition, and mental and behavioral health are primary determinants of outcomes for people living with HIV/AIDS. **Non-medical case managers work at three HIV/AIDS service organizations** in the state, and must have a high school diploma, documented work hours, and supervision by an LICSW, but certification is not required. Many case managers are HIV positive, although agencies often have mixed status teams.

RIDOH is currently supporting a **Peer Navigator** demonstration project with \$500K of Ryan White supplemental funds granted to eight recipients as part of its 90/90/90 program. Grantees include the three AIDS services organizations that have used non-medical case managers historically (**AIDS Care Ocean State, AIDS Project RI, Community Care Alliance**), as well the **Miriam Hospital, Sojourner House, Project Weber/RENEW, Youth Pride RI**, and the **Rhode Island Department of Corrections**. Five to ten peer navigators are compensated by grant funds, including as many as five new hires. PrEP navigators at the Miriam Hospital Infectious Disease Clinic focus on office-based follow-up with patients who have missed appointments or stopped adhering to PrEP regimens.

The **Lifespan Cancer Institute** is in the process of hiring a CHW to supplement the continuum of support for cancer patients. CHWs are different from, but complementary to the role of existing navigators and social workers, and will focus on finding patients who need extra support to get from a mammogram to follow-up services. They will extend ancillary services, beginning by sealing gaps in existing referral pathways. Lifespan is also hiring

a CHW for its **Community Asthma Programs at Hasbro Children's Hospital.**

RIDOH supports CHWs working for tobacco cessation and chronic disease management programs. A tobacco cessation specialist provides counseling as part of RIDOH's Tobacco Control Program. Chronic Disease Educators are paraprofessionals employed by RIDOH to use Stanford evidence-based models for educating patients to manage **diabetes, asthma, and cardiovascular disease.**

The **Home Asthma Response Program (HARP)** is an initiative of the New England Asthma Innovation Collaborative (NEAIC), implemented in Rhode Island through a collaboration among RIDOH, Hasbro Children's Hospital, Saint Joseph Health Center, and Thundermist Health Center. In HARP's model a CHW makes three home visits to pediatric asthma patients. CHWs are accompanied in the first visit by Certified Asthma Educators (AE-Cs). They perform home assessments, remove or ameliorate triggers, and educate caregivers on environmental control and medications. They also provide filtered vacuums, bed coverings, and cleaning and pest control supplies. Program staff members help families adhere to physician-directed Asthma Action Plans, or refer families without plans to primary care providers.

2. Who gets CHW services?

The short answer:

Most CHWs work with people with high levels of social need and health risk. Employers and payers use several tools to assess need and risk, including proprietary systems. HIV/AIDS organizations use a comprehensive acuity assessment. Two population-focused programs provide CHW services to all clients of specific prevention and education programs.

Tools and practices for assessing risk and social need

Because most CHW services are provided to patients with elevated health risks and social needs, a number of methods are being used to assess the acuity of these risks and needs. High cost and utilization is one factor in making referrals, but patients may also under-utilize needed services, or exhibit rising risk. The Health Leads and Cambridge Health Alliance Social Determinants of Health (SDOH) assessments, or adapted versions of these tools, are used at several sites. HIV/AIDS service organizations use a comprehensive assessment of acuity specific to their population to drive nonmedical case management. Free clinic Clínica Esperanza takes a different approach, providing CHW-led preventive activities to all patients enrolled in a pay-for-success program. And Dorcas International Institute provides short-term health systems orientations from CHWs to all arriving refugees.

CTC-RI Community Health Teams use several risk assessment tools to help providers make referrals to CHTs, and assess the socioeconomic and environmental determinants of health. The teams also use payer-generated high-risk and rising risk lists.

Thundermist Health Center entered an arrangement with Neighborhood Health Plan of RI (NHPRI) in 2014 to allow billing for Community Health Access Team (CHAT) services to the highest-risk 5% of patients in primary care at the health center. This pool has since expanded, but constitutes less than 10% of the center's medical patient population. NHPRI uses proprietary analytics to develop high-risk lists.

Thundermist developed an assessment process to identify patients in need of, and likely to benefit from CHAT services, who were not part of the population eligible for billing. They began by developing a report that queried those with three or more inpatient stays or Emergency Department visits within the past six months, and those with three or more chronic diseases including behavioral health conditions. This initial list of high-risk patients outstripped capacity. They narrowed the list by assessing the degree to which they could impact the conditions in question. For example, those with frequent

hospitalizations that could benefit from intensive home-based services, or those with unmanaged asthma, scored higher on impactability. The resulting list was not used to exclude patients, but as a starting point for Thundermist primary care providers to refer to CHATs. They have also developed and are piloting an assessment of Social Determinants of Health, drawing from a Health Leads toolkit³, which integrates with the health center’s Electronic Medical Record.

Providence Community Health Centers’ primary care patients receiving case management services from Community Health Advocates (CHAs) are assigned by payers to high-risk lists, or are identified as high-risk by providers and other referral sources. Patients assigned for case management outreach most often are high utilizers of the Emergency Department, and have frequent inpatient stays and chronic conditions including behavioral health diagnoses.

Connect for Health is **Lifespan’s** in-house social needs assessment and referral program based at Hasbro Children’s Hospital, and primary care clinics and Emergency Departments in the health system. Newly hired Lifespan CHWs will be trained to access and use Connect For Health, which was modeled on the Health Leads program.

Blue Cross & Blue Shield of Rhode Island actively seeks out opportunities to provide professional case management to members with high-risk needs, and works to inform their clinical partners in the community about high-risk patients. They use a variety of algorithms and analytics to identify high-risk patients based on claims data, behaviors, medications, and prescription and utilization patterns. Johns Hopkins Resource Utilization Bands (RUBs) are used to calculate risk acuity—categories based on a variety of measures in addition to cost. Members are referred to case management based on these measures, and providers are notified. Case management may refer high-risk members to CHWs on Community Health Teams. This information is particularly valuable to Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) who are accountable for quality and outcome measures.

Neighborhood Health Plan of RI’s Health@Home Program uses proprietary analytics to identify high-risk patients. Members can also be referred by primary care providers. Identified patients are referred to home-based, nurse practitioner-led teams integrating CHWs.

Case managers in **HIV/AIDS service organizations** use the Rhode Island Non-Medical Acuity Scale Worksheet to assess 19 dimensions of acuity. This tool assesses factors including housing, nutrition, and social supports, and is used to provide low income persons living with HIV/AIDS (PLWHA) with

³ <https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/>

comprehensive services including the AIDS Drug Assistance Program (ADAP), food bank assistance, etc.

Whereas many CHW models target only high-risk patients, all patients at **Clínica Esperanza/Hope Clinic (CEHC)** who enroll in the Bridging The Gap pay-for-success program are required to participate in Navegante-taught health education activities. They are enrolled in CurrentCare so that their data can be tracked, and CEHC has an in-house dashboard to support tracking. Five hundred to six hundred patients were enrolled in the first year; more than three hundred are enrolled as of the six-month point in Year Two. CEHC hopes to demonstrate cost savings for this pre-insured population, and promote this model among other free clinics nationally.

All arriving refugees who are clients of **Dorcas International Institute of RI (DIIRI)** receive a health systems orientation from a DIIRI CHW. Intensity of services depends on the individual or family's specific needs.

RIPIN provides services to children with special needs and their families who are trying to navigate social services, healthcare and education. RIPIN's RIREACH program also provides peer support to people in navigating and using health insurance.

The **Home Asthma Response Program (HARP)** focuses on families of pediatric asthma patients with inpatient and/or Emergency Department visits due to uncontrolled asthma. Families are recruited primarily after children have an emergency department visit at Hasbro.

3. How are CHWs funded?

The short answer:

No one has found the “silver bullet” solution yet. CHWs in Rhode Island are funded through a broad array of sources and methods. The majority of funding comes through time-limited philanthropic or categorical public grant funding (“soft money”), rather than payments that are built into health plans or core operating funds. Such “soft” money includes significant investments in health system transformation, and public grants and contracts for health and social services, in addition to philanthropic support. Community Action Programs (CAPs), employ CHWs with social services funding. Some grant funding targets specific health conditions or populations. Payers support CHWs on a Fee For Service basis only in extremely limited settings and situations, but support through Alternative Payment Mechanisms like capitation is gaining ground. Several larger organizations fund CHWs through core operating funds. And funding for CHW workforce development is supporting trainers and employers.

*“In the distinction between health care spending, and social services spending, can we imagine a **blended zone that bridges the two**, and push for investments in that zone to bend the healthcare cost curve, address the social determinants of health, and produce better outcomes?”*

-Larry Warner, Rhode Island Foundation

At a glance: How are CHWs funded?

How this section is organized

Funding Sources and Methods

Grant Funding

- **Grants for Health System Reform & Transformation**
 - Community Health Teams
 - Integra (not current CHW employer)
 - *Perspective:* Marti Rosenberg, James Rajotte
- **Public Grants and Contracts**
 - RIPIN
 - Health Equity Zones (HEZs)
 - Family Service of RI
 - HIV/AIDS programs (various)
 - Project Weber/RENEW
 - Center for Prisoner Health & Human Rights
 - Community Action Partnership of Providence
- **Private Philanthropic Grants**
 - Thundermist Health Center
 - (various)
 - Family Service of Rhode Island
 - Center for Prisoner Health and Human Rights
 - Dorcas International Institute of RI
 - Project Weber/RENEW

Funding Sources Identified

CMS, SAMHSA, Health Plans
CMS
SIM

Various
RIDOH
DCYF
RIDOH, Ryan White Supplemental
RIDOH
RIDOC
Various

Jessie B. Cox Foundation
RI Foundation
RI Foundation
Rhode Island Foundation
United Way of RI
RI Foundation, Elton John AIDS Foundation

Payer Support

- *Perspective:* Charlotte Crist
- **Fee For Service**
 - Thundermist Health Center
 - Cedar Family Centers (RIPIN)
 - Family Service of RI
 - Communities of Care (RIPIN)
 - HIV/AIDS service organizations
 - Dorcas International Institute (medical interpreters)
- **Alternative Payment Mechanisms**
 - CTC-RI
 - Providence Community Health Centers
 - Comprehensive Primary Care Plus
 - RIPIN
 - Blackstone Valley Community Health Center
 - Integra
 - Clinica Esperanza

NHPRI
Medicaid Plans
Beacon
RIDHS, NHPRI, UnitedHealthcare
Medicaid MCOs, EOHHS (Ryan White Part B)
Medicaid Plans

Multi-payer support from health plans
CTC-RI PMPM, Medicare PBPM
CMS

RI Foundation supports PFS model

Operating Funds

- Lifespan
- Neighborhood Health Plan of RI
- Blue Cross & Blue Shield of Rhode Island
- City of Central Falls

Patient Sliding Scale

- Our Journ3i

Funding for Workforce Development

- Institute For Education in Healthcare, RIC
- Clinica Esperanza
- Dorcas International Institute
- RIPIN / Apprenticeship RI
- Employer incentives & workforce devel resources

RIDLT's Real Jobs RI funding
Textron Foundation
United Way of RI
USDOL AAI, DLT OJT funding
Various

Funding Sources and Methods

Rhode Island employers use a broad range of approaches to fund CHW positions. The largest source by number and amount is grant funding, including public sector grants and contracts, private philanthropic grants, and grant funds from efforts to drive health system reform like the State Innovation Model (SIM) Test Grant. But there is also significant support from payers, and from employers' general operating budgets outside of grant funds. Payer support includes a small amount of Fee For Service in limited contexts, and a growing amount of resources through Alternative Payment Mechanisms that are part of the shift towards pay-for-value. Medicaid plans make up the bulk of payer support for CHWs, but not exclusively. Recertification of Medicaid Accountable Entities may present opportunities for growth. Grant funding is also being used to support CHW workforce development.

Grant Funding

Grants are the largest source of support for the CHW workforce, and they span a broad range of purposes, funders, and amounts. They are grouped here as grants for health systems reform and transformation; public grants and contracts; and private philanthropic grants:

Grants for Health System Reform & Transformation

Rhode Island has a high level of collaboration among state agencies, health plans and provider organizations. The SIM and CTC-RI are major systems change efforts involving large sets of stakeholders, braided funding, and substantial resources. A growing number of CHWs are funded through grants linked to health reform efforts.

Community Health Teams are supported from two major initiatives aimed at health system transformation. The Care Transformation Collaborative of RI (CTC-RI) has focused on implementing the Patient-Centered Medical Home (PCMH) model and driving payment reform with support from multiple payers. The State Innovation Model Test Grant (SIM) is a CMS-funded, \$20M project to drive the change from volume to value and achieve the healthcare “triple aim” of better care, healthier people, and lower costs.

Community Health Teams (CHTs) established by CTC-RI in 2014 were originally supported by grant funding from health plans, brokered by the Office of the Health Insurance Commissioner (OHIC). Health plans continue to support teams at South County Health, Blackstone Valley Community Health Center, and Thundermist, while expansion of CHTs currently underway at Family Service of RI, East Bay Community Action Program (EBCAP), and Thundermist is supported by grants from the SIM braided with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). Community Health Workers on CHTs are paid as part of a CHT's general budget.

Supporting the expansion of Community Health Teams (CHTs) that use integrated CHWs to work with high-risk patients, and promoting the CHT model is a major activity of SIM. SIM has allocated \$2 million to

interdisciplinary CHTs, and an additional \$0.5M for the SBIRT Training and Resource Center. SIM is funding a consolidated operations model to provide centralized administrative support to CHTs. CTC-RI is the vendor for this CHT initiative, and multi-payer support for CHTs continues to flow through CTC-RI as well. South County Home Health, a visiting nurse program with home-based occupational therapy, physical therapy and rehabilitation services, has also provided charity funding so CHTs can see people who are not enrolled in CHT-participating South County Health primary care practices. The Rhode Island College School of Social Work is the vendor for the SBIRT (Screening, Brief Intervention and Referral to Treatment) Training and Resource Center.

SIM and the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) have also braided a five-year, \$7.5M grant for SBIRT into the CHT project, creating an aligned effort to address substance use through connections in primary care offices. Many patients seen by Community Health Teams have substance use and behavioral comorbidities. Community Health Workers on the CHTs are also uniquely positioned to address underlying socioeconomic and environmental determinants of health faced by these patients.

The Integra Community Care Network was recently awarded a \$4.5M Accountable Health Communities grant from the Centers for Medicare and Medicaid Services (CMS), to identify and address health-related social needs to decrease total health costs, improve health, and improve quality of care of Medicaid & Medicare beneficiaries. Integra/Care New England do not currently employ CHWs, but project activities include screening for social needs, and navigation services to high-risk beneficiaries to increase connection with effective community resources.

Perspective

From an interview with

Marti Rosenberg, Director, State Innovation Model Test Grant, OHIC

James Rajotte, MS, State Innovation Model Test Grant, RIDOH

Rosenberg: SIM is a payment reform grant that is also focused on improving Rhode Island's population health. We are moving our healthcare system from volume to value.

As we think about how to make Community Health Teams (CHTs) sustainable, we need to deal with a number of challenges. First, even though we are focused on a value-based system where we want to move away from paying for healthcare in a fee-for-service (FFS) system, we need to recognize that the system is still based on this FFS model.

For example, even if some providers take on risk and use a Total Cost of Care model to take care of their patients, there are still services that will be billed individually. And that would be the case if to sustain CHTs, providers wanted their CHT members to bill for each service they provided.

There are two possibilities here. First, we could recognize that since FFS will continue to be a large component of our system, we use it to incentivize the activities that we really want to see. In that case, it would work to encourage carriers to reimburse providers for CHT activities that are shown to work – because we want to see a lot more of those activities carried out in Rhode Island practices.

The other possibility would be for Accountable Care Organizations and Accountable Entities through Medicaid to embrace the CHT concept, if they see that it works to improve quality and lower costs. If they support CHTs from a business perspective, they can cover the CHT costs as a way to address social and environmental determinants of health for their patients.

We are excited about the model that the Care Transformation Collaborative of Rhode Island (CTC-RI) is creating, consolidating the administration functions and costs of the CHTs. As we test the model, we are looking to determine whether it does hold down administrative costs for the teams. We are hopeful that this will work to make CHTs more accessible for provider offices.

Rajotte: What we're finding from the CHTs is they see about 400 unique patients a year, but these patients don't need services all year long. Most CHTs follow up for about six months or until needed, addressing the patients' primary challenges within the community. This suggests another payment possibility. If we follow the FFS model, we may be able to look at CHW services as a particular healthcare episode, eligible for an episode-based payment. Therefore, we would be open to be exploring how we might categorize referral to and treatment by a CHT as an episode. Over time that would get us to be more self-sustaining, allow CHTs to address mold in the home, the need for enrollment in SNAP, and other socioeconomic determinants, for example, using the same kind of episode-based payment as could be done for procedures such as a knee replacement (i.e., surgery, physical therapy, etc.). Over time, the referral could probably be based on some specific eligibility risk and triage criteria, and we could set a finite amount of time for each episode once we have enough data from our pilot tests and beyond.

Public Grant and Contract Funding

Public sector grants and contracts supporting CHWs come not only from health funders, but education, corrections, and social services streams.

RIPIN supports its large staff of Community Health Workers primarily through a broad array of public grants and contracts. The Rhode Island Department of Health (RIDOH) contracts with RIPIN in a number of capacities, including staffing patient navigators and peer educators in the Community Health Network and WISEWOMAN program, and providing four CHW liaisons to the Health Equity Zones (HEZs). RIPIN is also the federal designee to operate a parent information and training center, supported with a grant administered by the Rhode Island Department of Education (RIDE). They have also received grants from the Executive Office of Health and Human Services, and from the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). Lifespan/Hasbro Children's Hospital has carved out a 20-hours/week RIPIN position from a LEND grant from the Health Resources and Services Administration (HRSA)'s Division of MCH Workforce Development, to provide support in the neural development unit.

Health Equity Zone (HEZ) seed funding grants from RIDOH are assembled from multiple braided federal and state funding streams.

Family Service of RI receives funding from the Rhode Island Department of Children, Youth and Families (DCYF) to conduct Trauma Systems Therapy with minors.

Ryan White grant funding supports CHWs working in the HIV/AIDS field. In 2017 RIDOH's Peer Navigator demonstration project granted \$500K of Ryan White supplemental funds to eight recipients as part of its 90/90/90 program, supporting CHW salaries. Supplemental funding varies from year to year, but RIDOH expects this round of funding to be renewed if positive outcomes are seen. Project Weber/RENEW is one recipient.

Project Weber/RENEW is funded by 13 grants as of this writing. The largest public grant is a RIDOH/Executive Office of Health and Human Services (EOHHS) grant for return-to-care outreach and incentives for HIV-positive individuals, and assessments of high-risk HIV-negative individuals. RIDOH also provides funds for HIV, Hepatitis C, and syphilis testing, as well as condom distribution and street outreach.

The Center for Prisoner Health and Human Rights (Miriam Hospital, Lifespan) has a contract from the Rhode Island Department of Corrections to provide a nurse case manager and CHW at the Adult Correctional Institutions (ACI) to provide medical discharge planning. The CHW will provide transitions support for individuals with comparatively lower levels of need, such as those with substance use disorders or diabetes, and work to strengthen the link to primary care.

Community Action Partnership of Providence (CAPP) is funded by federal, state, and local social services grants, and program staff are supported through operations and program budgets. Funding sources include the Low Income Heating Assistance Program (LIHEAP), Supplemental Nutrition Assistance Program (SNAP) Education & Training funds, and the City of Providence.

Private Philanthropic Grants

The Rhode Island Foundation is a major supporter of CHW programs in the state, but there are several other philanthropies contributing resources.

Thundermist Health Center secured a three-year grant from the Jessie B. Cox Foundation to expand patient access to Community Health Team services.

⇒ *See Fee For Service for details*

The Rhode Island Foundation has supported as many as 10 CHW programs in recent years with grant funding. Grant-making focuses on primary care and health systems reform, but recognizes that much of health is determined outside of the clinical care setting. The Foundation is working with grantees to document return on investment, and hopes to build the business case for CHWs and other means to address the socioeconomic and environmental determinants of health.

⇒ *See case study for details on Rhode Island Foundation funding.*

⇒ *See “How can the CHW Workforce Grow?” section for Grant Program Officer Larry Warner’s perspective on next steps for Community Health Workers.*

Family Service of Rhode Island piloted its CHW services at the Olneyville location of the Providence Community Health Centers with support from the Rhode Island Foundation.

The **Center for Prisoner Health and Human Rights** funds its Transitions Clinic CHW positions with philanthropic grants. After an initial planning grant from the Healthiest Cities & Counties Challenge, matched by the Rhode Island Foundation, the Center received a larger Rhode Island Foundation grant to cover 1.5 FTE Community Health Worker salaries during the first program year.

Dorcas International Institute of RI uses grant funding to support CHW training and stipends in its refugee resettlement program. This program is currently funded by a three-year United Way of Rhode Island grant, and was previously funded by the Rhode Island Foundation.

Project Weber/RENEW has several philanthropic grants. The largest is from the Elton John AIDS Foundation. The Rhode Island Foundation and AIDS United support trans* outreach and trans* leadership development programs. Managing the reporting requirements of many small grants simultaneously is

challenging. Project Weber/RENEW notes that certification of its CHW staff is viewed favorably by funders.

