

Charting a Roadmap for Community Health Workers in Rhode Island

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Why We Needed a Roadmap:
A Letter from the CHW Strategy Team and the Rhode Island Department of Health,

Dear Friends and Colleagues,

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, the quality of education, 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. Community Health Workers also bridge cultural differences between communities and health and social services by providing culturally appropriate health education.

RIDOH has been a steadfast champion of community health workers to grow and support the workforce, to educate stakeholders on their role, to advance policy initiatives, to tirelessly share their impact, and to amplify their voices in systems change. For two decades, RI's CHW workforce has grown across different clinical and social service sectors, thanks to so many early adopters and steadfast advocates. It goes without saying that so many of you also paved the way for RIDOH to secure pivotal funding from the Centers for Disease Control and Prevention (CDC's COVID Response and Resilient Communities Grant Award) to help grow and strategically support our CHW workforce. We did not want to let the incredible opportunity of the CDC grant pass without preparing for the future and make a bold commitment to sustaining the community health worker workforce.

Since early 2023, RIDOH and the CHW Strategy Team in partnership with WE in the World have heard many CHW voices and partners in development of this Rhode Island Community Health Worker Roadmap. We are certain you will see your voices, stories, perspectives, experiences, expertise, and ideas reflected in the Roadmap. Please join us in reviewing and actualizing the Rhode Island Roadmaps.

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ADVANCING INTEGRATED HEALTHCARE

B. The Process for Developing this Roadmap

We engaged in the following process to develop this roadmap:

1. Engaged with 140+ stakeholders within the state, and in particular the CHW Strategy Team and Rhode Island Department of Health, to design the process.
2. Developed definitions and key principles.
3. Reviewed what was already happening in the state and in states across the country who have advanced CHWs to become sustainable.
4. Identified points of convergence, divergence, and clarity that are needed to build a roadmap.
5. Brought together a series of design sessions to gain clarity and detail on the points of convergence and divergence.
6. Engaged workgroups of the CHW Strategy team in four key areas of the roadmap
7. Interviewed key agencies across sectors to identify potential implementation opportunities.
8. Identified feasibility, implementation, assets, and timelines together with the CHW Strategy Team
9. Shared initial results at the Community Health Workers Association of Rhode Island CHW Conference
10. Shared final recommendations at the CHW Strategy Team

C. Landscape Analysis

CI. Strategic Investments in Community Infrastructure for Health and Well-being

Community health workers (CHWs) are a key ingredient of a national strategy to improve community health, especially when sourced from trusted communities, supported, and empowered to meet the needs of the community as part of a broader community health team. Community health workers need a broader support system to achieve impact. A national landscape analysis of what was needed to sustain community health workers to achieve both immediate and long-term impacts demonstrated the following characteristics of CHW supports and broader supports.

Characteristics of community health worker systems that have sustained.

1. **Place-based** - Community health workers that are sourced from and serve a particular geography tend to be far more effective because they have and can build trusted relationships and have a long-term perspective about the community. It also allows CHWs to be part of creating deeper change in the community's context.
2. **Comprehensive** – Rather than parsing CHW workforce by individual diseases, it is far more efficient and effective to consider them a part of a comprehensive health improvement

strategy to address the mental, physical, and social needs of people and communities.

3. **Connected** - Community health workers are far more effective when they are part of health teams that are connected with health care and community-based partners across sectors in their geography. This may require access to technology supports, internet and broadband as well as regular processes of connecting with teams.
4. **Workforce development** - A process and policies for workforce development, training, and certification for peer workers, such as community health workers, and their supervisors in both health education and navigator activities and broader community transformation skills needs to be in place. There needs to also be training of health care administrative and clinical leaders to effectively engage and mobilize the assets that CHWs bring to communities.

Essential broader supports necessary to achieve sustainable community well-being.

5. **Shared stewardship and governance** – Community health workers cannot solve community problems by themselves. As they identify challenges, there needs to be a mechanism for shared stewardship and governance across sectors with significant inclusion of community residents affected by inequities to address underlying challenges in the community. Community health workers should be part of this governance.
6. **Place-based coordinating infrastructure with a facilitative, risk-bearing entity** that can receive payments and be held accountable for outcomes related to the use of common funds. CHWs may be hired by this entity or by community-based organizations contracted by this entity. Sometimes this is called a hub. This should not be a health care system but rather a neutral entity in the community.
7. **Financial sustainability** - Mechanisms for sustainable payment for community health teams as well as mechanisms for multi-sector financing and distribution of savings and accountability across sectors. This includes assuring a living wage and benefits for these essential workers.
8. **Equitable Policies** that directly assure that funds support people and communities most affected by health inequities should be in place. CHWs can play an important role in the identification of needed policies, the education and mobilization of community members, and the engagement of key leaders to advance policy development.
9. **Equitable measurement and data** - An equitable **measurement and data system across sectors exists** that is real-time and organized with an equity lens. Equitable data-sharing agreements are in place. Measurement includes full scope of role of community health worker and support systems needed to support community health workers.

C2. The History and Current State of CHWs in Rhode Island

Rhode Island has a long history of investing in community health workers over decades, dating its origin story from the Jack Geiger movement and the formation of community health centers to the global movement of community health workers and promotoras following Alma Ata and the primary health care movement. The Community Health Worker Association of Rhode Island formed in 2007 as a CHW formed association and network. While CHWs, funded often by different grants, had many different titles—they had the same spectrum of role that is represented today.

There became an understanding of the need for policy to drive CHW support and to support a broader strategy around health equity. The Commission on Health Advocacy and Equity was brought together to address health disparities to ask--how do we benchmark, and how do we diversify the health workforce?

In recent years, this shared journey of health equity and community health workers has accelerated. The formation of Health Equity Zones (HEZs), investments in community health teams that work as an extension