*A client was suddenly admitted into a recovery facility, forgetting his teeth at home in the process. Weber/RENEW CHWs retrieved the teeth and preserved the client's dignity, easing his path to recovery. **“What grant form do you put that on?”***

-Colleen Daley-Ndoye, Executive Director, Project Weber/RENEW

Perspective

Charlotte Crist, RN-BC, CCM, CPHQ

Managing Director of Clinical Programs, Blue Cross & Blue Shield of Rhode Island

Community Health Workers are a terrific resource to expand for the state of RI, particularly in high poverty, high immigrant, poor infrastructure and poor transportation areas. The CHW is a role with tremendous potential to support the clinical delivery of care. CHWs are knocking on doors, speaking in patients' language, and understanding household dynamics. CHWs bring value to the vulnerable patient in a way that supports the clinical setting. How to financially support growth of the CHW role in a fee-for-service (FFS) model remains unclear.

The entire national healthcare system is seeking ways to move away from FFS models and toward value-based programs (VBPs). The CHW role aligns perfectly with this, but financial support for this supportive role is in a state of evolution as we all transition to VBPs. Sustainability of payment would be hard to establish, as we work on sustainability around return on investment, looking at three-year windows of like eligible cohorts. If you start to prove financial outcomes, you'll be able to drive investment. It's likely to be delivery systems like Accountable Care Organizations (ACOs) and provider groups, or groups seeking different reimbursement models, investing themselves, not payer-supported FFS. If an ACO has shared savings, or financial gain for meeting certain cost or clinical outcomes, it's up to them to drive the cost down and the quality up. Let's look at how these CHWs can influence that. As an ACO if I want to invest 100K in a team-based staffing model, I would research how CHWs could support that investment. CHWs are one way to do this, telemedicine is another. There are lots of different ways you can influence your patient, but coming in for FFS, that's the opposite incentive of the move towards value-based programs. The tragedy of our system is payment based on volume, the "Target department store model." It doesn't incentivize health or outcomes. As long as we support FFS models, we continue to have the problem of care delivered outside of a reimbursable model. FFS doesn't support CHW services, it doesn't fit well in this model, and we are trying our best to move towards value.

There is an ongoing tension for how to pay for healthcare in a team-based model, and a role shift for payers, trying to move towards being a partner and collaborator.

A per-member-per-month (PMPM) model of the kind that supports Nurse Care Managers would be challenging to attribute to people who need CHWs. CHW workloads are based on social determinants of health (SDOH), and the healthcare community hasn't done as good a job assessing SDOH as we have medical needs. We typically don't say things about SDOH in diagnosis.

Many local providers still need to understand the models of value-based care delivery and moving away from FFS. In a high functioning model, and using a team approach, the provider would manage the highest level of care, and the team would surround and support the overall care coordination. CHWs can support nursing teams to find out about the home environment. Discussions about team-based care, and the availability of CHWs have been introduced, or are in place with a large volume of providers and local healthcare organizations. There is still work to be done to measure and present the social and financial value or contribution to a patient and to the healthcare system. For those actively working with CHWs, that value is already clear. Growth in this area may depend on the level of transformation within a health system, or broad public education that supports adoption of this role into new value-based care design.

Payer support

Resources from health insurance plans, including private and public payers, support CHWs in a number of settings. FFS arrangements are very limited and specific, while opportunities within alternative payment mechanisms seem to be expanding in the state.

Fee For Service (FFS)

Minnesota is the only state that allows traditional Medicaid FFS reimbursement for CHW services, billed through licensed providers. But at least one Managed Medicaid plan in RI has an arrangement with an FQHC to allow billing for select high-risk patients seen by CHWs on a Community Health Team. Case management services are also billable in certain circumstances, including non-medical case management for persons living with HIV/AIDS (PLWHA), which is reimbursed through Medicaid or Ryan White Part B.

Thundermist Health Center has an arrangement with Neighborhood Health Plan of Rhode Island (NHPRI) to bill for licensed and unlicensed CHW services provided by its Community Health Access Teams (CHATs) to plan-designated high-risk members using billing codes. CHWs on the teams are funded by billable codes for certain patients and activities, by a philanthropic grant, and now by SIM funds.

NHPRI initially identified the most costly and highest-risk five percent of their patients receiving care at Thundermist, 800 individuals. They developed codes that could be used with these patients to cover CHAT services, including those delivered by licensed (behavioral health and RN), and unlicensed (CHW) practitioners, both in the office and in the community. This pool of patients expanded to 1400 in 2015-16, and 3000 in 2016-17, still less than 10% of Thundermist's medical patient population. To be able to provide CHAT services to patients not covered by NHPRI, or not eligible for these billing codes, Thundermist secured a three-year grant from the Jessie B. Cox Foundation. One aim of the grant is to negotiate with additional payers for sustainability of CHAT services, but the health center has not yet achieved this goal. In mid-2017, SIM funded Thundermist through vendor CTC-RI to add a new Community Health Team. Thundermist worked with SIM funding to leverage existing billable resources. This arrangement is allowing the health center to start two new teams for the price of one.

Paying for CHWs with a small portion of patients eligible for billing is challenging in practice. Doctors want to be able to refer patients to CHAT services regardless of their payer (or lack of payer), and according to their own assessment of need. There are also complications when a patient already enrolled in a CHAT and receiving CHW services (not billed to payers other than NHPRI) begins receiving billable behavioral health services such as psychotherapy that incur copays. Different payers have different populations with different needs.

Cedar Family Centers are medical homes providing intensive care coordination and support for families of children with chronic disease and severe mental illness or emotional disturbance, who are covered by Medicaid. **RIPIN** operates

a Cedar, and has CHWs embedded in two hospital-based Cedars. RIPIN bills for CHW services at Cedars on a basis they have nicknamed “fee-for-product.” RIPIN CHWs develop annual comprehensive care plans, billing Medicaid plans every 365 days.

Family Service of RI supports CHWs involved in outpatient mental health services through FFS in specific contexts. At some levels of care, private insurance pays for case management of outpatients who need extra help to meet treatment goals because they have social and basic needs. These services are billable to private insurance carrier Beacon. FSRI is a preferred provider because they meet benchmarks for evidence-based care, allowing them to bill on an open basis annually, rather than requiring reauthorizations. CHWs have a case manager attached, and the licensed provider is able to bill for the CHWs’ time for a certain number of units. For the most part, this work is done with traumatized children.

Communities of Care (CoC) is a RIPIN-staffed Emergency Department diversion program established by the Rhode Island Department of Human Services, and currently connected with NHPRI and UnitedHealthcare Medicaid plans. RIPIN Peer Navigators provide care coordination within this program. CoC is fully funded through Medicaid plans, with a negotiated contract. This is a high-touch program with low volume, addressing complex and long-term problems including living circumstances and transportation.

AIDS Care Ocean State, AIDS Project RI, and the Community Care Alliance have FFS arrangements for case management of persons living with HIV/AIDS (PLWHA) through Medicaid and Ryan White. Non-medical case management for PLWHA is reimbursable to these three HIV/AIDS organizations through Medicaid Managed Care Organizations and EOHHS. People who are not eligible for Medicaid may have these services reimbursed through HRSA Ryan White Part B dollars administered by EOHHS. There is a significant burden of documentation and supervision, and meeting requirements would likely be a significant hurdle for an organization new to the process.

Apparently unique to Rhode Island, Medicaid has approved a category for case management of **high-risk HIV-negative** patients, but a reimbursable program has not yet been established.

Dorcas International Institute of RI (DIIRI) receives Medicaid reimbursements for medical interpreter services, and is interested in establishing an arrangement for CHW services in its refugee program. Part of the hope for securing CHW certification is to be able to be funded through Medicaid, but this effort has not gotten very far to date, and DIIRI is “testing the waters,” says Baha Sadr, director of the program. Ideally the arrangement would be similar to DIIRI’s medical interpreters, in which Medicaid pays DIIRI for interpretation services to providers through carriers UnitedHealthcare, Neighborhood Health Plan of RI and Tufts Health Plan. They currently have hospital contracts for interpreters, and help to manage contacts with insurance companies about

medical interpreting. Sadr notes that medical interpreters are currently pulled into a de facto CHW role, but not paid for it.

RIPIN interviewees noted that Medicare intends⁴ to pay for **Diabetes Prevention Program** services beginning in 2018, which may present opportunities for support of CHWs involved in these activities.

Alternative Payment Mechanisms

Capitation arrangements have potential to allow greater provider investment in CHWs. At least one FQHC is currently funding CHW positions through CTC-RI per member per month (PMPM) payments and its Medicare ACO. The state's Medicaid Accountable Entities may open up resources and incentives for providers and plans to invest in CHWs. And a free clinic is developing a Pay-For-Success model that could share savings it generates to payers by providing CHW preventive services to pre-eligible patients.

CTC-RI is a multi-payer initiative supported by Blue Cross & Blue Shield of Rhode Island (BCBSRI), Tufts Health Plan, Neighborhood Health Plan of RI and UnitedHealthcare. CTC-RI practices receive a Per-Member-Per-Month (PMPM) infrastructure payment by patient attribution, and incentives for quality in customer service and utilization. BCBSRI notes that all Patient-Centered Medical Home (PCMH) practices they work with have access to CHWs working with CTC-RI Community Health Teams. These teams are funded by health plans and the state's SIM grant. PMPM administrative payments are used to support nurse care managers at PCMH practices. Most interviewees who discussed PMPM capitation arrangements thought supporting CHWs in this manner might be challenging because of uneven distribution of need for CHW services, but that capitation warrants further investigation as a path to sustainability.

⇒ See “*How can the CHW Workforce grow?*” for more information and perspectives on capitation.

Providence Community Health Centers (PCHC) Community Health Advocates (CHAs) are funded through primary care capitation. As a CTC-RI primary care practice, PCHC receives a Per-Member-Per-Month payment for qualifying patients for nurse case management and care transformation, and has been able to use these resources to support four CHWs in case management. One CHA is assigned to Medicare patients covered under an Accountable Care Organization (ACO) arrangement, whose budget also supports case management.

⁴ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-3.html>

Comprehensive Primary Care Plus (CPC+) is a Medicare initiative to implement advanced payment models in primary care practices, and RI is a participant. 31 practices are participating, and the payment model includes Per Beneficiary Per Month (PBPM) and pay-for-performance, as well as reduced fee-for-service. CPC+ practices do not currently employ CHWs, but project leaders at Healthcentric Advisors believe CPC+ might offer opportunities to integrate CHWs in care teams. CHWs could help nurse care managers follow up on community resources and high-risk patients, and address the social drivers of health that the CPC+ model includes. Most CPC+ practices are affiliated with ACOs, which might provide further incentive to pursue access to CHW services for population health. Interviewees noted the development of the nurse care manager position over the last ten years, and suggested efforts to expand the CHW workforce might draw lessons from this experience.

A **RIPIN** care coordinator working at a PCMH Kids primary care office had been funded using care coordination money to support a 20-hours/week position, but the funds and position were subsequently cut.

Absent a large-scale move to capitation using a population-based primary care model with integrated CHWs, Dr. Michael Fine of **Blackstone Valley Community Health Center** is not convinced that CHWs can be sustained outside of public grant funding. “The essential problem is: can we prove we have so much value that insurers will come begging to take money to do it? We can prove the value, but it’s yet to be seen if we have the market power, or if it’s enough without political and regulatory power.

Integra member organizations do not currently employ CHWs, but Integra is a Medicaid Accountable Entity and Medicare ACO, receiving capitated payments. Leaders interviewed at Integra noted that Rhode Island’s Medicaid Accountable Entities are expected to go through a recertification process in 2018, and larger-scale resources for infrastructure development to support population health may become available.

Clínica Esperanza/Hope Clinic (CEHC) is developing a “**Pay for Success**” (PFS) pilot that measures the financial impact of clinical and CHW services, and could lead to the implementation of a fee-for-service method for reimbursing the clinic for those savings. The “**Bridging the Gap**” (BTG) PFS pilot project is an umbrella program tracking all participating patients and the effect of CEHC services on state healthcare expenditures. The rationale for the project is that ‘pre-insured care’ that leverages community health workers, volunteers, and grant-funded free clinics, may lower the cost of insured care for patients that transition to insurance. Newly arrived non-citizens (lawful permanent residents, green card holders), usually have a five-year waiting period before they are eligible for Medicaid. After this period, expenditures are highest during the first two years of coverage, as patients seek care they had been deferring. Diabetic patients have particularly high expenses.

Through the BTG program, CEHC provides prevention and care services to the pre-eligible population, and is looking for ways to measure how this

program reduces healthcare costs to the state once patients are insured. If patients are maintaining their health more effectively through free care before transitioning to coverage, then CEHC expects to have generated downstream savings for Rhode Island. Clinic volunteers who are documenting participation in Bridging the Gap are working to measure these savings, and plan to propose a payment arrangement in which a mix of payers return a portion of those savings as payments to sustain CEHC's activities. This arrangement is in the planning phase, but potential payers include RIDOH, hospital systems with a financial interest in Emergency Department diversion and conserving charity care, and Medicaid plans.

Perspective

Marie Ganim, PhD

Health Insurance Commissioner

Office of the Health Insurance Commissioner (OHIC), State of Rhode Island

Community Health Workers are a valuable addition to the health care workforce for our state. The Office of the Health Insurance Commissioner recognizes the significant impact of social and economic factors on health status, outcomes, and costs. Community Health Workers take on the valuable role of engaging, supporting, and connecting consumers with the care they need to achieve better health—most often, in the least costly settings. The benefit of Community Health Workers includes extending the reach of primary care practices. OHIC has long-held that investment in evidence-based primary care is a powerful tool to bend the cost curve—keeping us healthier, and deterring high-cost emergency and acute care. In this way, Community Health Workers are important partners in our efforts to achieve the triple aim—improving the health of the population, enhancing the patient experience of care, and reducing the per capita cost of health care.

Operating Funds

At least four larger organizations fund CHWs directly from general operating budgets, or fund staff members who help patients access CHWs.

While several CHW positions at **Lifespan** are grant-funded, the CHW at the Lifespan Cancer Institute will be paid by core operational dollars.

Neighborhood Health Plan of Rhode Island directly employs CHWs as Community Care Coordinators on interdisciplinary care teams, and as CHWs on the Health@Home program. These positions are funded directly by the organization, not by grant or contract funding.

Blue Cross & Blue Shield of Rhode Island directly employs Health Advocates in its Case Management Department, who help guide high-risk members to CHWs.

The City of Central Falls funds a Blackstone Valley Community Health Center CHW who works at the City Office on Health. This position was originally supported by a grant from the Rhode Island Foundation's RIGHA (Rhode Island Group Health Association) fund, but the City now supports it from general revenue.

Patient Sliding Scale

Quatia Osorio of **Our Journ3i** sees clients regardless of ability to pay, and is supported by sliding-scale and grant funding. Our Journ3i received a RIDOH grant in 2015 to provide services to ten women. If patients have the ability to pay, they are asked for a contribution, but doula care is often free. Osorio has offered barter and payment plans. She would like to pursue a reimbursement arrangement with Medicaid Managed Care Organizations.

Funding for Workforce Development

A number of funders support CHW training and workforce development efforts, by funding external and on-the-job educational opportunities, and by incentivizing employers to hire CHWs.

The **Institute for Education in Healthcare at Rhode Island College (RIC)** is currently funded by a Real Jobs RI grant from the RI Department of Labor and Training. RIC is offering three cycles of 72 hours of classroom training aligned to CHW certification standards for incumbent CHWs and jobseekers.

Training of CHWs at **Clínica Esperanza/Hope Clinic (CEHC)** is funded by grants from the Textron Foundation and RIDOH.

Training of **Dorcas International Institute of RI** CHWs is funded by a United Way of RI grant that also pays for CHWs stipends.

RIPIN is establishing CHW apprenticeships using Apprenticeship RI's technical assistance, which is funded by the American Apprenticeship Initiative of the US Department of Labor. RIPIN plans to use On the Job Training (OJT) funding from the Rhode Island Department of Labor and Training to reimburse up to 50% of apprentices' salaries for the first six months of their employment.

Employer incentives and workforce development resources are available to support on-the-job training strategies including CHW. Several funding streams are available through the Rhode Island Department of Labor and Training, the Governor's Workforce Board and netWORKri partners that can support Community Health

Worker apprenticeships, or CHW employment and training in general. Apprenticeship RI staff noted:

- [On the Job Training](#) (OJT) funds reimburse up to 50% of the wages of new hires during a training period up to six months.
- The [Non-Traditional Apprenticeship Incentive Program](#) provides a \$1,000 per apprentice incentive to employers for up to five apprentices per 12-month period, for apprenticeships outside the construction sector.
- [Non-Trade Apprenticeship Development Grants](#) –are typically awarded annually and offer companies/organizations funding for program/curriculum design and other apprenticeship program planning costs.
- The [Incumbent Worker Training Program](#) offers up to \$45,000 of matching grant funds to employers to train incumbent workers. Nonprofit employers, including many healthcare organizations, cannot currently access incumbent worker training funds through the Governor’s Workforce Board, because they do not contribute to the state’s Job Development Fund (JDF).

4. How are CHWs trained and sustained?

The short answer:

CHWs and their employers need more than financial resources to sustain them. Interviewed employers identified key factors including certification and continuing education, administrative infrastructure, hiring procedures, integration onto teams, workplace supports, a career ladder, a professional community building a clear CHW role and identity, and evaluation as important resources for a sustainable workforce.

*“There is an unending need for Community Health Workers. **They are the mortar that builds the building.** [...] But CHWs are often over-utilized and under-respected.”*

-Bob Robillard, Family Services of RI

At a glance: How are CHWs trained and sustained?

How this section is organized

Sustainability beyond the money

Certification, Training and Continuing Education

- **Rhode Island CHW Certification**
- **Training and Continuing Education**
 - Rhode Island College (RIC) Institute for Education in Healthcare
 - Clinica Esperanza/Hope Clinic
 - RIPIN
 - Dorcas International Institute of RI
 - Community Health Innovations
 - Center for Prisoner Health & Human Rights
 - EBCAP
 - Neighborhood Health Plan of RI
 - Apprenticeship RI & RIC
 - Blackstone Valley Community Health Center
 - Community Action Partnership of Providence (CAPP)

Administrative infrastructure and hiring

- State Innovation Model Test Grant (SIM)
- Lifespan

Integrated teams and workplace supports

- **Integration and teams**
 - State Innovation Model Test Grant (SIM)
 - Thundermist Health Center
 - Neighborhood Health Plan of RI
 - Family Service of RI
- **Workplace supports for specific populations**
 - RIPIN
 - Project Weber/RENEW
- **Career ladder**
 - Thundermist Health Center
 - Neighborhood Health Plan of RI
 - Dorcas International Institute of RI
 - Family Service of RI

Professional Community

- Community Health Worker Association of RI (CHWARI)

Evaluation

- State Innovation Model Test Grant (SIM)
- Dorcas International Institute of RI
- Center for Prisoner Health & Human Rights
- RIDOH Ryan White Peer Navigator programs
- Providence Community Health Centers
- Clinica Esperanza/Hope Clinic

Perspective

Rick Brooks, Director, Healthcare Workforce Transformation
Executive Office of Health & Human Services, State of Rhode Island

There is a growing awareness among healthcare policy-makers and providers alike that social and environmental determinants of health often have a far greater impact on the health of individuals and populations than do the medical services they receive. This is particularly true for racial minorities, immigrants, and poor people, for whom discrimination, language barriers, poverty, and sub-standard education, jobs, housing, and public services contribute to increased health risks and worse health outcomes.

Community health workers (CHWs) are uniquely positioned to help reduce the impact of these factors by educating and advocating for at-risk individuals and communities to ensure that they receive the care and services they need. Yet, despite the positive impact that CHWs have made, our health system continues to struggle with how to train, deploy, and support this valuable member of our health teams.

The responsibilities (and even job titles) of CHWs vary widely – from navigator, to case worker, to educator, to organizer – as does their education and training, contributing to some confusion about the role. Rhode Island has recently created a voluntary certification process for CHWs to help standardize their training and “professionalize” their role, even as some caution against imposing unnecessary barriers to employment and creating distance between CHWs and the populations they serve. Similarly, many believe that CHWs should be incorporated into medical teams, while others argue that CHWs should be based in grassroots community organizations or social service agencies.

Regardless of how these important issues are resolved, the overarching question of who pays for CHWs remains. Healthcare providers are under enormous pressure to improve outcomes while reducing costs. This would seem to be to the advantage of CHWs, whose relatively low wages and impact on reducing high-cost utilization appear to make them a good value. However, under our still-dominant fee-for-service (FFS) system, there remains significant resistance to employing any member of the care team whose services are not directly reimbursed.

As we shift to value-based payment (VBP) models, the value of every team member – as demonstrated by their impact on outcomes – will be what matters. Of course, even under FFS, healthcare providers have recognized the value of employees whose time is not directly reimbursed by payers. For example, most provider organizations could not function without the nurses, technicians, assistants, and support staff needed to ensure quality care, patient satisfaction, and positive outcomes – and their salaries have been viewed as part of the “cost of doing business”. So, while the transition to VBP is not yet complete, opportunities exist today to incorporate CHWs into the care team. Whether directly reimbursed, grant funded, part of bundled payments, or simply the cost of doing business, the value of CHWs merits additional consideration and support if we are genuinely committed to ameliorating the devastating health effects that social determinants can have on our most vulnerable populations.

Sustainability beyond the money

Financial resources are necessary but insufficient for sustainable community health work. Study participants highlighted a number of needs for CHW sustainability, and promising practices for developing it. This section details examples of sustainability factors from training and certification, through hiring and workplace supports, through evaluation of CHWs' work and impact.

Certification, Training and Continuing Education

A growing number of states offer CHW certification in some form. The National Academy for State Health Policy (NASHP) maintains a [map of State Community Health Worker Models](#) that provides detail on this changing landscape. Rhode Island's adoption of certification standards and procedures has influenced training providers and employers to align their training to the requirements of the standards. There are trainings available for jobseekers or in-service CHWs, and several employers provide in-house training.

Rhode Island CHW Certification

The Rhode Island Department of Health (RIDOH) adopted CHW certification standards in 2016 after a Job Analysis by the RI Certification Board. RIDOH established a grandfathering process in which in-service CHWs could obtain certification through November, 2017. CHW certification requires:

- 6 months, or 1000 hours experience
- 50 hours supervision
- 70 hours education aligned with domains
- Portfolio
- Recertification every 2 years

There are no additional educational attainment requirements, although some employers specify educational level in hiring criteria.

Standards require CHWs demonstrate competency in nine domains:

1. Engagement Methods and Strategies
2. Individual and Community Assessment
3. Culturally and Linguistically Appropriate Responsiveness
4. Promote Health and Well-Being
5. Care Coordination and System Navigation
6. Public Health Concepts and Approaches
7. Advocacy and Community Capacity Building
8. Safety and Self-Care
9. Ethical Responsibilities and Professional Skills

These standards have significant overlap with the national Community Health Worker [Core Consensus \(C3\)](#) Project, but are not identical.

At least 15 employers interviewed for this project had certified CHWs through the grandfathering process, or planned to certify new hires.

Training and Continuing Education

Several training organizations have provided CHW training since before certification was formalized in 2016, including Rhode Island College (RIC), Clínica Esperanza/Hope Clinic (CEHC), Dorcas International Institute of Rhode Island (DIIRI), the Rhode Island Parent Information Network (RIPIN), and Community Health Innovations of RI (CHI). CHI has been a significant advocate and source of training in the CHW field, and founder Dannie Ritchie contributed a perspective piece above. RIC, CEHC, DIIRI, and RIPIN have aligned their training activities to certification standards, and trainings are currently available for in-service CHWs and jobseekers. Most employers have built in training opportunities for CHWs to lead towards certification. None interviewed described plans to use certification as a hiring requirement, although this may change as certification matures.

The **Rhode Island College Institute for Education in Healthcare** offers Community Health Worker training, providing the required 70 hours of instruction aligned to certification standards. RIC is currently funded by a Real Jobs RI grant through the Rhode Island Department of Labor and Training to train three cohorts during the 2017-18 academic year.

Clínica Esperanza/Hope Clinic (CEHC) trains a cohort of up to 15 Community Health Workers annually, and has aligned its training to the RIDOH certification standards.

RIPIN entry-level staff are hired with various titles, and are trained on the job as Community Health Workers with in-house curriculum aligned to state certification standards, meeting their in-service requirements through paid employment. Most RIPIN CHWs have been certified through the grandfathering process. RIPIN has provided expertise on CHW training, policies and procedures to other employers and education agencies in the state, and embeds contracted CHWs in a variety of settings.

Dorcas International Institute of Rhode Island has trained three cohorts of refugee CHWs, and its most recent training was aligned to certification standards and met the 70-hour requirement.

Community Health Innovations of RI has worked to advocate for CHWs since 2003, developing and delivering a CHW training curriculum since well before certification standards were adopted.

The **Center for Prisoner Health and Human Rights** has budgeted for 72 hours of training, including CHWs' time, in order to bring new hires to state certification.

CHWs at East Bay Community Action Program (**EBCAP**) have BSWs or other bachelor's degrees, and have received or have pending certification through the grandfathering process.

Neighborhood Health Plan of RI provides ongoing education and support for CHWs. Neighborhood values personal and professional development of staff and will provide on-site in-services, or will make external trainings and conferences available to CHW staff whenever possible.

Apprenticeship RI worked with **Rhode Island College** to develop an apprenticeship curriculum for Community Health Workers in older adult care, including the development of stackable certificates such as a behavioral health specialization and one related to dementia care. The Rhode Island Assisted Living Association (RIALA) and RIPIN assisted in writing the curriculum, and the initiative was funded by a Governor’s Workforce Board nontrade apprenticeship development grant. **Care New England** is working with Apprenticeship RI to train medical assistants, medical coders, and bilingual obstetrics CNAs cross functionally, and has started to institute nurse residency programs.

Blackstone Valley Community Health Center noted a CHW training that took place in Central Falls through RIC’s Parent College program in 2016-2017, and hopes to benefit from trainees looking to fulfill their hours requirements through internships. There are particular needs for CHWs who share language and experience to coach diabetes patients and promote colonoscopy screenings in Central Falls. But Chief Medical Officer Dr. Michael Fine has concerns about the certification process setting up barriers to employment for community members. Training should be simple and accessible, CHWs should work closely with clinical teams to develop skills, and career ladders should be available to CHWs, he says.

Community Action Partnership of Providence (CAPP) cross-trains its program staff on internal and external resources that clients can access, as well as motivational interviewing, ethics and cultural humility. Staff are not participating in the RIDOH CHW certification, and are not formally classified as CHWs, although Executive Director Rilwan Feyisitan views them as de facto CHWs.

*“There is a place for lay people that may or may not have formal education, but have received training or life experience that contribute to their being certified in the field of community health work. With that they could be **recognized for their skills and contributions, and have a wage conducive to their work.**”*

–Rilwan Feyisitan, Community Action Partnership of Providence

Administrative infrastructure and hiring

CHWs are interdisciplinary, work in diverse institutional settings and roles, and have strengths not easily captured by formal credentialing systems. There are administrative challenges, accordingly. How can employers track outcomes and economize resources across multiple teams with different foci? How can lived experience be prioritized in hiring, particularly stigmatized lived experience like incarceration?

The **State Innovation Model Test Grant (SIM)** is developing centralized infrastructure to support Community Health Teams (CHTs). Project leaders are currently working to develop a consolidated operations model that can provide a unified data source, consistent information on return on investment (ROI), training, and wraparound services. The hope is to develop economies of scale that can benefit CHTs, reducing overhead and allowing more resources to flow to direct service.

Lifespan's Community Health Worker position descriptions include an attached pay scale and job classification. The generic description can be specialized for desired skills and experience, such as the Center for Prisoner Health and Human Rights positions that prioritize lived experience of incarceration.

Integrated teams and workplace supports

Sustainability of CHWs requires that they be integrated effectively into workplaces, and supported in their work. Study participants identified several key practices, including supports for specific populations and the opportunity for advancement through career ladders.

Integration and teams

The relationship between CHWs and other professionals is different in different contexts, and can be both challenging and rewarding. Approaches include CHTs, support from a social worker, and structured supervision. Several interviewed employers observed that CHWs benefit their colleagues.

SIM leadership believes that CHWs work best in the context of interdisciplinary Community Health Teams (CHTs). There is a risk if individual CHWs are employed by practices that they can be marginalized within a hierarchical system of healthcare. With CHTs, at any one point, a different occupation may be the most important player depending on the needs and situation of the patient. There may be opportunities for CHWs in other contexts, such as PCMH Kids practices, specialty care settings, cancer navigation, high-intensity environments—but not in general adult practice. SIM is supportive of CHW certification, efforts to develop career ladders, and increasing compensation with CHW specialization.

Matthew Roman, COO of **Thundermist**, believes that having CHW services available has helped recruit and retain doctors at the health center.

Working with a high-risk population can be challenging for the CHW.

Neighborhood Health Plan of RI (NHPRI) provides a variety of venues in which staff can express frustrations, problem solve, or get feedback from other team members as well as managers. An independent licensed clinical social worker on the Health@Home team is available to help individuals and teams manage stressful situations, which may include grieving for lost patients.

CHWs also provide support and value for other staff. “From our perspective, having a CHW on the team allows us to provide the appropriate resources to meet the patient’s needs” says Nancy Harrison, Director of Strategies and Operations – Primary Care at NHPRI. The goal is to have each individual work to the highest level of her license or certification to support a patient’s needs. CHWs are utilized to provide chronic condition education. This model connecting medical and social determinants of health is “just the right fit for working with communities,” says Heredia.

FSRI provides supports for CHWs, and views them as necessary. FSRI prides itself on supervision. Program staff get an hour of individualized supervision, and an hour of group supervision each week. CHWs participate in regular team meetings. FSRI CHWs are embedded in a number of other organizations, and needs and organizational culture are different at each. “We are respectful of the culture that’s in place, and we can adapt ourselves to support that,” says Clinical Administrator Bob Robillard. “We are thinking of integrated care in everything we do. [...] The CHW role is a necessity in the way we work. We always team everything, from the administrator to clinician to case worker assigned to high-need clients. This is not a change for us, we are renaming our case workers Community Health Workers. We are getting to the point where we try and fully integrate all services we provide.”

Quatia Osorio of **Our Journ3I** supports a career ladder in which CHWs could specialize, for example with a community development track, and become upwardly mobile. But there is a risk of tokenism and mistreatment within medical hierarchies. How will CHWs be treated in doctor’s offices and hospitals, and will they be viewed as competition rather than reinforcement? There is a risk that CHWs become “the colorful bottom base of the pyramid,” in which people of color with associate’s degrees get stuck with no opportunity to advance educationally and professionally. Another risk is that CHWs become a fad, and people join for the wrong reasons—or that professionalization sets up barriers for people who should be included. What resources will be available to support CHWs in the workplace? “We are the change going forward. Our job is to get them from here to there.”

Workplace supports for specific populations

CHWs share lived experience with the communities they serve, or have an unusually close understanding of these communities. CHWs who come from communities that have a burden of trauma, stigma, and stress require specific supports.

RIPIN's workplace culture is designed to support peer CHWs. Staff share experience with each other and with their clients. RIPIN leaders interviewed say that supervising a peer requires finesse. There is a high possibility that stressful interactions with patients can trigger an emotional response, and supervisors provide an extra layer of support. Because of the complex family health needs of many staff members, there is a high proportion of staff on medical leave at any given time. RIPIN's benefit package is designed to accommodate these needs with generous paid time off. RIPIN leaders describe the pay as low, but with good benefits. They say that RIPIN has low turnover because of many other supports: supervisors who understand, a career ladder, training, the benefit package, an understanding of staff and their frustrations. That said, RIPIN CHWs are often hired in other settings.

As peers with lived experience of sex work, substance use and HIV, Project Weber/RENEW CHWs require specific supports. Individuals receiving SSI disability benefits have restrictions on their allowable income, and medical limitations on their work. After passing a low earnings threshold, beneficiaries' SSI payments are reduced by half of earnings—and if they are employed full time with medical coverage, they lose SSI coverage. It is challenging to budget for positions filled by persons receiving SSI benefits, whose health may be unstable. CHWs may get sick, take leave, and come back to work. Justice-involved individuals may be re-incarcerated, often due to missed court or parole/probation requirements rather than new criminal violations. People with a history of substance use may experience relapse. Repurposing grant funds for changing circumstances can be difficult. Managing staff turnover and attrition due to these life circumstances can be difficult, but is easier with many part-time positions, rather than a few full-time positions. Project Weber/RENEW CHWs have very specialized skills, and often can't cover for each other. If someone's strength is being in the streets with the trans* community, other staff members may not be able to step in to work with that population.

Career ladder

Many study participants expressed that they would like to see career ladders available to CHWs, and that advancement should be tied to enhanced compensation. At least two employers have developed tiered CHW employment.

Thundermist Health Center is developing a tiered CHW compensation system based on experience, specialization, and training.

Neighborhood Health Plan of RI's Health@Home Program recently added a Lead CHW position, providing opportunities for advancement.

Dorcas International Institute of RI currently pays its CHWs a stipend, but would like to see increased resources to allow for hourly wages and a career ladder including a supervisory-level position.

“There is an unending need for CHWs. They are the mortar that builds the building,” says Bob Robillard of **Family Services of RI**. He sees opportunities for generalized CHWs to train for specialties that should be respected and financially enhanced, such as trauma-informed care, and HIV/AIDS care. “CHWs are often over-utilized and under-respected.”

Perspective

Marianne Raimondo, Executive Director, Institute for Education in Health Care, Rhode Island College

Training of Community Health Workers has been around for a good while. What we have begun offering at the Institute for Education in Healthcare’s CHW training is a focus on behavioral health issues. A partnership with the Department of Labor and Training, through the RealJobs initiative, has enabled us to develop a rigorous curriculum that aligns with the new certification requirements of the Department of Health. Community Health Workers, like other frontline health workers, find themselves often facing situations that they really need certain skills to finesse, at the crucial point of first contact. It is very clear that the kind of people who come to our trainings are primed to be interested in all aspects of people’s health. Our students want to learn to be more active listeners. They are full of compassion and keen to direct that to people who are facing all kinds of challenges. We often hear from them that they have already been doing this kind of work, but now they feel a new sense of professional identification about it. And they should – they are a critical part of prevention and the transformation of healthcare that is surging forward these days. Education must keep up with the demand and we are doing our best to be part of filling that need.

We developed a core competency curriculum that we’ve offered to two cohorts and will start our third this winter ‘18. Several are certified and the rest are well on their way, and everyone is anxious to get jobs! They are truly a remarkably devoted and enthusiastic group of people.

Participants in the program often recognize that they have already been doing this work, but that receiving formalized training helps them identify more as professionals and as a part of a contingent of healthcare workers that adds unique value to patients. Instructors are constantly amazed at how much these students are already doing in their communities and how they truly have a finger on the pulse. They have a lot of resources at their fingertips, just what you hope for in this role. They for their part become more aware of any gaps in the core competencies of their work – like needing to practice active listening more, or ways to establish professional boundaries while maintaining open lines of communication – and they get an appetite to learn more. We at the Institute for Education in Healthcare at Rhode Island College are eager to serve employers engaged in this exciting transformation work by meeting their demand for these competent and skilled liaisons between community and provider!

Professional community

Many study participants identified the need for a professional community of CHWs, to raise their profile and clarify their role, and to provide opportunities for ongoing professional development.

The **Community Health Worker Association of Rhode Island (CHWARI)** developed from an informal convening in 2009, but has been dormant for several years. A partnership including Rhode Island College (RIC) and RIDOH was awarded funding from Real Jobs RI in 2017 to reactivate CHWARI. The partnership has hired a coordinator and is commencing activities as a professional association. RIC also hosted a conference in 2017 called “What is a Community Health Worker?,” to convene CHWs, employers and stakeholders and build momentum around the field.

“How do we quantify quality?”

-A conversation with Nicole Hebert, Deborah Masland, and Nancy Silva of RIPIN

Evaluation

This study did not take a comprehensive look at evaluation strategies or results for CHW employers. But most CHW employers interviewed have evaluation systems in place, or are developing them. Evaluation metrics include financial measures, patient satisfaction, outputs and activities, and patient health outcomes.

SIM will evaluate return on investment of CHTs and a consolidated operations model to support them. Project leaders are interested in understanding provider and patient experiences working with CHWs on health teams, and whether these experiences support the case for these investments.

DIIRI tracks the number of CHWs it trains, and their number of home visits and orientation activities. They are evaluating the number of missed follow-up appointments, and Emergency Department (ED) visits by refugee clients. They are also evaluating provider satisfaction with its refugee CHW program, and note that some primary care providers have observed increased independence from patients receiving CHW health orientations.

The **Center for Prisoner Health & Human Rights** intends to demonstrate the value of CHWs in correctional health, contributing to a conversation about the relationship between healthcare and social services. A program evaluation is being developed that will explore health outcomes, retention in care, and impacts on hospitalization and ED use. It will hopefully include a qualitative evaluation of CHWs’ work.

For **RIDOH’s Ryan White Peer Navigator** program, evaluation metrics for grantees focused on HIV-positive populations include engagement in care and viral suppression, while others focus more on HIV testing. Tom Bertrand, Chief of the Center for HIV, Hepatitis, Sexually Transmitted Diseases & Tuberculosis Epidemiology at RIDOH, would like to see data linking case management to viral suppression, and believes it would be a strong predictor, noting excellent outcomes locally and nationally.

At the **Providence Community Health Centers (PCHC)**, return on investment for Community Health Advocate-delivered case management services will be measured in terms of cost savings, patient satisfaction, reduced inpatient stays, etc. PCHC is evaluating these metrics, but case management activities are new, and the return on investment remains to be seen. In terms of patient experience and outcomes, the results have been promising and positive. Transitions from hospital care to the home are challenging, and an area where Community Health Advocates may have a great deal of potential impact.

Clínica Esperanza/Hope Clinic's Bridging The Gap model is evaluating cost savings to the state generated by providing clinical and CHW services to pre-insured patients. The hope is to use these data to develop a method to share in these savings, and sustain the free clinic's activities.

5. How can the CHW workforce grow?

The short answer:

Key themes emerged from interviews with employers and stakeholders, indicating a growing consensus in the field. There is momentum building among employers, payers and government for expanding the CHW workforce. Employers are using innovative strategies to support CHWs. Pay-for-value approaches hold more promise than fee for service. Training and workforce development resources are available now. And employers and CHWs may learn from each other's practices related to workplace supports and evaluation.

“We have many more meetings about CHWs than we have CHWs.”

–Dr. Michael Fine, Blackstone Valley Community Health Center

“Where is the care model going? What’s the support that’s needed? Care moves at a rapid pace.”

–Jody Jencks, Care New England

“We are the change going forward. Our job is to get them from here to there.”

–Quatia “Q” Osorio, Our Journ3i

✓ **There is momentum now to grow Rhode Island's CHW workforce.**

- ⇒ **Rhode Island has implemented CHW certification**, moving from a grandparenting period to a regular certification process in November 2017.
- ⇒ 25 interviews revealed **broad-based support for the value of CHWs** in diverse organizational contexts and roles.
- ⇒ **Community Health Teams (CHTs)** are expanding with financial support from health plans, SIM, and SBIRT.
- ⇒ **CHTs' results are promising**, and project leaders are working to document their impacts on health, patient and provider satisfaction, and finances.
- ⇒ **The largest health system in RI is investing in CHWs.**
- ⇒ Community Health Workers are a valued member of the interdisciplinary care team at **Neighborhood Health Plan of RI.**
- ⇒ **Blue Cross & Blue Shield of Rhode Island** sees the value of CHWs, especially for vulnerable populations.
- ⇒ **The Home Asthma Response Program's (HARP's) health outcomes are positive and substantial. Return on investment was positive, ranging from 33% to 126%** depending on utilization group.
- ⇒ As Rhode Island's population ages, there is potential to drive new career options and approaches. CHWs could improve health of older adults in the community by acting as **a bridge with healthcare, improving care transitions, and providing patient education.**
- ⇒ **RIDOH's Health Equity Zone (HEZ) initiative is** a collective impact, place-based approach that uses CHWs for innovative, community-driven public health interventions.

✓ **Employers are using innovative financial strategies to support CHWs.**

- ⇒ **Most CHW positions in the state are grant-funded**, but grants include a broad range of sources and purposes. Managing multiple small grants requires a high level of coordination, particularly for small organizations.
- ⇒ RIDOH supports CHWs in HEZ partnerships with **braided state and federal funding** that leverages local resources.
- ⇒ CHWs at Lifespan will be paid through **core operational funding** and **grants.**
- ⇒ Thundermist Health Center is an FQHC that operates two Community Health Access Teams (CHATs). CHWs are funded with a combination of **billable codes for select patients of one payer** and **grant funding.** Billing for selected patients presents challenges in practice. There may be opportunities to expand this model to other payers and patients.
- ⇒ Blackstone Valley Community Health Center (BVCHC)'s CHWs are funded by **grants** and **City of Central Falls general revenue. Capitated funding** could help drive coherent thinking about managing resources for public health and prevention, using CHWs—but until then, public grants are the most likely source, says BVCHC's Medical Director. Their **Neighborhood Health Station** model of population-based primary care would integrate CHWs.

⇒ The HIV field has expertise in care coordination, managing socioeconomic and environmental determinants of health. **Non-medical case managers are reimbursable** and used by AIDS service organizations. RIDOH supports a new multisite HIV peer navigator demonstration with Ryan White-funded grants.

✓ **Pay-for-value holds more promise than fee-for-service (FFS).**

- ⇒ SIM leaders see potential to structure Community Health Team services as **episode-based payments**. They also believe that FFS financial incentives could be established for CHT services within a transition to a pay-for-value structure.
- ⇒ **CHWs on CTC-RI Community Health Teams have payer support to target high-cost patients**, and do not use FFS. CTC-RI believes **Per-Member-Per-Month (PMPM) capitation models** may present opportunities for primary care practices to support CHWs in pay-for-value arrangements.
- ⇒ Thundermist's COO says that PMPM and FFS models each have benefits and drawbacks. **Per Member Per Month** payment is likely to be the most effective funding mechanism going forward, in which a calculation is made that, for example, of every 1000 patients, 10 will need a CHW. If a CHW costs a certain amount in salary, benefits, training, and mileage, a certain PMPM can be calculated accordingly, as was done with Nurse Care Managers. However, this is problematic where need is not distributed evenly. Communities impacted by a greater concentration of socioeconomic and environmental determinants of health, and with a higher prevalence of chronic disease, would have a greater need for CHW services. The challenge with PMPM would be to right-size it.
- ⇒ **FFS billing, even if possible, would be difficult** for RIPIN as a nonprofit. But RIPIN uses diverse payment arrangements, including contracts with payers, and sees future opportunities.
- ⇒ **Providence Community Health Centers** is an FQHC funding CHWs in case management through health plan capitated payments via CTC-RI and their Medicare Accountable Care Organization (ACO). Return on investment for case management has yet to be seen, but is promising.
- ⇒ **Rhode Island Comprehensive Primary Care Plus (CPC+)** leaders believe participating practices or affiliated ACOs may have greater flexibility and incentives to pursue CHW services.
- ⇒ A **Pay-for-Success** model proposes that preventive services delivered by CHWs at free clinic Clínica Esperanza/Hope Clinic (CEHC) would save the state money, and CEHC is designing a payment mechanism to share a portion of these savings to sustain its work.
- ⇒ **Integra / Care New England** is not currently a CHW employer. They have an Accountable Health Communities grant, and will recertify as a Medicaid Accountable Entity in 2018. Both the grant and recertification require a population health focus and provide resources to expand, and interviewed leaders are considering strategies to meet these accountabilities.

- ⇒ A Rhode Island Foundation grant program officer encourages the field to ask how **CHWs and payers can best communicate** with each other, and explore what opportunities for dialogue we can create to build momentum towards expansion and sustainable funding. How can CHWs explain their work in language that payers understand, while building towards a shared, qualitative conversation in the long term?

✓ **Resources exist to train, grow and integrate the CHW workforce.**

- ⇒ The Rhode Island Executive Office of Health and Human Services (EOHHS) **Healthcare Workforce Transformation** initiative includes a focus on CHWs.
- ⇒ Training providers including Rhode Island College are offering **classes aligned to certification standards**, supported by Real Jobs RI workforce development grants and other grants.
- ⇒ **Apprenticeship** may offer one way to formalize CHW career pathways and integrate training, and RIPIN and Apprenticeship RI are piloting a CHW apprenticeship. **Technical assistance, and several workforce development funding streams** can support CHW programs and wages.
- ⇒ **Community Health Teams (CHTs) allow CHWs to be integrated** more effectively than in individual practices, project leaders believe. Economies of scale from the **consolidated operations model**, and return on investment data may help build the case to providers and payers for CHTs with CHWs.
- ⇒ RIC and RIDOH are working to revitalize the **Community Health Worker Association of Rhode Island (CHWARI)**, and have hired a coordinator.
- ⇒ Blackstone Valley Community Health Center uses a **weekly interdisciplinary meeting including CHWs** to bring many stakeholders together to create strategies to solve high-risk patients' health problems, including by addressing socioeconomic and environmental determinants of health with CHWs.
- ⇒ **Prioritizing peer experience in hiring processes** may pose challenges, but technical assistance is available, says the Center for Prisoner Health & Human Rights. There are opportunities to infuse healthcare in traditional social services, and infuse social services in healthcare for high-risk populations.
- ⇒ Lifespan has recently **formalized CHW job descriptions** and is in the process of **hiring CHWs** for positions in prisoner transitions, cancer and asthma.
- ⇒ Standardizing roles, communication, and training expectations will build CHW credibility in primary care, says CPC+. Clarification of the role to providers was key in developing the nurse care manager position.
- ⇒ **RIPIN provides specialized supports to staff with peer experience**, including training, leave, and supportive supervision.
- ⇒ Peer CHWs have **highly specialized skills, and require specific supports**, says Project Weber/RENEW.

Perspective

Essential questions about CHWs in Rhode Island

Larry Warner, MPH, Grants Program Officer, Rhode Island Foundation

- What is the best model of **transitional funding**? Large hospital providers can decide to hardwire a CHW program internally, but how do others sustain a model? Who is already doing this well? How can programs go from foundation funding to sustainability?
- What **unexplored models or variations of CHWs** have yet to be tried? For example, there is an idea to cross-train community paramedics as CHWs. Can hybrid Emergency Medical Services (EMS)/CHW models be tried here, and what other innovations might be effective?
- Is there an opportunity to provide more robust **pediatric services** through PCMH Kids using a Community Health Team (CHT) or CHW model?
- Can the **school system** be better utilized for health, and integrated with other resources? Can school nurses partner with CHWs to make these connections?
- What lessons can be learned from social service agencies with integrated clinical care, like Community Action Programs (CAPs) with Community Health Centers (CHCs)? Or health organizations with multidisciplinary stakeholder meetings like Blackstone Valley CHC (Central Falls Neighborhood Health Station)? **What infrastructure best facilitates the integration of clinical and non-clinical resources?**
- CHTs are based in medical homes. **Could the infrastructure that supports clinical CHTs be leveraged** to increase the capacity of CHTs without a clinical partnership—or even independent CHWs?
- From a funding equity perspective, **how do we support people who aren't engaged in primary care**, but are connected with social services?
- What is the **plan for CHT sustainability** when SIM dollars sunset in two years? Can we look to Medicare and Medicaid to lead the way in setting parameters around payment for addressing the social determinants of health?
- What role can **academic centers** play in leveraging dollars to support CHWs, and to contribute to the research on CHW return on investment?
- In the distinction between healthcare spending, and social services spending, can we imagine a **blended zone** that bridges the two, and push for investments in that zone to bend the healthcare cost curve, address social determinants of health, and produce better outcomes?
- How can **CHWs and payers best communicate** with each other, and what opportunities for dialogue can we create to build momentum towards expansion and sustainable funding? How can CHWs explain their work in language that payers understand, while building towards a shared, qualitative conversation in the long term?

Case Studies

Employers

Blackstone Valley Community Health Center	FQHC
Blue Cross & Blue Shield of Rhode Island	Payer
Care Transformation Collaborative of RI (CTC-RI)	Multipayer Initiative
Center for Prisoner Health & Human Rights	Population-Focused Program
Clínica Esperanza Hope Clinic	Free Clinic
Community Action Partnership of Providence (CAPP)	Social Services
Dorcas International Institute of RI (DIIRI)	Population-Focused Program, CBO
East Bay Community Action Program (EBCAP)	Health & Social Services
Family Services of RI	Health & Social Services
Home Asthma Response Program (HARP)	Health Condition-Focused Program
Lifespan Community Health Institute	Health System
Neighborhood Health Plan of RI (NHPRI)	Payer
Our Journ3i	Owner-operator
Project Weber/RENEW	Population-Focused Program, CBO
Providence Community Health Centers (PCHC)	FQHC
RI Parent Information Network (RIPIN)	Health & Social Services
RIDOH: Health Equity Zones, Programs	Funder, CBO Partnerships
RIDOH: HIV Program	Funder
South County Health	Health System
Thundermist Health Center	FQHC

Stakeholders

Apprenticeship RI	Workforce Development
Comprehensive Primary Care Plus (CPC+)	Health Reform Initiative
Integra/CareNE	ACO, Health System
Rhode Island Foundation	Funder
State Innovation Model Test Grant (SIM)	Health Reform Initiative
University of RI (URI)	Higher Education

Blackstone Valley Community Health Center

FQHC

Interview: **Dr. Michael Fine**, Chief Medical Officer. **September 11, 2017.**

Blackstone Valley Community Health Center serves the cities of Central Falls and Pawtucket.

Blackstone is an FQHC that serves 13,300 patients in the area. Chief Medical Office Dr. Michael Fine is also the Chief Health Strategist for the City of Central Falls, where he works to bring together public health and clinical care.

BVCHC employs CHWs in school-based, city government, and Community Health Team settings. Two CHWs have been employed by the health center for two years. One CHW is employed by BVCHC to work at the Central Falls City Office on Health. This CHW calls all Central Falls residents who

have had EMS transportation after 72 hours to connect them to primary care. She runs data on EMS transports, focuses on frequent users, does intensive case management, and connects them to resources. BVCHC has seen a reduction in ambulance transport since this intervention started. BVCHC also embedded a CHW in its school-based clinic at Central Falls High School. She focused on enrolling students as patients, and reducing teen pregnancy. BVCHC has reported strong increases in enrollment and reductions in pregnancy as a result. A Community Health Team has also been based at Blackstone since 2014, employing two CHWs, who do outreach to high-risk primary care patients of the health center and five associated primary care practices. This CHT is one of two pilot teams set up and funded by the Care Transformation Collaborative of Rhode Island (CTC-RI, see separate summary).

CHWs have been grant funded, and one is now a City position. CHW positions on the Community Health Team continue to be funded by CTC-RI. School-based and City Office on Health CHWs were originally funded by the Rhode Island Foundation through a RIGHA grant, but funding was recently discontinued. The City of Central Falls picked up the City-based CHW's salary from general revenue, but the future of the school-based position is uncertain. The City of Central Falls has been supportive of these initiatives.

Key Takeaways

- BVCHC is an FQHC that **employs CHWs in public health and primary care** initiatives in Pawtucket and Central Falls.
 - CHWs conduct **outreach and coaching to high-risk patients**, and BVCHC is observing positive outcomes.
 - A **weekly interdisciplinary meeting including CHWs** brings many stakeholders together to create strategies to solve high-risk patients' health problems, including by addressing SDOH with CHWs.
 - CHWs are funded by **grants and City of Central Falls general revenue.**
- ⇒ The **Neighborhood Health Station** model of population-based primary care would integrate CHWs.
- ⇒ **Capitated funding** could help drive coherent thinking about managing resources for public health and prevention, using CHWs—but until then, public grants are the most likely source.

BVCHC addresses SDOH through a multi-stakeholder approach that includes CHWs. Central Falls is an unusual community. It is a densely populated small city, with little private transportation. More than 70% of residents speaking a language other than English. “CHWs really are the glue in how you make the theory of prevention practical to real people,” says Dr. Fine. A multidisciplinary team meets weekly at BVCHC to discuss high-risk patients. The meetings typically include representatives from housing agencies, EMS, a recovery organization, the police department, and others. BVCHC CHWs participate. Anyone can bring a patient to the meeting’s attention, and the goal is “to figure out how to take care of everybody.” This may mean sending a CHW to knock on someone’s door, often to help with mental health and substance abuse referrals. In working with homeless people, the group takes a Housing First approach, working to address housing needs as prerequisites to solving medical problems. The meeting relies on personal communication, rather than data sharing that would create a heavy privacy burden.

BVCHC is building a Neighborhood Health Station to deliver a new-to-the-US primary care model. The goal is to create a population-based model that addresses 90% of the healthcare needs of 90% of Central Falls’ population. Planned services include general medicine, urgent care and behavioral health. The new facility under construction is being funded by patient services revenue. The hope at some point is to move to a capitated payment arrangement. Capitation, Dr. Fine believes, would allow managers to think more coherently about resources, spending money on preventive services like CHWs to avoid ED visits and disease complications, shifting away from pay-for-volume. But realigning financing towards capitation is a central challenge, and CMS may not sustain the move towards pay-for-value. Drivers of this transition could include clinicians tiring of “the hamster wheel,” or state leadership recognizing the economic case for reduced healthcare costs that could attract business to the state. Absent a large-scale move to capitation using a population-based primary care model with integrated CHWs, Dr. Fine is not convinced that CHWs can be sustained outside of public grant funding. “The essential problem is: can we prove we have so much value that insurers will come begging to take money to do it? We can prove the value, but it’s yet to be seen if we have the market power, or if it’s enough without political and regulatory power.” Primary care is an essential service, he says, and should be funded directly, and tied to meaningful public health indicators that clinicians can be held accountable to by addressing the social conditions that matter for public health.

BVCHC noted the CHW training that took place in Central Falls through RIC’s Parent College program, and hopes to benefit from trainees looking to fulfill their hours requirements through internships. There are particular needs for CHWs who share language and experience to coach diabetes patients and promote colonoscopy screenings in Central Falls. But there are concerns about the certification process setting up barriers to employment for community members. Training should be simple and accessible, CHWs should work closely with clinical teams to develop skills, and career ladders should be available to CHWs. **“We have many more meetings about CHWs than we have CHWs.”**

Blue Cross & Blue Shield of Rhode Island

Payer

Interview: **Charlotte Crist**, Managing Director of Clinical Programs;
Kathleen Simon, Case Management Department.
August 17, 2017.

Blue Cross & Blue Shield of Rhode Island (BCBSRI) is the largest private health insurance carrier in the state, with a larger market share than other RI commercial payers. BCBSRI offers a variety of products for Commercial and Medicare members, provides robust case management services, and can be accessed via the exchange marketplace.

BCBSRI actively seeks out opportunities to provide professional case management to

members with high risk needs, and works to inform their clinical partners in the community about high-risk patients. Algorithms and analytics identify high-risk patients based on claims data, behaviors, medications, prescription and utilization patterns. Johns Hopkins Resource Utilization Bands (RUBs) are used to calculate risk acuity. Members are placed in a risk band not based on cost alone, but using diagnoses and behaviors, prescriptions, age, gender and comorbidities. Customer service also refers members to case management. Patients are attributed to practices, and providers are notified. This kind of risk information is important to Patient-Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs), and Community Health Centers (FQHCs), who are accountable to quality and outcome measures.

Case management teams engage high-risk members through outreach, and care coordination. Case management provides support to the clinical team, focusing on keeping members engaged and committed. Case managers partner with external providers and internal practice facilitators. Teams think about complex cases, recent trauma, comorbid conditions, and chronic cases coming to a head. They engage in Motivational Interviewing. “We align, actively listen and participate. We help our members put into words what’s important, build rapport, and come back [to care].” With the dual eligible Medicare Advantage population, staff work to make sure members are aware that Medicaid can help with copays, so that they don’t avoid needed care due to financial barriers. The goal is to improve members’ health, and reduce cost trends. “Community Health Workers are one big piece of that whole puzzle.”

BCBSRI Health Advocates in case management do outreach and health education. The Care Management department employs Health Advocates who

Key Takeaways

- BCBSRI is the **largest private health plan** in the state.
 - BCBSRI **Health Advocates** support case management through outreach.
 - Health Advocates refer high-risk members to **Community Health Teams** integrating CHWs, which BCBSRI supports through the CTC-RI multipayer initiative.
- ⇒ **BCBSRI** sees the value of CHWs, especially for vulnerable populations.

support members and case managers, and offer some of the services provided by CHWs in the community. Health Advocates direct and refer patients to health education classes at BCBSRI retail locations. Classes include balance for fall prevention, diabetes education, yoga, resource assistance, biometrics, and Alzheimer's support. They help to normalize difficult or anxiety-producing subjects through peer education. All classes are evidence-based, and trainers have been trained through specialized classes, some provided by RIDOH. The Health Advocate's role supports the team approach to care and may provide information, referrals, or support for non-clinical care needs.

Members are referred to CHWs on Community Health Teams through CTC-RI.

All 135 PCMH sites that Blue Cross works with have access to these CHTs. As a participant in a multipayer collaborative, Blue Cross supports CTC administrative costs, Community Health Team costs, as well as a Per Member Per Month payment to participating providers. Past and current CTC practices have access to CHWs working with Community Health Teams. "CHWs are the boots on the ground, knocking on doors, speaking the language." A CHW might go to a patient's house, see an eviction notice, speak to a provider about it, and take action to find safe housing and support for other basic needs. CHWs are addressing foundational safety net issues, immediate healthcare improvements are strengthened by a focus on security in housing, food, safe surroundings, and access to obtain healthcare calls for these to be addressed first. There are not strict parameters on the scope of CHWs' work: they can have very different relationships depending on the context.

Care Transformation Collaborative (CTC-RI)

Multipayer Initiative

Interview: Susanne Campbell, RN, Senior Project Director. May 15, 2017.

The Care Transformation Collaborative Rhode Island (CTC-RI) is a **multipayer-supported initiative reforming payment to primary care practices in order to drive improvements in quality, customer service, costs, and ED utilization.** CTC-RI is funded by four major health plans: Blue Cross Blue Shield of RI, Tufts, United, and Neighborhood Health Plan of RI. After an initial pilot of 5 primary care practices in 2008, CTC-RI has grown to 83 primary care practices. Participating practices must meet criteria including Patient-Centered Medical Home certification, and use of electronic health records. Once enrolled, practices receive a Per Member Per Month (PMPM) infrastructure payment, and incentives for quality in customer service and utilization.

Key Takeaways

- CTC-RI is a **multipayer-supported initiative to use PMPM payments in primary care** to improve quality and reduce costs.
 - **Community Health Teams provide care to high-risk patients** in CTC primary care practices. CHTs have CHWs and behavioral health specialists, and are funded by payers.
 - **CTC-RI's CHTs are geographically-based and payer-agnostic.** CHTs are expanding, and some follow other approaches.
- ⇒ **CHWs on Community Health Teams have payer support to target high-cost patients,** and do not use FFS at CTC-RI.
- ⇒ **PMPM models may present opportunities for primary care practices to support CHWs in pay-for-value arrangements.**

CTC-RI uses Community Health Teams (CHTs) with Community Health Workers and behavioral health specialists to improve care and decrease ED utilization among high-risk patients of CTC practices. By 2014, quality and customer service metrics were improving, but ED utilization remained unchanged. Drawing on models from Maine Quality Counts and Vermont Blueprint for Health, CTC-RI proposed CHTs to stakeholders. Health plans funded two pilots that were implemented at the Blackstone Valley Community Health Center and South County Health System, with a total budget of \$600K. The population focus is high-risk, high-utilization patients who are frequently in the ED or admitted as inpatients, have behavioral health conditions, and are disengaged from primary care. Patients are screened for CHTs using a risk assessment tool adapted from the Cambridge Health Alliance, and health plans' assessment that they are high cost. Nurse Care Managers at CTC-RI practices can refer patients to a CHT in their geographic area if they meet a threshold of current risk, or exhibit rising risk. CHTs work with RI Quality Institute to enroll patients in CurrentCare, and manage patient information. CHTs have a memorandum of agreement with PCPs to allow information exchange. Referrals are geographically-based, and payer agnostic—an arrangement that could pose challenges for an ACO or Accountable Entity.

Community Health Workers are members of all Community Health Teams, are assigned based on patients' main drivers of disease, and are paid as part of a CHT's general budget. Each Community Health Team has 1.5-2 CHWs.

During the first two years of operations, CHWs were contracted from RIPIN, a major employer of CHWs with an in-house training system. When CHW certification was adopted in Rhode Island, both CHTs decided to hire full-time CHWs directly rather than contracting, and grandfathered their CHWs to achieve certification. Although there are billable codes for CHWs, and for SBIRT, these codes have not been turned on by the payers. Because of the time-consuming nature of CHWs' and behavioral health specialists' work, Senior Project Director Susanne Campbell views this as an advantage. Building a trusting relationship is key, and time constraints from billing can interfere with the process. Successfully establishing a trusting relationship has been life-saving for some patients. And primary care providers, once they are used to CHWs, begin to love them. "They go from feeling they are under water, to feeling like this is a team effort."

CTC-RI is working with SIM to expand CHTs. A number of Community Health Teams are operating in RI, in diverse institutional settings. CTC-RI responded to an RFP from the SIM to expand CHTs to Providence, Woonsocket and West Warwick.

Clínica Esperanza / Hope Clinic

Free Clinic

Interview:

Dr. Annie De Groot, Volunteer Medical Director;

Damaris Rosales, Navegante Coordinator.

July 29, 2017.

Clínica Esperanza / Hope Clinic (CEHC) is a free clinic providing care to uninsured, predominantly Spanish-speaking patients in the Olneyville neighborhood of Providence. CEHC focuses on culturally-attuned care for a largely immigrant population, whose status prevents or delays eligibility for coverage. The clinic served more than 2,500 patients in 2016, and is supported by grants and volunteers. 2016 grant funding included foundations, corporate donors, the RI Dept. of Health, and federal CDBG. Services include primary care for the uninsured, screening, health and prevention education, and a walk-in clinic.

Navegantes are at the core of

CEHC programs, providing outreach, health education and interpretation.

Six navegantes (Spanish for “navigators”) currently work at CEHC—four full-time, two part-time. Navegantes, have played a central role in service delivery since 2009, when CEHC trained its first cohort of five. Working with Lifespan, CEHC implemented a curriculum on chronic disease for low literacy adults, focused primarily on diabetes, hypertension and obesity into an interactive social club. The resulting program, called Vida Sana/Healthy Life, won an award from the American Medical Association that established [proof of efficacy](#) for a group of 192 participants. Building on the program’s success, CEHC was awarded a Centers for Health Equity and Wellness (CHEW) grant from RIDOH and expanded Vida Sana outside the clinic, into community locations, incorporating chronic disease screenings as a means of recruiting participants in those settings. The Navegantes were also recently trained to teach the Diabetes Prevention Program (DPP). Outreach events such as health screenings, classes and “information sessions” enable the CEHC Navegantes to reach people affected by chronic disease, diagnose them and teach them to manage their illness at an earlier timepoint, limiting the long term impact of their disease.

Key Takeaways

- **CEHC uses CHWs (Navegantes) to provide culturally-attuned health education and outreach** to uninsured patients, and links to free medical care.
 - **CEHC is a free clinic** supported by grants and volunteers; it does not bill payers or patients.
 - **Navegantes “tear down the clinic walls,”** and focus on prevention and peer education in the community.
- ⇒ **A Pay for Success** model proposes that CEHC services save the state money, and is designing a payment mechanism to share a portion of these savings to sustain its work.
- ⇒ CEHC offers **CHW training** to prepare community members for jobs at healthcare employers, and provide a pipeline of new candidates to CEHC.

Navegantes “reach and teach” to prevent problems, connecting patients with access to care, and, “tearing down the clinic walls.”

Navegantes provide peer-to-peer education for patients attending clinic sessions and in outreach settings. As peers of CEHC patients, the Navegantes share dietary preferences with the patient population and are trusted by patients and class participants. They talk about how to make behavioral changes with the support of tailored materials. They promote medication adherence among patients with diabetes, and link uninsured people to free diagnostic tests as needed. All of the CEHC Navegantes are also certified as medical interpreters, and are better able to assist with patient visits at CEHC, since some CEHC clinician volunteers do not speak Spanish.

CEHC is currently engaged in the integration of Navegante-assisted healthcare access in a “Pay for Success” (PFS) pilot that measures the financial impact of CEHC services, and could lead to the implementation of a fee for service method for reimbursing the clinic for those savings. The “Bridging the Gap” PFS pilot project is an umbrella program tracking all participating patients and the effect of CEHC services on state health care expenditures. The rationale for the project is that ‘pre-insured care’ that leverages community health workers, volunteers, and grant-funded free clinics, may lower the cost of insured care for patients that transition to insurance. Newly arrived non-citizens (lawful permanent residents, green card holders), usually have a five-year waiting period before they are eligible for Medicaid. After this period, expenditures are highest during the first two years of coverage, as patients seek care they had been deferring. Diabetic patients have particularly high expenses.

Through the BTG program, CEHC provides prevention and care services to the pre-eligible population, and is looking for ways to measure how this program reduces healthcare costs to the state once patients are insured. If patients are maintaining their health more effectively through free care before transitioning to coverage, then CEHC expects to have generated downstream savings for Rhode Island. Clinic volunteers who are documenting participation in Bridging the Gap are working to measure these savings, and plan to propose a payment arrangement in which a mix of payers return a portion of those savings as payments to sustain CEHC’s activities. This arrangement is in the planning phase, but potential payers include DOH, hospital systems with a financial interest in ER diversion and conserving charity care, and Medicaid plans. Clinic volunteers working on the Bridging the Gap project use a data dashboard to track patients enrolled in the program. All BTG patients are required to participate in navegante-taught health education activities, and are enrolled in CurrentCare so that their data can be tracked. 500-600 patients were enrolled in the first year; more than 300 are enrolled as of the 6-month point in Year 2. CEHC hopes to demonstrate cost savings and promote this model among other free clinics nationally.

CEHC believes that community healthcare workers play a key role in community access to healthcare. CEHC has support from Textron Foundation and RIDOH to train a cohort of Community Health Workers on

an annual basis. The current curriculum fulfills Rhode Island state certification standards and as many as 15 CHW trainees graduate from the program each year. CEHC's Advanced Navegante Training classes incorporate medical interpreter training, CPR and First Aid, electronic medical record documentation training, and training in research with human subjects. CEHC hires several graduates of the program each year, and also helps to place them as navigators, CHWs, interpreters and advocates with healthcare employers in the state. CEHC views the Navegante training as a core clinic activity and benefit to the community, not as a revenue generator. Both the Navegante trainors and the new graduates finish the program with a sense of pride about the role that CHW play in the Rhode Island healthcare community.

Community Action Partnership of Providence (CAPP)

Social Services
Organization

Interview: Rilwan Feyisitan, Executive Director. October 12, 2017.

Community Action Partnership of Providence (CAPP) is a social service agency connecting Providence residents with resources. Programming includes the RIHEAP heating assistance program, food pantries, economic self-sufficiency and workforce development. CAPP is a successor organization to ProCAP, which was restructured after a receivership process.

CAPP operates at its main office in Olneyville, and at the Elmwood Community Center, and serves residents throughout the city. CAPP is not collocated with an FQHC like some other Community Action Programs in the state, but Executive Director Rilwan Feyisitan views their work as addressing the social determinants of health. “We believe everything is interconnected to health.”

Navigators addressing basic needs and help people connect to systems. CAPP programming includes housing stabilization, food and nutrition (with a training component), and direct case management. Navigators help clients get through red tape and bureaucracy. Resident Educators work on issues of lead contamination in the LEAD Safe Providence program. During home visits, they conduct health and safety risk assessments, swabs and analysis, remodeling and renovation, and asthma risk and radon testing. The weatherization department has specialized auditors cross-trained to detect health concerns. A VISTA volunteer works on veterans’ issues, including connection to health services. The Individual Development Account Program provides matched savings to assist residents in purchasing a home, business, or post-secondary education. The RI Home Energy Assistance Program provides heating assistance to low-income residents, staffed by 8 seasonal Benefit Eligibility Specialists annually. Wraparound case management aims to transition clients out of dependency on benefits. Executive Director Rilwan Feyisitan considers all of these staff to be CHWs.

Program staff are funded through operations and program budgets. RIHEAP assistance comes from a federal grants program, managed by a state administrator. LIHEAP funding provides for seasonal workers and a case manager. LEAD Safe is funded by the City of Providence. SNAP Education and Training funds support program staff. Unrestricted funds support the case manager position for Individual Development Account program. Feyisitan says he would like to see a federal block grant program create a dedicated CHW funding stream.

Key Takeaways

- CAPP is a **social service agency** in Providence.
 - CAPP programs **address the social determinants of health**, and CAPP’s Executive Director views its staff as CHWs.
 - Staff are funded by a **variety of grants** primarily from public sector social services.
- ⇒ **A Community Action Program views non-clinical programming as connected to health, and staff as Community Health Workers.**

CAPP supports program staff with training. RIHEAP staff are cross-trained on internal and external resources, receiving two weeks of orientation before each seasonal cycle. They receive training in motivational interviewing, ethics, and cultural humility, and participate in continuing professional development weekly. Although CAPP staff are not participating in RIDOH CHW certification, Feyisitan supports credentialing. “There is a place for lay people that may not have formal education, but have received training or life experience to contribute to their being certified in the field of community health work. With that they could be recognized for their skills and contributions, and have a wage conducive to their work.” CHWs experience stress and burnout, and a formalized trade association will help to CHWs manage these stresses and extend their professional development.

Dorcas International Institute of RI (DIIRI)

Interview:

Anna Kancharla, Medical Case Worker;

Baha Sadr, Refugee Program Director.

September 28, 2017.

Dorcas International Institute of RI operates a refugee resettlement program in Providence. DIIRI is one of two organizations in the state funded by the Office of Refugee Resettlement (ORR) to receive and place new refugee arrivals. DIIRI hosted an unusually high number of arrivals in 2016, and has received an unusually low number in 2017 due to changes in federal policy. Refugee populations have unique health needs.

DIIRI trains and contracts

CHWs with shared language and experience to provide health orientations to newly arrived refugees. Upon arrival, most refugees need intensive orientations to US systems. DIIRI's CHWs meet with refugee families within a few weeks of arrival to begin providing health systems navigation for the first three months. Using clients' native languages, they introduce the basics of the healthcare system, language, and cultural customs around health. They help clients understand appointments, how to pick up prescriptions, use medical insurance, and take the bus. They introduce the US emphasis on medical specialization and preventative care, and ensure proper documentation of vaccinations. They do not only teach, but show clients directly how to use these systems. They not engage in disease or medication management, although some have had disease-specific trainings. The program has partnerships at Hasbro Children's Hospital, RI Hospital primary care clinics, and the RISE Clinic, among others.

DIIRI has completed three training cohorts to date, using a curriculum developed in partnership with Hasbro. The most recent cohort involved 70 hours of training aligned to the RIDOH certification standards. A total of 22 CHWs have been trained, and 18 retained. DIIRI is currently focused on getting trainees the hours and supervision they need to become certified. They are using group supervision in several formats to meet the 50-hour requirement.

Key Takeaways

- DIIRI has a refugee resettlement program that includes **health systems orientation**.
 - Specially-trained CHWs help **refugees understand US health services and culture using their native languages**.
 - **CHW training and stipends are grant-funded**, but DIIRI is interested in Medicaid funding for sustainability.
- ⇒ **CHWs are reaching a population with unique health needs.**
- ⇒ **Medical interpreter billing arrangements may be potential models for CHW funding.**

CHWs are Arabic, Swahili or Somali speakers. Some Congolese CHWs also speak Kirundi and other languages. Several Iraqi CHWs are physicians. Some CHWs are also medical interpreters. There is also one Spanish-speaking CHW who was trained at Clinica Esperanza, who works with unaccompanied minors. This population is comparatively very challenging because they do not have access to the public benefits that refugees do, but the CHW is skilled in finding resources. There are CHWs working at Providence Public Schools, in the Newcomer School in support of unaccompanied minors and refugee children. These CHWs focus primarily on parent engagement.

CHWs are contracted on a per-case stipend; they are not DIIRI employees. CHWs are paid a flat stipend per case, and some cases may require more or less time. Service is most intensive during the first medical appointments. Contracted positions are very part-time, and do not add up to full time employment.

CHW training and stipends are grant-funded. They are currently funded through a three-year United Way grant, and were previously supported by the Rhode Island Foundation. This program is not funded by ORR. Medical Case Worker Anna Kancharla says that DIIRI would love to see sufficient resources to pay CHWs hourly wages rather than stipends, and a career ladder including supervisory-level positions.

Evaluation includes health utilization measures, training output and provider satisfaction. CHWs perform some documentation using a checklist such as pharmacy demonstrations and home visits. DIIRI is evaluating the number of missed follow-up appointments, and ER visits, and has noted a reduction in emergency department utilization. They are tracking the number of CHWs trained, retained, on track to be certified. And they have spoken with some PCPs who have given positive feedback, noting increased independence from patients receiving CHW orientations.

DIIRI receives Medicaid reimbursements for medical interpreter services, and is interested in establishing an arrangement for CHW services. Part of the hope for certification is to be able to be funded through Medicaid, but this effort has not gotten very far to date, and DIIRI is “testing the waters,” says Baha Sadr, director of the refugee program. They would like to make a deal with insurance companies and hospitals as a cost-effective, well-located intervention, possibly with a portion of costs coming from DIIRI’s budget. Ideally the arrangement would be similar to DIIRI’s medical interpreters, in which Medicaid pays DIIRI for interpretation services to providers through carriers UnitedHealth, Neighborhood and Tufts. They currently have hospital contracts for interpreters, and help to manage contacts with insurance companies about medical interpreting. Sadr notes that medical interpreters are currently pulled into a de facto CHW role, but not paid for it.

Center for Prisoner Health & Human Rights

A population-focused program

Interview with Sarah Martino, MPA, Project Director.
August 14, 2017.

The Center for Prisoner Health & Human Rights conducts research, education, and programming to improve the health and human rights of justice-involved populations.

Based at The Miriam Hospital, part of Lifespan, the Center began with a primary focus on research in correctional health, HIV, and care continuity between prison and the community. Programs include student internships and training, partnering with the Department of Corrections on public health programming inside the Adult Correctional Institutes (ACI), and participating in advocacy efforts.

A new Transitions Clinic will link individuals discharged from incarceration with primary care, using Community Health

Workers. Drawing from a model developed by the [Transitions Clinic Network](#), the clinic will focus on providing primary care during the period immediately after release, a window of high risk for hospitalization, ED use, overdose and death. In this model, formerly incarcerated CHWs on the care team meet with patients before release, provide a warm hand-off, meet patients in clinic at regularly-scheduled times, and offer long term support. The majority of individuals released from the ACI will be Medicaid-eligible, and CHWs will help enroll those who are not already covered. Program leaders at the Transitions Clinic Network, and at the Center consider shared peer experience of incarceration crucial to success. The City of Providence and Lifespan Community Health Institute are program partners, and the program is likely to be located at RI Hospital's Center for Primary Care at a designated time each week.

CHWs will be supported through grant funding, and hired by Lifespan through a process that prioritizes peer experience. After an initial planning grant from the Healthiest Cities & Counties Challenge, matched by the Rhode Island Foundation, the Center received a larger Rhode Island Foundation grant to cover 1.5 FTE Community Health Worker salaries during the first program year. These are the first positions at Lifespan to use the title "Community Health Worker." The Center worked with the Lifespan Community Health Institute, Lifespan Human Resources

Key Takeaways

- **Formerly incarcerated CHWs at a Transitions Clinic** supported by grant funding will link individuals to primary care, and manage SDOH during the high-risk period after release from prison to the community.
 - **A prison-based peer navigator will help manage medical discharge planning** under a DOC contract.
 - Staff will be **the first CHWs employed by Lifespan**, RI's largest private employer.
- ⇒ **Prioritizing peer experience in hiring processes** may pose challenges, but technical assistance is available.
- ⇒ There are opportunities to infuse healthcare in traditional social services, and infuse social services in healthcare for high-risk populations.

staff, and with technical assistance from the Transitions Clinic Network to develop job descriptions that prioritize peer experience. Community Health Institute staff will supervise these employees. The Center has budgeted to pay for 72 hours of CHW training, and supporting participants' time in training, in order to bring them to state certification if needed.

The Center will provide medical discharge planning for the Department of Corrections using a nurse case manager and a peer navigator. In addition to Rhode Island Foundation funding, the Center has recently entered a contract with DOC to coordinate care for individuals being released with medical needs. A nurse case manager will work with those who require high levels of care upon release, such as medical residential or hospice care settings. A peer navigator, who will be employed with the "Community Health Worker" title, will provide transitions support for individuals with lower levels of need, such as those with substance use disorders and diabetes, working to strengthen the link to primary care. These patients will be connected to the Transitions Clinic program, as well as other primary care sites across the state.

The Center intends to demonstrate the value of CHWs in correctional health, contributing to a conversation about the relationship between healthcare and social services. A program evaluation is being developed that will explore health outcomes, retention in care, and impacts on hospitalization and ED use. It will hopefully include a qualitative evaluation of CHWs' work. These positions are fully grant funded, and there is currently no plan to pursue payer support, or internal funding for CHW services. Martino sees these initiatives as contributing to the long-term conversation about the value of this work. "We want to envision a world in which [health systems] understand the importance of providing patients with support outside of medical settings. We don't have the answers about how that gets paid for. There's no way a system will just decide to pony up unless they link the position to clear changes in the bottom line." Service organization-based workers, outside of healthcare settings, work under many titles that could be considered CHWs. Streetworkers at the Institute for the Study and Practice of Nonviolence, for example, address some of the same determinants of health that Transitions Clinic CHWs tackle with the justice-involved population. She sees opportunities to infuse healthcare among high-risk populations congruently with a traditional service model, and infuse social service into traditional healthcare.

East Bay Community Action Program (EBCAP)

Health & Social Services

Carla Wahnnon, Integrated Health Manager. October 10, 2017.

East Bay Community Action Program (CAP) is a CAP with an integrated FQHC providing health and human services in Rhode Island's East Bay communities. EBCAP has roughly 10,000 patients in primary care. The Integrated Health program—under the health center, but working closely with Family Development—works to connect EBCAP's health and social services across both sides of the organization.

Key Takeaways

- EBCAP is both a **human services organization** and an **FQHC**.
 - CHWs work in the Integrated Health program to **bridge health and human services**.
 - CHWs are grant-funded, and focus on addressing social needs as part of primary care, engaging disconnected high-risk patients, and insurance enrollment and navigation.
- ⇒ **EBCAP CHWs play a role bringing health to social services and social services to health.**

Community Health Workers in the Integrated Health program focus on outreach, health insurance enrollment, and connecting patients to social services. CHWs work under three job titles, each with two full-time employees:

- *Health Advocates* – join patients in exam rooms at the CHC, to do social service assessments as part of intake, intervene in social crises, and work to prevent homelessness and food insecurity.
- *Patient Engagement Specialists* – find, and work to engage patients in the community who have not been in contact with EBCAP, but are attributed to the primary care practice by Medicaid through HealthSource RI. They target high-risk patients with ER use but little or no connection to primary care.
- *Outreach and Enrollment Navigators* – provide health insurance enrollment navigation and support to community members under contract with the RI Health Center Association.

CHWs at EBCAP have BSWs or other bachelor's degrees, and have received or have pending certification through RIDOH's grandfathering process. Along with other program staff, they perform social needs "get-to-knows" for everyone new to the practice, to identify social determinants of health. "If someone comes in with a specific need, there's probably something else that's attached to it," says Carla Wahnnon, Integrated Health Manager. CHWs coordinate with Nurse Care Managers to engage people in primary care, increase levels of screenings, and connect them to other available services. **CHWs are grant-funded.**

EBCAP is in the process of assembling a Community Health Team. (See summaries on South County Health, SIM, and CTC-RI).

Family Service of Rhode Island

Interview: Robert Robillard. October 12, 2017.

Family Service of Rhode Island is large social service organization that operates and supports a variety of health programs. FSRI serves approximately 9,000 Rhode Islanders yearly, and has more than 350 staff members. The majority of clients served are under 18, but there are adult services in several program areas, including HIV/AIDS service provider AIDS Project Rhode Island.

Twelve CHWs at FSRI are Case Managers working in at least four programs. Case Managers are primarily existing FSRI employees who are being grandfathered in as certified CHWs. CHWs at FSRI have bachelor's degrees, or are working towards masters or licensure.

FSRI is participating in the Community Health Team expansion, adding a CHT in Providence that incorporates SBIRT. At Providence Community Health Centers' Olneyville site, two new bilingual CHWs and SBIRT workers have started integrating with the pediatric practice, and providing SBIRT screening for adults. LICSWs are also on staff, integrated into the team as behavioral health clinicians. The team has capacity in Spanish, Cape Verdean Creole and Haitian Creole. FSRI's work at the Olneyville location started with a Rhode Island Foundation grant, and FSRI is now a subcontractor of CTC-RI's contract with the State Innovation Model (SIM) to expand CHTs. CHWs on the CHT will also work at Crossroads doing SBIRT among the homeless population and referring to a new program to work on Medically Assisted Treatment for opioids. At St. Joseph's Health Center a CHW will assist with screenings and assessments, and the CHT is working out the details of a relationship with a PCP in East Providence.

Mental health services at FSRI use CHWs in-home and outpatient programs. The In-Home Services Department uses Case Manager CHWs to conduct Trauma Systems Therapy with minors and their families, under contract with the RI Dept. of Children, Youth and Families. In Outpatient and Enhanced Outpatient Services, the case management team supports functional family therapy. Using a CHW as part of the team is a strategic way to integrate all of the systems a child has contact with, so that no matter the system, there is coordination and consistency.

Key Takeaways

- FSRI is a **social service agency** with a variety of health programs and partnerships.
 - FSRI CHWs are **Case Managers** working in several programs, including **mental health, HIV/AIDS** and a **new CHT**.
 - CHWs are supported by **grant funding** and **limited payer support**.
- ⇒ CHWs help drive integration of social and clinical services.
- ⇒ FSRI finds CHWs valuable across a wide spectrum of patient populations

AIDS Project Rhode Island also uses CHW case managers who will be trained in SBIRT. This division already has a strong case management and clinical component, and will train case managers in SBIRT so they will understand what the on-site CHW will be doing to facilitate a warm handoff. The CHW will also screen for social determinants of health, using an assessment from Health Leads, which has been translated into Spanish.

FSRI provides supports for CHWs, and views them as necessary. FSRI prides itself on supervision. Program staff get an hour of individualized supervision, and an hour of group supervision each week. CHWs participate in regular team meetings. FSRI CHWs are embedded in a number of other organizations, and needs and organizational culture are different at each. “We are respectful of the culture that’s in place, and we can adapt ourselves to support that,” says Clinical Administrator Bob Robillard. “We are thinking of integrated care in everything we do. [...] The CHW role is a necessity in the way we work. We always team everything, from the administrator to clinician to case worker assigned to high need clients. This is not a change for us, we are renaming our case workers Community Health Workers. We are getting to the point where we try and fully integrate all services we provide.”

CHWs are paid primarily by grant funding, with a smaller portion of payer support in some cases. Grant funding includes DCYF positions funded through the Trauma Systems Therapy model, and the CTC-RI SIM grant for a CHT, and support from the Rhode Island Foundation. At some levels of care, private insurance pays for case management of outpatients who need extra help to meet treatment goals because they have social and basic needs. These services are billable to private insurance carrier Beacon. FSRI is a preferred provider because they meet benchmarks for evidence-based care, allowing them to bill on an open basis annually, rather than requiring reauthorizations. CHWs have a case manager attached, and the licensed provider is able to bill for the CHWs’ time for a certain number of units. For the most part, this work is done with traumatized children.

“There is an unending need for CHWs. They are the mortar that builds the building,” says Robillard. He sees opportunities for generalized CHWs to train for specialties that should be respected and financially enhanced, such as trauma-informed care, and HIV/AIDS care. “CHWs are often over-utilized and under-respected.”

Home Asthma Response Program (HARP)⁵

Health condition-
focused program

The Home Asthma Response Program (HARP) is an initiative of the New England Asthma Innovation Collaborative (NEAIC), implemented in Rhode Island through a collaboration among RIDOH, Hasbro Children's Hospital, Saint Joseph's Health Center, and Thundermist Health Center. NEAIC, in turn, is a program of Health Resources in Action, and also operates in Connecticut, Massachusetts and Vermont.

In HARP's model a CHW makes three home visits to pediatric asthma patients. CHWs are accompanied in the first visit by Certified Asthma Educators (AE-Cs). They perform home assessments, remove or ameliorate triggers, and educate caregivers on environmental control and medications. They also provide filtered vacuums, bed coverings, cleaning and pest control supplies. Program staff members help families adhere to physician-directed Asthma Action Plans, or refer families without plans to PCPs. Families are recruited primarily after children have an emergency department visit at Hasbro. The majority of families have Medicaid coverage through NHPRI or UHC, but a small minority had BCBSRI, other insurance or none.

Health outcomes have been dramatic. HARP evaluates its outcomes through hospital discharge data, claims analysis, focus groups and parent report. A 2017 RIDOH report on the HARP program highlights these outcomes:

- **“Quality Improvement:** The asthma medication ratio HEDIS score for participants increased from 32% to 46%.
- **Improved Asthma Control:** Patient population went from 20% well controlled to 51.5% well controlled.
- **Improved Quality of Life:** Caregiver quality of life improved 17% on validated surveys.

Key Takeaways

- HARP is an **evidence-based pediatric asthma intervention**
 - CHWs work with Certified Asthma Educators in families' homes to **educate, provide supplies and support for action plans.**
 - **Higher-risk patients have particularly high benefits** from HARP.
- ⇒ **HARP's health outcomes are positive and substantial.**
- ⇒ **ROI was positive, ranging from 33% to 126%** depending on utilization group.

⁵ Sources: RIDOH, 2017. “The Home Asthma Response Program (HARP).” <http://health.ri.gov/publications/programreports/HomeAsthmaResponseProgram.pdf>, retrieved 11/6/2017.

- **Reduction of Environmental Triggers:** HARP Community Health Workers observed reductions in mold, dust, pests, pets, tobacco smoke, and chemicals.
- **Reduction in Missed School/Work Days:** Caregivers report reducing missed work days due to asthma by 62%. Patients cut missed school days almost in half.
- **Increased Asthma Action Plans:** Availability and patient use of asthma action plans created by providers increased from 20% to 80% of participants.”

HARP’s financial outcomes have also been dramatic, especially for high utilizers. According to RIDOH’s 2017 [report](#), “HARP has a positive return on investment. This means that every dollar invested into reducing preventable ED/hospital visits gets returned, with additional savings earned. Overall, HARP participants had a 33% ROI on ED/hospital costs (\$1 investment returned with extra 33 cents saved). The subset of high utilizers had an ROI of 126%. Including overall asthma costs which show an encouraging increase in medication costs, HARP was still cost effective (i.e., investment equal to savings). For high utilizers, the overall asthma cost ROI was positive at 65%.”

Lifespan Community Health Institute

Interview: **Carrie Bridges Feliz, MPH, Director. October 6, 2017**

Lifespan is the largest health system, and largest private employer in Rhode Island.

Lifespan includes a number of hospitals and medical practices, including RI Hospital, and Hasbro Children's Hospital and has nearly 15,000 employees.

The Lifespan Community Health Institute (LCHI) promotes population health.

LCHI works “to ensure that all people have the opportunities to achieve their optimal state of health through healthy behaviors, healthy relationships, and healthy environments,” facilitating

cooperative efforts with community partners to address the full spectrum of conditions that affect health. The Institute is corporately funded by Lifespan, and has an extensive history of providing health education and screening. LCHI is currently rebalancing initiatives towards the base of the public health pyramid, expanding programming that addresses the social and environmental determinants of disease. Investing in Community Health Workers is one strategy.

Community Health Workers positions are currently being added to cancer, asthma and prisoner transitions programs. Lifespan had employed individuals in CHW-like roles in the past, typically as consultants. As of mid-2017, Lifespan has established a formal job description, and several positions have been posted with the official job title “Community Health Worker.” LCHI helped to create a position description, an attached pay scale and job classification. The generic job description can be specialized for desired skills and experience. Three positions were posted as of this writing, for CHWs working at the adult ambulatory Center for Primary Care's new Transitions Clinic (*see summary on the Center for Prisoner Health and Human Rights*) and the Community Asthma Programs at Hasbro Children's Hospital. The Lifespan Cancer Institute also plans to hire a CHW.

Lifespan CHWs are supported through core operational funding and grants. While CHW positions at the Transitions Clinic are grant-funded, the CHW at the Lifespan Cancer Institute will be paid by core operational dollars. Ms. Bridges Feliz, who made the case to fund these positions, says that it wasn't

Key Takeaways

- **Lifespan** is a large health system with a Community Health Institute engaged in population health programs.
- Lifespan has recently **formalized CHW job descriptions** and is in the process of **hiring CHWs** for positions in prisoner transitions, cancer and asthma.
- **CHWs will be paid through core operational funding and grants.**

⇒ **The largest health system in RI is investing in CHWs.**

difficult. People were primed, and she wasn't the first to introduce the issue. "I just needed to pull together the evidence and make the argument. People want not just evidence, but local evidence. [...] What is key for us—we do have navigators in the Cancer Institute, primarily for breast cancer—is being able to articulate how CHWs will supplement the continuum of support for the Cancer Institute." They are different from, but complementary to the role of navigators and social workers. CHWs will work to find patients who need extra support to get from mammogram to follow-up services, for instance, addressing barriers. CHWs can go out and extend ancillary services inexpensively, beginning by sealing gaps in existing referral pathways.

LCHI is working to support new CHWs at Lifespan. Ms. Bridges Feliz will supervise CHWs at the Center for Primary Care, Transitions Clinic, and CHWs in the asthma and cancer programs may collaborate with LCHI as well. CHWs will have the same onboarding as any other employee, and participate in in-house and external trainings. CHWs will participate in LCHI's biweekly meetings with other outreach staff. They are not currently set up to document in Epic, although LCHI hopes it will be possible to track CHW-supported patients using Epic in the future. CHWs will also train with Connect for Health, a Lifespan program that performs social needs screening, community referrals, and follow-up at Hasbro primary care clinics and emergency department.

Neighborhood Health Plan of RI

Interview with

Nancy Harrison, RN, MPH, Director of Strategies and Operations –Primary Care; **Gary Chavez**, MPA, CHW, Medical Management Project Lead; **Yvonne Heredia**, MS, PhD, Manager of Case Management; **Donna Mowry**, Operations Manager.
August 8, 2017.

Neighborhood Health Plan of RI is a nonprofit offering Medicaid and exchange plans that cover one in five Rhode Islanders. NHPRI was originally founded by, and maintains close partnerships with FQHCs, where 52% of its members receive primary care. This summary discusses NHPRI's activities as an **employer** of CHWs.

Key Takeaway

- **Community Health Workers are a valued member of the interdisciplinary care team at Neighborhood Health Plan of RI.**

NHPRI directly employs Community Health Workers (CHWs) as Community Care Coordinators on interdisciplinary care teams. NHPRI staff interviewed observed that many health needs for the Medicaid population are driven by social needs. Without access to housing and food, their health is not a priority. Understanding and addressing social determinants of health for a patient is an integral part of the work done by CHWs. NHPRI CHWs may have different roles depending on the needs of the patient. Their work may include completing health risk assessments or referring members to services, utilities, food and housing supports. “Sometimes it’s amazing what the CHW uncovers in the home, [...] bringing people to a higher level of care,” says Yvonne Heredia, Manager of Case Management at Neighborhood.

Neighborhood’s Health@Home Program, employees CHWs to support home-based primary care for high-risk patients. Patients enrolled in the Health@Home Program typically have multiple chronic conditions, frequent emergency room visits and inpatient hospitalizations. The Health@Home Program uses proprietary analytics to identify high-risk patients. Members can also be referred by Primary Care Providers.

Nurse practitioner (NP) led teams for the Health@Home program are assigned geographically. One or two CHWs work with each NP. A comprehensive in-home assessment is conducted by the NP to identify medical, behavioral and social needs. The CHW’s role is to support the treatment plan outlined by the NP, which may include providing services such as taking vital signs, reinforcing medication adherence as directed by the NP, or facilitating transportation to provider visits using the state’s Logisticare program or cab vouchers. Health@Home CHWs go through the state’s CHW certification process.

Neighborhood provides ongoing education and support for CHWs.

Neighborhood values personal and professional development of staff and will provide on-site in-services, or will make external trainings and conferences available to CHW staff whenever possible. Working with a high-risk population can be challenging for the CHW. NHPRI provides a variety of venues in which staff can express frustrations, problem solve or get feedback from other team members as well as his or her manager. An independent licensed clinical social worker on the Health@Home team is available to help individuals and teams manage stressful situations that may include, grieving for lost patients. The Health@Home program recently developed a CHW Lead role, providing opportunities for advancement.

CHWs also provide support and value for other staff. “From our perspective, having a CHW on the team allows us to provide the appropriate resources to meet the patient’s needs” says Nancy Harrison, Director of Strategies and Operations – Primary Care at Neighborhood. The goal is to have each individual to work to the highest level of her license or certification to support a patient’s needs. CHWS are utilized to provide chronic condition education. This model, connecting medical and social determinants of health is “just the right fit for working with communities,” says Heredia.

Our Journ3i Doula Services

Interview with Quatia “Q.” Osorio. September 28, 2017

Owner-Operator

Our Journ3i is owned and operated by maternal and child health CCHW Quatia “Q” Osorio. Our Journ3i is a “perinatal community based wellness organization primarily focused on eliminating disparities of health and identifying social health determinants within infant and maternal health by providing empowering education and services.” Our Journ3i is based in Providence, and provides doula services and breastfeeding support primarily to African American women, to combat disparities in maternal and child outcomes.

Our Journ3i takes a personal, culturally-situated, holistic approach.

Osorio was inspired by her own experience in childbirth to train as a doula. “I had a doula. Because I had a doula, I *am* a doula.” She focuses in particular on trauma, anxiety and empowerment. For example, one mother’s experience of trauma required changes in standard procedure after delivery, and Osorio helped advocate with providers to ensure her instructions were followed. Another experienced anxiety after learning she was expecting a boy, given experiences of police violence. Osorio worked to accompany her through pregnancy, birth and postpartum, and ease her anxiety. Whereas low-income patients often experience judgment, stigma and distrust in interacting with medical and government institutions, Osorio provides a non-judgmental, culturally concordant approach. “There’s not this big fear because DOH [or DCYF] is coming in—I’m just Q.”

“The Community Health Worker has the whole story. The employer wants data, needs to piece it together to justify services, what to include in a Medicaid package. Sometimes basic stuff like being there talking about a budget, you find out other issues like transportation and childcare.” “Community health workers are so valuable. We bring the story with the data.”

Osorio sees clients regardless of ability to pay, and is supported by sliding scale and grant funding. Our Journ3i received a RIDOH grant in 2015 to provide services to ten women. If patients have the ability to pay, they are asked for a contribution, but oftentimes doula care is free. Osorio has offered barter and payment plans. She would like to pursue a reimbursement arrangement with Medicaid MCOs.

Key Takeaways

- Our Journ3i is an **owner-operated maternal and child health CHW service** focused on reducing MCH disparities among African American women.
 - A key focus is **supporting women with trauma and anxiety** before, during and after birth.
 - Our Journ3i uses **client payments arrangements** and **grant funding**.
- ⇒ There is a need for **technical assistance** and **continuing education**.
- ⇒ There are potential pitfalls to incorporating CHWs in medical organizations, but enormous value to employers.

Technical assistance in securing coverage would help maternal and child health CHWs / doulas. Osorio believes that technical assistance for achieving NCQA accreditation, or establishing a billing relationship with an MCO would help grow the field. As a CHW without an employer, she does not have a method to independently validate and bill for her work. She sees opportunities for the newly revamped CHW professional association to provide support in these areas. It is also a priority to build interconnections among organizations and resources that work on the social determinants of health, including RIDOH, DCYF, DEM, farmers markets, pharmacies. “Not creating a separate bubble [of CHWs], but linked to all of these areas.”

CHWs need upward mobility, and they face challenges working within organizations. Osorio believes it would be wise to tailor continuing education to specific plans to impact community health. CHWs could specialize, for example with a community development track, and become upwardly mobile. But there is a risk of tokenism and mistreatment within medical hierarchies. How will CHWs be treated in doctor’s offices and hospitals, and will they be viewed as competition rather than reinforcement? There is a risk that CHWs become “the colorful bottom base of the pyramid,” in which people of color with associate’s degrees get stuck with no opportunity to advance educationally and professionally. Another risk is that CHWs become a fad, and people join for the wrong reasons—or that professionalization sets up barriers for people who should be included. What resources will be available to support CHWs in the workplace? “We are the change going forward. Our job is to get them from here to there.”

Project Weber / RENEW

Interview: Colleen Daley Ndoye, Executive Director. August 16, 2017.

Population-Focused Program

Project Weber/RENEW united two harm reduction programs for at-risk people in Rhode Island. RENEW had focused on the needs of female sex workers in Providence, Pawtucket and Central Falls, while Project Weber focused on male sex workers in Providence. The two organizations merged in 2016, “in order to serve the full range of sex workers and high risk women and men, including transgender sex workers.”

[weberrenew.org] Both programs were historically peer-led, and continue to be staffed predominantly by people with lived experience of sex work, substance use and HIV.

Weber/RENEW has a positive relationship with law enforcement, who see the program as a resource to reduce arrests, and refer sex workers to the CHWs in the program.

Key Takeaways

- **Project Weber/RENEW works with male and female sex workers, including transgender sex workers, as well as high risk people, for harm reduction, health and recovery.**
 - **Most staff are CHWs with peer experience, and conduct specialized outreach, education and support.**
 - **Programming is grant-funded.**
- ⇒ **Peer CHWs have highly specialized skills, and require specific supports.**
- ⇒ **Managing multiple small grants requires a high level of coordination.**

Weber/RENEW CHWs focus on outreach, HIV and recovery support, trans* health, education and basic needs. CHWs at Weber/RENEW work under several titles. Peer Outreach Workers provide health education, support, HIV testing, needle exchange, and basic needs support. Drop-In Center Managers manage these services, and are CHWs themselves. A Transgender Peer Outreach Worker focuses on street outreach to at-risk trans* community members. The PrEP case manager is focused on enrolling high-risk HIV-negative male sex workers for a Brown University/Miriam Hospital study on case management and PrEP adherence, but provides referral services for others. Most staff are trained recovery coaches or peer recovery support specialists, and help deliver naloxone and fentanyl training. All participated in a recent RIDOH CHW training, using a fee waiver program, and 7 of 8 are now RI-certified Community Health Workers. Certification is viewed favorably by funders.

CHW activities are funded through a number of small grant sources. Project Weber/RENEW is funded by 13 grants as of this writing. The largest are grants from the Elton John AIDS Foundation, and a RIDOH/EOHHS grant for return-to-care outreach and incentives for HIV+ individuals, and assessments of high-risk negative individuals. RIDOH also provides funds for HIV, Hepatitis C, and syphilis testing, as well as condom distribution and street outreach. The RI Foundation and AIDS United support trans* outreach and trans* leadership development programs. Managing the reporting requirements of many small grants simultaneously is challenging.

As peers, Weber/RENEW CHWs require specific supports. Individuals receiving SSI disability benefits have restrictions on their allowable income, and medical limitations on their work. After passing a low earnings threshold, beneficiaries' SSI payments are reduced by half of earnings—and if they are employed full time with medical coverage, they lose SSI coverage. It is challenging to budget for positions filled by persons receiving SSI benefits, whose health may be unstable. CHWs may get sick, take leave, and come back to work. Justice-involved individuals may be re-incarcerated, often due to missed court or parole/probation requirements rather than new criminal violations. People with a history of substance use may relapse. Repurposing grant funds for changing circumstances can be difficult. Managing staff turnover and attrition due to these life circumstances can be difficult, but is easier with many part time positions, rather than a few full time positions. Training is another needed support: "People's life experiences makes them incredible, but oftentimes they've missed many important training or job experience milestones," says Executive Director Colleen Daley Ndoye. Weber/RENEW CHWs have very specialized skills, and often can't cover for each other. If someone's strength is being in the streets with the trans community, other staff members may not be able to step in to work with that population.

Project Weber/RENEW is working for sustainability on other fronts. They are receiving technical assistance to connect a number of different data and evaluation systems. Program staff are offering training to other organizations, and developing a fee structure for these trainings. Daley Ndoye would like to see a dedicated funding stream for CHWs that her program could apply to, as well as networking and peer learning opportunities. She believes CHWs are on the cusp of becoming part of the popular vernacular. She describes a client who was suddenly admitted into a recovery facility, forgetting his teeth at home in the process. Weber/RENEW CHWs retrieved the teeth and preserved the client's dignity, easing his path to recovery. "What grant form do you put that on?"

Providence Community Health Centers

An FQHC

Interview with Deborah Powers, Chelsea Depaula.
August 1, 2017.

Providence Community Health Centers is an FQHC with ten locations in Providence, RI, serving 45,000 patients yearly.

PCHC employs Community Health Advocates (CHAs) in their Case Management department, who work with high-risk patients. Four CHAs currently work in case management at PCHC, primarily with patients who are assigned by payers to high-risk lists, or who are identified as high-risk by providers and other referral sources. Patients assigned for case management outreach most often are high utilizers of the emergency department, have frequent inpatient stays and chronic conditions including behavioral health diagnoses.

CHAs connect patients to community resources and support English-Spanish translation. 60% of PCHC patients are bilingual. CHAs must be bilingual as well, and pass a language test. Their primary role is to provide case management including culturally sensitive translation, and connections to social and community resources identified by the nurse case manager through assessment and plan of care interventions. CHAs may work on social determinants that are identified as barriers, as well as help patients fill out forms, understand written materials, or speak with medical or service providers. CHAs frequently help patients access transportation and food resources. They identify and help overcome obstacles to keeping medical appointments. CHAs do not currently provide independent chronic disease management. Case management teams meet daily to coordinate activities. One CHA was grandfathered into state certification, and others are preparing for CHW certification.

CHAs are funded through PMPM payments made via the Care Transformation Collaborative of RI (CTC-RI), and through PCHC's Medicare ACO. As a CTC-RI primary care practice, PCHC receives a Per Member Per Month payment for qualifying patients for nurse case management and care transformation. The primary referral source into the current case management program is through payer-provided high-risk

Key Takeaways

- PCHC employs Community Health Advocates (CHAs) for **case management of high-risk patients.**
 - **CHAs connect patients to community resources,** and focus on **bridging language barriers.**
 - **Funding for the case management program, including its CHAs, comes from PMPM arrangements with CTC-RI, and through PCHC's Medicare ACO.**
- ⇒ An FQHC is funding CHWs in case management through health plan capitated payments.
- ⇒ ROI on case management activities has yet to be seen, but is promising.

lists. One CHA is assigned to Medicare patients covered under an ACO arrangement, whose budget also supports case management.

Future directions include evaluating case management's ROI, improving transitions from hospital care, improving information-sharing technology, and training CHAs as health educators. The return on investment for CHA-delivered case management services will be measured in terms of cost savings, patient satisfaction, reduced inpatient stays, etc. PCHC is evaluating these metrics, but case management activities are new, and the ROI remains to be seen. In terms of patient experience and outcomes, the results have been promising and positive. Transitions from hospital care to the home are challenging, and an area where CHAs may have a great deal of potential impact. Information-sharing technology to alert primary care providers and case managers at the health centers that patients are admitted to or discharged from the hospital is still limited. PCHC has designed a workflow to improve these transitions, which will be implemented in the future. The CHAs have attended state trainings such as colorectal screening, diabetes, asthma. Their role in the future may include providing health education in chronic disease.

PCHC also employs patient navigators to promote and support cancer screenings through grant funding. Navigators have a different scope of practice than case management CHAs, and work in the clinical practice. They are funded by a RI Dept. of Health grant to support screenings for cancer among women, and colorectal cancer.

Rhode Island Parent Information Network (RIPIN)

Health & Social Services

Interview with: **Nicole Hebert**, Chief Operating Officer; **Deborah Masland**, Director of Peer Support; **Nancy Silva**, Program Manager. **August 16, 2017.**

RIPIN serves families of children with special needs, and provides peer support in other areas of health and prevention.

The Rhode Island Parent Information Network was founded in 1991 to connect parents helping each other navigate the special education system in their children's schools. RIPIN has maintained a core focus on children with special needs, while expanding to provide peer navigation, coaching and advocacy in a number of health and social service arenas. RIPIN has a strong belief in centering shared experience: all frontline staff are peers of their programs' target populations, or have experience navigating the systems the programs engage. RIPIN also takes an active role in statewide policy and advocacy, sitting on 75 different advisory councils and committees.

Key Takeaways

- **RIPIN is RI's largest CHW employer.**
 - **Peer CHWs help navigate health and education systems**, with a particular focus on families of children with special needs. They are also embedded in a number of healthcare settings and health promotion programs.
 - **CHWs are funded primarily through public grants and contracts** from a variety of sources.
- ⇒ **FFS billing, even if possible, would be difficult** for RIPIN as a nonprofit. But RIPIN uses diverse payment arrangements and sees future opportunities.
- ⇒ **RIPIN provides specialized supports to staff with peer experience**, including training, leave, and supportive supervision.

RIPIN is the largest employer of Community Health Workers in the state, with roughly 61 active certified CHWs playing many roles. Job titles include Peer Navigator, Peer Care Coordinator, Parent Consultant, Family Support Staff and Resource Specialist. Entry-level staff are hired with these titles, and trained as CHWs with in-house curriculum aligned to state certification standards, meeting their in-service requirements through paid employment. Most RIPIN CHWs have been certified through the grandfathering process. RIPIN has provided expertise on CHW training, policies and procedures to other employers and education agencies in the state, and embeds contracted CHWs in a variety of settings.

CHWs are funded primarily by public grants supporting navigation in health and education systems. Within RIPIN's in-house programs, CHWs support systems navigation, coaching and advocacy for parents of children with special needs. Parents of children who have completed early intervention provide peer support to parents beginning the process. The Family Voices program provides healthcare information, leadership development and support for children and youth with special healthcare needs or disabilities. One role RIPIN CHWs play is to train families and providers to use the Family Voices national website to access vetted health information and

resources, and access the medical home portal. RIPIN is also the federal designee to operate a parent information and training center, supported with a grant administered by the RI Dept. of Education (RIDE).

RIPIN CHWs are also embedded in healthcare and health promotion settings. Patient Navigators work with the RI Dept. of Health to operate the Community Health Network, a centralized system to provide telephone-based referrals to patient education and prevention programs, including diabetes prevention and chronic disease self-management, and the WISEWOMAN cancer screening program. Four RIPIN CHWs act as technical assistance liaisons to Health Equity Zone programs. CHWs also support programs in fall reduction for older adults, WIC referrals, immunization, birth defect prevention, and emergency preparedness.

RIPIN uses, or has used several innovative funding sources to support CHWs:

- Cedar Family Centers are medical homes providing intensive care coordination and support for families of children with chronic disease and severe mental illness or emotional disturbance, who are covered by Medicaid. RIPIN operates a Cedar, and has CHWs embedded in two hospital-based Cedars. RIPIN bills for CHW services at Cedars on a basis they have nicknamed “fee-for-product.” RIPIN develops annual comprehensive care plans, billing every 365 days.
- Communities of Care is an Emergency Department diversion program established by the RI Dept. of Human Services, and currently connected with NHPRI and United Medicaid plans. RIPIN Peer Navigators provide care coordination within this program. CoC is fully funded through Medicaid plans, with a negotiated contract. This is high-touch program with low volume, addressing complex and long-term problems including living circumstances and transportation. ROI may not be evident over a short-term timescale for these interventions.
- Lifespan/Hasbro has carved out a 20-hours/week RIPIN position from a LEND grant from HRSA’s Division of MCH Workforce Development, to provide support in the neural development unit.
- A PCMH Kids primary care office had previously used care coordination money to support a RIPIN care coordinator at 20-hours/week, but the funds and position were subsequently cut.
- RIPIN interviewees noted that Medicare [intends](#) to pay for Diabetes Prevention Program services beginning in 2018, which may present opportunities.

FFS is very difficult for nonprofits to pursue, because of the overhead needed to chase the money. RIPIN leaders interviewed said that if they were a bigger organization they would have their own billing department, but that they don’t want to get too big and lose their personal touch. A centralized billing system shared among CHW employers might facilitate this. They also noted a struggle between reality on the ground, and the outcomes that primary or managed care hope for, whose metrics are ER diversion, and ROI. They identified a need to value the work of CHWs at more than \$13-17/hour.

RIPIN’s workplace culture is designed to support peer CHWs. Staff share experience with each other and with their clients. RIPIN leaders interviewed say

that supervising a peer requires finesse. There is a high possibility that stressful interactions with patients can trigger an emotional response, and supervisors provide an extra layer of support. Because of the complex family health needs of many staff members, there is a high proportion of staff on medical leave at any given time. RIPIN's benefit package is designed to accommodate these needs with generous paid time off. RIPIN leaders describe the pay as low, but with good benefits. They say that RIPIN has low turnover because of many other supports: supervisors who understand, a career ladder, training, benefit package, an understanding staff and their frustrations. That said, RIPIN CHWs are often hired in other settings.

Among high-risk populations, RIPIN sees anecdotal miracles, but lower volume in some programs. Interviewed leaders asked, if you're a certified CHW, where's the code for that for Medicaid or private insurance? Could they or a doctor get reimbursed, either through FFS or bundled payments? A CHW working at the top of the salary range could accomplish more on the social determinants of health, and still be cheaper than bottom range of other occupations, either in medical setting or CHTs. These services and savings could be marketable. **“How do we quantify quality?”**

RI Department of Health

Health Equity Zones (HEZ) & health promotion programs

Funder,
Partnerships

Rhode Island's Health Equity Zone (HEZ) initiative is a place-based, community-driven approach to eliminating health disparities. Partnerships in 9 geographically contiguous areas in the state receive seed funding from RIDOH to carry out locally-tailored approaches to prevent chronic disease, improve birth outcomes, and improve the social and environmental conditions of neighborhoods. HEZ grants from RIDOH are assembled from multiple braided federal and state funding streams. HEZs range in size from neighborhoods to counties. Backbone agencies are municipal governments, nonprofits, a community health center and a health system. HEZ programming includes access to local food, safe transportation to school, overdose prevention education, exercise, teen pregnancy prevention, mental health first aid training, and outreach to seniors. "Because they are *so* local, place-based initiatives are well-structured to avoid the pitfalls of "one-size-fits-all" public health, and they have great potential to harness social capital, and to grow it into the *local* ownership of public health that promotes the most effective sustainability." (Alexander-Scott, 2017).

Key Takeaways

- **Health Equity Zones** are Rhode Island's innovative, place-based approach to community health, supported by braided funding.
 - Many **HEZs employ CHWs** in diverse activities addressing SDOH in geographic regions
 - RIDOH also employs CHWs as **tobacco cessation counselors** and **chronic disease educators**.
- ⇒ **A collective impact, locally-tailored approach uses CHWs for innovative public health interventions.**
- ⇒ **RIDOH supports CHWs with braided state and federal funding that leverages local resources.**

Many Health Equity Zones employ CHWs. HEZ Community Health Workers:

- Build resident skills related to civic engagement.
- Assess the number of public venues utilizing nutrition guidelines and educate based on findings.
- Educate businesses about the benefits of bike and pedestrian access.
- Conduct resident "Knock and Talks" to provide information & resources, and gather resident input on creating a healthy community.
- Create a signage campaign to encourage walking.
- Support racial minority groups in accessing diabetes education.
- Create a local maternal health resource guide.
- Facilitate access to fresh fruits and vegetables through pop-up markets.
- Create a referral system with local schools and social service partners to identify and support mothers in need.
- Conduct lead-safe house parties.

- Mobilize community members to advocate for no smoking policies.
- Serve as liaison between public officials / law enforcement and the community.
- Convene breastfeeding support groups.

In addition to the HEZs, RIDOH supports CHWs working for tobacco cessation and chronic disease management. A tobacco cessation specialist provides counseling as part of RIDOH's Tobacco Control Program. Chronic Disease Educators are paraprofessionals employed by RIDOH to use Stanford evidence-based models for educating patients to manage diabetes, asthma, and cardiovascular disease. These services are not currently reimbursed, but Medicare will cover diabetes education beginning in 2018. Some RI employers offer these health promotion programs to their workforce.

RI Department of Health Center for HIV, Hepatitis, STDs & TB Epidemiology

Funder, CBO
Partnerships

Interview:

Thomas Bertrand, MPH, Chief;

Katharine Howe, HIV Prevention Epidemiologist.

May 15, 2017.

The HIV field has a great deal of expertise in managing the social determinants of health (SDOH), and navigating health and social service systems. Factors such as housing, linkage to care, nutrition, and mental and behavioral health, are primary determinants of outcomes for persons living with HIV/AIDS (PLWHA). Accordingly, the field has significant insight and best practices about the management of SDOH through CHWs that can be applied to other contexts.

Non-medical case managers are used by three HIV/AIDS service organizations in the state, and these services are reimbursable through Medicaid MCOs and EOHHS. Non-medical case managers have clear and specific requirements from Medicaid in order for their services to be reimbursable: they must be supervised by an LICSW, there must be established care plans approved by the supervisor, and extensive documentation of case files which can be audited. Meeting these requirements would be a significant hurdle for organizations new to the process. Non-medical case managers must have a high school diploma, and a certain number of work hours documented, but there is no certification requirement. All Medicaid plans in the state reimburse this service, and people who are not legal residents eligible for the Affordable Care Act (ACA) may have these services reimbursed through HRSA Ryan White Part B dollars administered by EOHHS.

Case managers use the RI Non-Medical Acuity Scale Worksheet developed for HIV patients to assess the need for services. The scale assesses 19 dimensions of acuity, including housing, nutrition, support system, etc. Based on this assessment, case managers provide low-income PLWHA with comprehensive services including support for transportation, insurance, and healthcare navigation, the AIDS Drug Assistance Program (ADAP), food bank assistance, etc. AIDS Project RI has a fact sheet about services provided through nonmedical case management. Many case managers are HIV positive, although agencies often have mixed-status teams. Some

Key Takeaways

- The HIV field has **expertise in care coordination, managing SDOH.**
- **Non-medical case managers are reimbursable** and used by AIDS service organizations.
- RIDOH supports a new multisite **HIV peer navigator demonstration** with Ryan White-funded grants.

Key questions:

- ⇒ Should HIV peer navigators engage in training and certification as CHWs?
- ⇒ How should peer navigator programs plan for sustainability?
- ⇒ What is the evidence that CHW case management can drive HIV viral suppression?

HIV positive staff have barriers to full-time employment related to disability benefits, and work part time by necessity or preference.

RIDOH is supporting a Peer Navigator demonstration project through Ryan White supplemental funds granted to eight recipients in late 2016 as part of its 90/90/90 program. Grantees include the three AIDS services organizations that have used non-medical case managers historically (AIDS Care Ocean State, AIDS Project RI, Community Care Alliance), as well as the Miriam Hospital, Sojourner House, Project Weber/RENEW, Youth Pride RI, and the Department of Corrections. 5-10 peer navigators are compensated by grant funds, including as many as 5 new hires. Funds totaled \$500K, and the aim is to advance the 90/90/90 goal through peer navigation that each agency could tailor to its own target population. Evaluation metrics for those focused on HIV positive populations include engagement in care and viral suppression, while others focus more on HIV testing. RIDOH did not specify training and supervision requirements for peer navigators, in order to grant agencies the freedom to pursue their own approach. Project Weber/RENEW navigators took part in CHW certification training at the agency's own discretion. The Department of Corrections Peer Advocate program is focused on testing IDUs and commercial sex workers who are awaiting trial, and linking those who are positive to care, either in prison if sentenced, or in the community if not.

RIDOH also noted two other HIV-focused CHW initiatives. **PrEP navigators** at the Miriam Hospital Infectious Disease Clinic focus on office-based follow-up with patients who have missed appointments or stopped adhering to PrEP regimens. Apparently unique to Rhode Island, Medicaid has approved a category for **case management of high-risk HIV-negative patients**, but a reimbursable program has not yet been established.

RIDOH provides some direct services, including Return to Care for HIV patients who have fallen out of care, partner services, and DOT for tuberculosis patients.

Ryan White supplemental funding varies year to year, and may not be a sustainable source of peer navigator employment, although RIDOH expects this round of funding to be renewed if EOHHS sees good outcomes. Sustainability was not the initial focus of this demonstration project. If the peer navigator function could become reimbursable, there wouldn't be a need for these funds—but certification is a complex question, and the initial focus was to hire a workforce and demonstrate their value. RIDOH is very supportive of peer navigators: they can fill in the gaps in time and connection between services that are reimbursable by non-medical case managers.

Mr. Bertrand would like to see some improvements in intensive case management services, using the acuity scales to create a tiered and thoughtful approach. A CHW could be automatically designated to develop care plans for a special track of patients—particularly the 10% who occupy 90% of service providers' time. He would also like to see data linking case management to viral suppression, and believes it would be a strong predictor, noting excellent outcomes locally and nationally.

South County Health & CTC-RI Community Health Teams (CHTs)

Health System,
Initiative

Interview: Elizabeth Fortin, CHT Program Director. October 5, 2017.

South County Health is a health system serving rural

Washington County. SCH includes South County Hospital, a number of medical practices and other partners. South County Hospital is a member of Integra Community Care Network, an ACO working on a statewide Accountable Health Communities initiative (*See summary on Integra*).

SCH has operated a Community Health Team since 2014, and is managing the expansion of CHTs in the state.

Community Health Teams include two FTE

Community Health Workers, a nurse care manager, and a behavioral health clinician (*See summary on CTC-RI*). SCH's CHT was one of two pilot teams established through CTC-RI in 2014, and SCH began providing administrative oversight and data support for the second team at Blackstone Valley CHC. When CTC-RI was awarded a SIM grant (*See summary on SIM*) to expand CHTs in mid-2017, SCH took the role of coordinating the state level expansion and consolidated operations model. This initiative has been integrated with a SAMHSA grant to expand SBIRT training, with new SBIRT workers currently being added to CHTs. Elizabeth Fortin, of South County Health, is the CTC-RI Program Director for Community Health Teams.

CHTs currently operating or newly established:

- **South County Health** – Currently operating. Washington County. CTC-RI Health Plan funding and SBIRT funding. 2 FTE CHWs, 1 SBIRT worker, 1 Behavioral Health Care Manager.
- **Blackstone Valley CHC** – Currently operating. Pawtucket/Central Falls. CTC-RI Health Plan funding. 2 FTE CHWs, 1 SBIRT worker, 1 Behavioral Health Care Manager.
- **Thundermist Health Center** – One new CTC CHT split between West Warwick, Woonsocket, supported with SBIRT and SIM funding. 2 CHATs leverage Fee For Service arrangement with NHPRI, and philanthropic support. 2 FTE CHWs split between teams, 2 SBIRT workers, Behavioral Health Care Manager.
- **Family Service of RI** – New CHT forming. Providence. SIM and SBIRT funding. 2 FTE CHWs, 1 SBIRT worker, 1 Behavior Health Care Manager.

Key Takeaways

- SCH is a health system operating a **Community Health Team (CHT)** with Community Health Workers.
 - SCH staff are overseeing the **expansion of CHTs** in the state through CTC-RI.
 - CHT expansion is supported with **braided funding from multiple sources**.
- ⇒ CHTs are an **expanding model with financial support from several players**.
- ⇒ **CHTs' results are promising but difficult to demonstrate**.

- **East Bay Community Action Program (EBCAP)** – New CHT forming. Newport. United Healthcare funding via OHIC. 2 FTE CHWs, 1 SBIRT worker, 1 Behavioral Health Care Manager.

CHTs focus on high-risk adult patients. Community Health Workers on the teams are the “eyes and ears in community, in homes—the teams see a lot, bring back very valuable information to the medical team who they rely on to make sure their medical care is appropriate,” says Fortin. CHWs and behavioral health clinicians have done care coordination and advocacy, and work hand-in-hand with nurse care managers on medication issues. In South County, CHTs make hospital visits, and are more and more integrated with SCH’s Case Management Department. CHWs and Behavioral Health Care Managers on CHTs work with pharmacists and nurse care managers to address patients’ medication concerns. CHWs have caseloads of roughly 50 patients at a time, seeing 200-300 over the course of a year.

CHTs are supported by braided funding from the State Innovation Model Test Grant, health plan support of CTC-RI, and BHDDH support for SBIRT expansion. SIM is funding expansion of CHTs and a consolidated operations model to provide centralized administrative support. CTC-RI is the vendor for this SIM initiative, and multi-payer support for CHTs continues to flow through CTC-RI as well. The state braided a five-year BHDDH grant to expand SBIRT into these initiatives. South County Home Health, a visiting nurse program with home-based OT, PT and rehab services, has also provided charity funding so CHTs can see people who are not enrolled in CHT-participating South County Health primary care practices.

SCH seeks CHWs with a level of skill with social work and behavioral health. CHWs should feel capable around behavioral health, helping people manage and seek services for anxiety and depression. SCH looks for CHWs with BSWs, and a philosophical orientation towards case management and social work.

Results have been strong, but challenging to demonstrate. CHTs have had strong buy-in from primary care offices, particularly large practices and FQHCs. CHTs face challenges related to demonstrating their outcomes in standardized ways. Ms. Fortin says she “hope[s] not too many people rest success or failure on whether we proved anything financially” in the time window available, and that being clear about the business case for sustainability would be helpful. But the value of CHTs from the patient’s perspective has been clear, and SCH is looking for opportunity to better capture this perspective. The SCH Marketing Department has begun this process, putting together a brochure with patient testimony.

Billing for time would incentivize the wrong thing. Fortin would not want to bill for CHWs’ time, unless there were a case rate method. “It is important to provide services for as long as they are needed. A visit can last an hour or three. CHWs attend court with patients. This level of support might be the only way an individual could get through a hearing on a disability claim denial. It’s difficult to put a time limit on this type of activity.

Thundermist Health Center

An FQHC

Interview with **Matthew Roman**, Chief Financial Officer. July 28, 2017.

Thundermist Health Center is an FQHC with locations in Woonsocket, West Warwick, South Kingstown, serving 46,000 patients per year with medical and dental care.

Thundermist uses Community Health Access Teams (CHATs) with CHWs to target high-risk patients.

Thundermist has employed two CHATs since 2014 that include two CHWs, an LICSW, and behavioral health specialists. CHATs were originally proposed to the health center by Neighborhood Health Plan of RI (NHPRI) as a way to address social determinants of health outside of the clinic walls among high-risk Medicaid

patients. In addition to CHWs working with CHATs, Thundermist also employs a CHW focused on asthma, funded by the RI Dept of Health.

CHWs on the teams are funded by billable codes for certain patients and activities, by a philanthropic grant, and now by SIM funds. NHPRI initially identified the costliest and highest-risk 5% of their patients receiving care at Thundermist, 800 individuals. They developed codes that could be used with these patients to cover CHATs' services including those delivered by licensed (behavioral health and RN), and unlicensed (CHW) practitioners, both in office and in the community. This pool of patients expanded to 1400 in 2015-16, and 3000 in 2016-17, still less than 10% of Thundermist's medical patient population. To be able to provide CHAT services to patients not covered by NHPRI, or not eligible for these billing codes, Thundermist secured a three-year grant from the Jessie B. Cox Foundation. One aim of the grant is to negotiate with additional payers for sustainability of CHAT services, but the health center has not yet achieved this goal. In mid-2017, the SIM funded Thundermist through vendor CTC-RI to add a new Community Health Team. Thundermist worked with SIM leadership to create a braided funding mechanism to allow them to bill FFS when available, and use SIM dollars when not. This arrangement is allowing the health center to start two new teams for the price of one.

Thundermist developed an assessment process to identify patients in need of, and likely to benefit from CHAT services, who were not part of the population eligible for billing. They began by developing a report that queried those with three or more inpatient stays or ED visits within the past six months, and those with three or more chronic diseases including behavioral health conditions. This initial list of

Key Takeaways

- Thundermist is an FQHC that operates two **Community Health Access Teams (CHATs)**
 - CHWs are funded with a combination of **billable codes for select patients of one payer and grant funding.**
 - **Billing for selected patients presents challenges** in practice.
- ⇒ There may be opportunities to expand model to **other payers and patients.**
- ⇒ **PMPM and FFS models** each have benefits and drawbacks.

high-risk patients outstripped capacity. They narrowed the list by assessing the degree to which they could impact the conditions in question. For example, those with frequent hospitalizations that could benefit from intensive home-based services, or those with unmanaged asthma, scored higher on impactability. The resulting list was not used to exclude patients, but as a starting point for Thundermist PCPs to refer to CHATs. They have also developed and are piloting an assessment of Social Determinants of Health, drawing from a Health Leads [toolkit](#), which integrates with the health center's Electronic Medical Record.

Paying for CHWs with a small portion of patients eligible for billing is challenging in practice. Doctors want to be able to refer patients to CHAT services regardless of their payer (or lack of payer), and according to their own assessment of need. There are also complications when a patient already enrolled in a CHAT and receiving CHW services (not billed to payers other than NHPRI) begins receiving billable behavioral health services such as psychotherapy that incur copays. Different payers have different populations with different needs.

ROI may not be apparent to payers in the short term. Not all high-risk patients are high cost. Some patients may have very low costs for payers because they are not utilizing care that is badly needed. Using CHWs to engage them in primary care may lead to costs that are higher in the short term, although they may avert costly catastrophic events in the long term. Some high cost patients may not need CHW services, such as accident victims. There are also confounders in comparing ROI on CHTs employed directly by payers vs. CHTs employed by providers who bill for services. ROI may be more apparent on a longer time scale, but is hard to measure in a way that convinces payers.

There are benefits and drawbacks to both PMPM and FFS mechanisms of funding CHWs. Chief Operating Officer Matthew Roman believes a Per Member Per Month payment is likely to be the most effective funding mechanism going forward, in which a calculation is made that, for example, of every 1000 patients, 10 will need a CHW. If a CHW costs a certain amount in salary, benefits, training and mileage, a certain PMPM can be calculated accordingly, as was done with Nurse Care Managers. But this is problematic where need is not distributed evenly. Communities impacted by a greater concentration of social determinants of health, and with a higher prevalence of chronic disease, would have a greater need for CHW services. The challenge with PMPM would be to right-size it. And small practices would be unlikely to have sufficient PMPM to support their own CHTs, and would need to rely on regional teams. Geographic- and practice-based teams are both useful. With Fee For Service, codes could be turned on for CHW billing. The risks would be incentivizing payment for volume, and limits on the maximum number of units billed. Community Health Workers work best when they spend time on a particular issue until it's resolved, and time constraints implied by billing could interfere. Grant funding to date has allowed for nearly payer-blind CHAT services at Thundermist, but with the grant period ending, there are questions about how to sustain the teams going forward.

CHW certification seems to be working well in practice, but CHWs would benefit from training in documentation and supporting clients' transitions to

independence. CHW classes are well-reviewed and requirements aren't onerous. Thundermist is developing a tiered CHW compensation system based on experience, specialization and training. Mr. Roman suggests two training priorities for CHWs: improved documentation skills, and strategies for moving clients towards independence. He notes transportation as a major barrier in Rhode Island, and that Thundermist sometimes pays for Uber transportation with CHWs to help patients keep appointments. He also believes that having CHW services available has helped recruit and retain doctors at Thundermist.

Apprenticeship Rhode Island*

Amy Weinstein, Employer Liaison. August 15, 2017.

Workforce
Development

Apprenticeship RI promotes apprenticeship in the health sector and other industries, by providing in-kind technical assistance. In registered apprenticeship, an employer provides integrated on-the-job and classroom skills training to entry-level employees. Apprentices receive a wage progression as their skills and experience grow, progressing to become fully qualified employees over the course of one or more years. This model of workforce development is widely used in a number of developed countries, and can increase employee retention, allow employers to train for the skills they need, and reduce student debt. The American Apprenticeship Initiative is a US Department of Labor program to promote the expansion of

apprenticeship to sectors outside of the construction industry where it has traditionally thrived. Apprenticeship RI is funded by this initiative to expand apprenticeship in Rhode Island, and is developing apprenticeships in a number of health occupations. Apprenticeship RI provides free technical assistance to help design apprenticeship programs, identify training providers or support in-house training, assist employers in accessing funding resources, help register the program and participants, and assist with implementation as needed. They are also working to pilot an initiative to train mentors/preceptors of healthcare apprentices, partnering with [H-CAP](#).

ARI is developing Community Health Worker apprenticeships. The Rhode Island Parent Information Network (RIPIN) is the largest employer of CHWs in the state, and plans to pilot a CHW apprenticeship with two new hires in 2017. They have worked with ARI to compile and adapt in-house training activities, and build program standards for a Peer Navigator program that will be registered shortly. Peer Navigators will work in school-based settings while completing their training and certification over the course of a year. RIPIN will use OJT funding (see below) to reimburse up to 50% of apprentices' salaries for the first six months of their employment. ARI has also worked this year with Rhode Island College to develop an apprenticeship curriculum for Community Health Workers in older adult care, including the development of stackable certificates such as a behavioral health

Key Takeaways

- **Apprenticeship** is a paid employment model that **integrates customized on-the-job learning with related training and wage progression** from the date of hire, upskilling entry-level workers.
 - **Free technical assistance is available** from ARI to build apprenticeships in healthcare and other sectors.
 - ARI and RIPIN are piloting a **CHW apprenticeship**, and RIC has developed curriculum and stackable certificates for CHW apprentices.
- ⇒ Apprenticeship may offer one way to **formalize CHW career pathways and integrate training.**
- ⇒ **ARI's technical assistance, and several workforce development funding streams** can support CHW apprenticeship programs and wages.

specialization and dementia care. The Rhode Island Assisted Living Association (RIALA) and RIPIN assisted in writing curriculum, and the initiative was funded by a Governor's Workforce Board nontrade apprenticeship development grant.

Apprenticeship may be a promising practice for CHWs and other health occupations. A number of states have Community Health Worker apprenticeships underway, and ARI has visited programs in Massachusetts and New Jersey.

Apprenticeship may offer a path towards elevating the CHW occupation, because it requires consistent standardization of training and roles, with the opportunity for employer-specific customization, as well as articulating a clear path to onboard entry-level employees. A challenge is that both the occupation and the apprenticeship model are new to many employers, and adopting them simultaneously may be a challenge. The biggest obstacle encountered by ARI in promoting CHW apprenticeships is the question of sustainable funding for CHW positions. Still, ARI has generated interest at a variety of healthcare organizations in the state. They are currently investigating the potential of cross-training across entry-level occupations, such as CNAs and/or medical assistants, with Community Health Workers.

Workforce development resources are available to support CHW apprenticeships and other on-the-job training strategies. Several funding streams are available through the RI Department of Labor and Training, the Governor's Workforce Board and netWORKri partners that can support Community Health Worker apprenticeships, or CHW employment and training in general:

- **[On the Job Training \(OJT\)](#)** funds reimburse up to 50% of the wages of new hires during a training period up to six months.
- The **[Non-Traditional Apprenticeship Incentive Program](#)** provides a \$1,000 per apprentice incentive to employers for up to five apprentices per 12-month period, for apprenticeships outside the construction sector.
- **[Non-Traditional Apprenticeship Development Grants](#)** –are typically awarded annually and offer companies/organizations funding for program/curriculum design and other apprenticeship program planning costs.
- The **[Incumbent Worker Training Program](#)** offers up to \$45,000 of matching grant funds to employers to train incumbent workers. Nonprofit employers, including many healthcare organizations, cannot currently access incumbent worker training funds through the Governor's Workforce Board, because they do not contribute to the state's Job Development Fund (JDF).

**The author is a former employee of Apprenticeship RI, and continues to provide consulting services to the organization.*

Comprehensive Primary Care Plus (CPC+)

Health Reform Initiative

Lauren Capizzo, Karen D'Antonio. September 7, 2017.

Comprehensive Primary Care Plus (CPC+) is a Medicare initiative to implement advanced alternative payment models in primary care practices, and RI is a participant. The state was one of 14 recipients of a CMS grant to support transition to the CPC+ payment model. Healthcentric Advisors is the facilitation provider for RI, and CTC-RI is the designated convener for private health plans in support of the initiative. Because of CTC-RI's previous history as a multi-payer initiative, the state was highly competitive for this grant. CPC+ is CMS' gold standard for advanced alternative payment models (APMs). The model is rigorous enough that practices employing it are exempt from MIPS, since they already report on more comprehensive quality measures. Healthcentric believes that Rhode Island is at the forefront of the CPC+ cohort.

Key Takeaways

- **CPC+ is a Medicare Advanced Alternative Payment Model** whose adoption by RI PCPs is being facilitated by Healthcentric Advisors under a CMS grant initiative.
 - In RI, CPC+ is working with **31 practices** to build infrastructure to facilitate implementation of this model.
 - Considered Medicare's gold standard APM, CPC+ includes **PBPM, Performance and FFS payments.**
- ⇒ CPC+ practices or affiliated ACOs may have greater flexibility and incentives to pursue CHW services.
- ⇒ Standardizing roles, communication and training expectations will build CHW credibility in primary care.

The CPC+ Advanced Alternative Payment Model includes several components:

- **Medicare Per Beneficiary Per Month (PBPM) payments**, including care coordination payments, tiered by patient risk category.
- **Payments for performance** with respect to quality measures made at year-end.
- **Fee For Service payments**, in reduced proportion.

31 practices are participating on two tiers. Roughly two thirds of practices are participating on a more advanced track, for those further along in implementation of EMRs and related infrastructure. A third of practices are at the beginning of the transformation process, focusing on risk stratification capacity, and adding new infrastructure and staff including behavioral health and social workers. All practices have nurse care managers. Most of the 31 are also CTC-RI practices.

CPC+ PBPM payments, and a focus on social needs, might offer practices the flexibility to pursue CHW services. There may be an opportunity for CHWs within care teams, and some advanced practices may be closer. Nurse care managers don't have time to follow up on all referrals to community resources, or to track all high-risk

patients in depth. A CHW could help close that loop. CPC+ uses a model of social drivers of health, and the need to address these drivers effectively may lead practices towards CHWs. However some CPC+ funding buckets are restrictive, and practices have already been asked to rapidly expand into new staff roles. Most CPC+ practices are associated with ACOs, and often these ACOs provide nurse care manager services to practices, rather than practices employing them directly. CPC+ does not work directly with ACOs, but there may be opportunities for CHWs to work through ACOs affiliated with CPC+ practices on a model similar to NCMs. There is a great deal of opportunity outside of the exam room related to patient engagement, activation, and support that contribute to overall health and wellness. A preventive, proactive approach might include CHWs. The environment is getting to a place where providers and nurse care managers would be ready for that. If services were accessible, available and coordinated, the next step would be to have a team that providers can call to coordinate these services outside of the exam room.

Practices would be more likely to seek CHW services if they knew what to expect from CHW roles, training and communication. Having clarity about the kind of communications providers can expect, including standardized expectations for notes and documentation, would help to build credibility. Having an established model or curriculum in training, and clearly defined roles will be necessary in order for CHWs to take hold in primary practices. Looking back ten years, nurse care managers didn't have buy-in, and had various, less-defined roles within practices. Helping to standardize their work and expectations helped to establish the occupation as it is today.

Integra – Care New England

ACO, Health System

Interview with **John Minichiello**, Executive Director, Integra,
Jody Jencks, Director of Workforce Development, Care New England.
Chantelle Tangui, Workforce Development Specialist, Care New England.
October 19, 2017

The Integra Community Care Network is an ACO whose largest member is the Care New England health system. Integra is a Medicare and commercial ACO, and a pilot Medicaid Accountable Entity. Care New England is the state's second largest hospital system, including general and specialized clinical delivery sites, and large behavioral health capacity (The Providence Center, Butler Hospital). Integra's member organizations include South County Health and the Rhode Island Primary Care Physician's Corporation, which has 130 affiliated practices. Integra's Medicaid Accountable Entity works with UnitedHealthcare and NHPRI's Medicaid plans.

Integra and CNE do not currently employ Community Health Workers, but other positions have similar roles, and they are pursuing innovative workforce approaches. Although CNE does not employ CHWs, other positions play very similar roles, including patient navigation. CNE's Workforce Development office has considered whether CHWs could help link patients to ambulatory settings and entities, and what supports would be required to provide that 360° kind of service, including partnerships with external service providers. CNE is working with Apprenticeship RI to train medical assistants, medical coders, and bilingual obstetrics CNAs cross-functionally. They have started to institute nurse residency programs. Community Health Worker programs, or other approaches to population health, might draw from these initiatives. HR staff are continuously looking at how such approaches might fit into an ACO model. "Where is the care model going? What's the support that's needed?" asks CNE's Workforce Development Director Jody Jencks. "Care moves at a rapid pace."

CNE/Integra is working to expand population health initiatives. As an ACO, one of Integra's "driving responsibilities is population health," says Executive Director John Minichiello. Currently population health efforts are primarily driven by nurses

Key Takeaways

- **Integra is an ACO and a Medicaid Accountable Entity, including Care New England, the state's second largest health system.**
 - **Although Integra/CNE do not employ CHWs, existing staff have similar roles and workforce development is pursuing innovative approaches.**
 - **Integra/CNE have population health initiatives through a CMS grant and as an ACO/AE.**
- ⇒ **Recertification as a Medicaid Accountable Entity will require population health approaches and bring infrastructure resources to support them.**
- ⇒ **There may be opportunities for Integra/CNE to expand into community-based roles.**

and social workers. The focus to date has been on chronic disease management. Integra has 50-55 employees. Of these, the majority are nurses and social workers running the complex care program that manages the 5% of patients incurring 50% of expenses. Minichiello says that Integra is working well with this group, primarily those with multiple chronic conditions, and is now expanding its focus to population health more broadly. For the Medicaid population, this will require a different skill set, and many patients could benefit from greater outreach. Much will be done by PCPs. Integra is focused on how to address the social determinants of health, but how to connect the pieces within an ACO framework remains to be seen. There is a need to make sure patients have transportation to appointments, a basic understanding of disease and treatment plans. There is a role to play in keeping patients out of the ER, connecting them with food supports, and providing, for example, culturally and linguistically situated diabetes education. There is also a need to communicate SDOH concerns to a clinician. Says Minichiello, “We recognize that we are not really in the community. I’m not saying that we’re not having an impact, but with the exception of occasionally a few nurses making a house call, a lot of the work is telephonic. I think there’s a community that would benefit from outreach and engagement from Integra. [...] I can see employing people whose work is in the community.”

Integra sees opportunities and challenges in considering population health workforce strategies. “We are building infrastructure from a systems lens, asking what’s happening at [Medicaid] entities, and how can we build sustainability. We are building programs that are sustainable for the future,” says Jencks. “Is this going to be a function that’s reimbursable [...] Yes we want to invest in current demand, but where do we focus efforts if functions are not reimbursable?” Minichiello adds that “The state has been a vigorous proponent of ACOs and value-based payment, pursuing primary care capitation. That will literally free up resources and desires for workforce leading in the direction we’re headed. That can only help if it continues.” “Having this role be so critical, there has to be value added behind it so there’s not high turnover, or there’s a talent pipeline to support it. [...] From an employer’s perspective reimbursement is a challenge. There’s lots of opportunity, but there needs to be a track to a sustainable wage. [...] Who’s going to pay for that?”

Integra was awarded a five-year, \$4.5M Accountable Health Communities (AHC) grant from CMS in 2017 to “close the gap between clinical care and community services.” Major activities will include screening Medicare and Medicaid beneficiaries for health-related social needs, raising beneficiaries’ awareness of available services, providing navigation to connect people with resources, and optimizing the state’s capacity to address health-related social needs through QI, data and alignment of resources.⁶

Integra will need to recertify as a Medicaid Accountable Entity in 2018, which may bring resources to infrastructure development for population health.

⁶ Integra, Bliss, G. “Accountable Health Communities: Closing the Gap Between Clinical Care and Community Services.” Medicaid Summit, 2017.

Integra's Accountable Entity is currently in the pilot phase, and timing may be good to build new population health approaches. A large grant of infrastructure development funds is expected to be available from CMS to the state, and Integra expects to compete for them. Integra might consider addressing population health accountabilities through community-based outreach, caseworker and navigator roles similar to those established concurrently through the AHC grant, says Minichiello. Within a business plan submitted to Medicaid as part of recertification, it will be incumbent on Integra to figure out how to organize people, processes, technology, money and timelines to earn these funds.

Rhode Island Foundation

Funder

Interview with **Larry Warner**, MPH, Grant Program Officer. **August 7, 2017.**

The Rhode Island Foundation grants funds in the health sector with a focus on primary care access, quality and utilization, and reforms to the health system. Although the focus is on primary care, there is recognition in funding decisions that much of health is determined outside of the clinical care setting.

The Foundation has supported as many as 10 Community Health Worker programs in recent years. Funded programs using CHW models include pediatric behavioral health, diabetes prevention, justice-involved individuals, mental health navigation and housing, refugees, frequent users of Emergency Medical Services, and middle and high school students. Funded budget items have included salary and benefits, planning, and program overhead. RIF is working with grantees to document return on investment, and hopes to build the business case for investments in CHWs and other means of address SDOH.

Three staff-directed funding streams support health grantmaking:

- Healthy Lives – rolling deadline, grants typically greater than \$10K.
 - *“Increase the number of practicing primary care professionals to meet demand in Rhode Island.*
 - *Promote consumer use of primary care medical homes.*
 - *Identify, test, and spread integrated, innovative new approaches to healthcare, including integrated “full body” approaches (i.e. behavioral, dental, primary).*
 - *Educate consumers and community leaders about the importance of primary care.*
 - *Pursue strategic reforms to the state healthcare system.”* [[RI Foundation, 2017a](#)]
- RIGHA Fund – up to \$75K for one year of funding
 - *“Innovation in primary care and behavioral health*
 - *Innovation in primary care and social determinants of health”* [[RI Foundation, 2017b](#)]
- Fund for a Healthy Rhode Island – three-year funding cycle, proposals funded up to \$250K per year.
 - *“Testing innovative payment models that integrate and align incentives to address public health, social services, and behavioral health;*
 - *Testing safety-net-provider participation in payment reform;*
 - *Expanding systems of care that encourage collaboration and sharing of claims data and sharing of health care information;*
 - *Developing payment systems towards a value-based model and encouraging the sharing of claims data and health care information; and*
 - *Reducing administrative overhead and using best practices to improve clinical outcomes.”* [[RI Foundation, 2017c](#)]

State Innovation Model Test Grant (SIM)

Health Reform Initiative

Marti Rosenberg, SIM Project Director, OHIC; James Rajotte, SIM Liaison, RIDOH. August 16, 2017.

Rhode Island's State Innovation Model Test Grant (SIM) is an initiative to transform healthcare delivery and financing combining population health and payment reform. RI was one of 24 states to receive a SIM Test Grant from CMS in 2015, receiving \$20M to support activities in three categories: "improving the primary care and behavioral health infrastructure, engaging patients in positive health behaviors and self-advocacy, and expanding the ability of providers and policy makers to use and share data." [EOHHS] The project works to enable a transition to "value-based care that addresses social and environmental determinants of health," achieving the triple aim. Project Director Marti Rosenberg says that SIM is focused on population health and payment reform.

Key Takeaways

- SIM is a major multi-stakeholder, CMS-funded **population health and payment reform initiative**.
 - SIM supports **Community Health Teams with CHWs**, and is and promoting CHTs as a central strategy.
 - SIM is developing a **consolidated operations model** to support CHTs with centralized data, ROI, training, and services on retainer such as pharmacist and handyman.
- ⇒ **CHTs allow CHWs to be integrated** more effectively than in individual practices.
- ⇒ **Economies of scale from the consolidated operations model**, and ROI data may help build the case to providers and payers for CHTs with CHWs.

The SIM funds **Community Health Teams (CHTs) that use integrated CHWs to work with high-risk patients, and promotes the CHT model**. SIM has allocated \$2 million to interdisciplinary CHTs, and SIM has braided an additional \$0.5M for the SBIRT Training and Resource Center. CHTs in this model include at least two Community Health Workers and one Community-Based Licensed Health Professional. The Care Transformation Collaborative of RI (CTC-RI) is the vendor for these initiatives, and funds a number of subcontractors to implement them. Some subcontractors focus more on behavioral health, others more on CHTs. Four CHTs have been supported by SIM funds to date: two at Thundermist Health Center, two at CTC-RI. SIM is in the process of adding four additional teams: two covering Warwick and Woonsocket, one in Providence, and a planned team in the East Bay, funded by UnitedHealthcare. United and Neighborhood Health Plan also operate CHTs on this model, the Cedars operate specialty teams, and ACOs and Accountable Entities may be considering implementing CHTs on the same model.

SIM is working with CTC-RI to help them develop a centralized infrastructure to support CHTs. Project leaders are currently working to develop a consolidated operations model that can provide a unified data source, consistent information on ROI, training and wraparound services. The hope is to develop economies of scale that can benefit CHTs, reducing overhead and allowing more resources to flow to direct service. SIM will evaluate return on investment of CHTs and a consolidated operations model to support them. Project leaders are interested in understanding provider and patient experiences working with CHWs on health teams, and whether these experiences support the case for these investments. The consolidated operations model is funded through SIM, but future funding is uncertain.

SIM and related RI state healthcare reform efforts view Community Health Teams as the primary strategy to expand access to CHW services. RI is making an effort to use the umbrella term “Community Health Worker” across diverse occupations, signaling a commitment to supporting the workforce under this professional identity. SIM leadership believes that CHWs work best in CHTs. There is a risk if individual CHWs are employed by practices that they can be marginalized within a hierarchical system of healthcare. With CHTs, at any one point, a different occupation may be the most important player depending on the needs and situation of the patient. There may be opportunities for CHWs in other contexts, such as PCMH Kids practices, specialty care settings, cancer navigation, high-intensity environments—but not in general adult practice. SIM is supportive of CHW certification, efforts to develop career ladders, and increasing compensation with CHW specialization.

“We wish everyone in the system understood only 10% of health happens in the doctor’s office,” says Rosenberg. “Until we’re there, CHTs are the connector between the 10% and the rest.” The hope is to demonstrate cost containment of our CHT model, and show providers that addressing social determinants of health is the way to go.

CHWs need to be connectors and community organizers, Rosenberg believes. Although you can mentor for these skills, being a CHW is not for everyone. These positions need people who are able to put themselves out there, get out of institutions, break through barriers to get patients what they need. They need to be able to help patients take hold of the things that are within their ability to change, things that no one can do for you. We don’t always talk about those abilities in recruiting and training CHWs, but they are vital.

University of Rhode Island – RI Geriatrics Workforce Enhancement Program (GWEP)

Higher Education

Phillip Clark, ScD, Director. October 5, 2017

The University of Rhode Island houses the RI Geriatric Education Center (RIGEC), which collaborates with Care New England to implement the **Geriatric Workforce Enhancement Program (GWEP)**. The GWEP is HRSA-funded to “develop a comprehensive interprofessional geriatrics education model for patient-centered practice in primary care educational and clinical settings across the state.” GWEP partners with a number of organizations to improve care for older adults, including CTC-RI, SIM, and the Healthcare Workforce Transformation initiative. Rhode Island has the highest proportion of residents over 85 in the US, and is in the top ten states for residents over 65.

URI and GWEP do not employ CHWs, but Dr. Phillip Clark, director of the GWEP and RIGEC, is an expert on geriatrics and interprofessional practice. He sees a number of **avenues for integrating CHWs into the workforce to enhance the quadruple aim for older adults, including population health.**

Three key areas have potential for CHWs in caring for older adults, says Clark:

1. **Bridge between community and the healthcare system.** CHWs could link people to the right resources in primary care, and manage barriers to care such as transportation and stigma around accepting assistance.
2. **Care transitions.** CHWs could work with care teams and care managers to improve transitions, and reduce inappropriate hospitalization and ER use.
3. **Patient education and lifestyle change.** A URI staff member currently works with RIDOH evidence-based patient education programs on managing chronic disease, preventing falls, diabetes management and nutrition. A CHW would be a “really powerful addition to the team.”

Peer-to-peer models hold potential. Noting the power of lived experience among peer recovery coaches, Clark believes there is potential employ older peers as CHWs. Scripted curricula in evidence-based peer education limit the use of lived experience,

Key Takeaways

- **URI’s Geriatric Workforce Enhancement Program (GWEP)** collaborates to improve health for older adults in RI through interprofessional workforce education.
- URI does not employ CHWs, but there is **potential to integrate them in elder care in many areas.**
 - ⇒ CHWs could improve health of older adults in the community by acting as **a bridge with healthcare, improving care transitions and by patient education.**
 - ⇒ The **Village movement, peer-to-peer models and graded living in retirement communities** hold promise for CHWs.
 - ⇒ The **demographic transition** has potential to drive new career options and approaches.

but peer-led groups have great potential, particularly in reaching out to underserved older populations like the homeless.

The village movement may hold promise, but has not been applied in lower-income communities. Nationally the movement in elder services has trended towards aging in community. The Elder Village model is one high-profile approach that has historically been located in high-resource communities, such as the original Beacon Hill village in Boston. Villages have started in South County and Providence. “Could we create through CHW networks these sorts of places with external supports? [...] CHWs could support people aging in community in the absence of more structured organizations.” There are opportunities to use frontline workers to make a huge difference in people’s lives. Disasters are particularly damaging to isolated and low-income older people, and CHW outreach after disasters might be a promising approach.

CHW models may not fit in institutional care settings, but may work well in retirement communities. Long term care facilities have a unique environment that is not community-based in the traditional sense. But there might be a role in settings like retirement communities where there is graded living, from independent, to assisted, to dementia care. In this spectrum, CHWs could be the first line of defense to keep people in lowest level of assistance.

The demographic transition holds opportunities for transforming the workforce. “We are in the process with this demographic transformation of really inventing and developing exciting new career options that didn’t exist or existed in other forms,” says Clark. “The pieces that have to be in place are training, funding, and integrating in a meaningful way into settings and teams where there might be some resistance on part of traditionally trained medical professionals. There is danger in the power hierarchy of CHWs being on low end of the spectrum.”

“If we’re serious that we’re going to change the system, we need to pay people like CHWs. All these demonstrations have been done to demonstrate cost effectiveness. **I can’t believe that the impact of CHWs is not far beyond the cost of their salary in terms of saving money to the system.**”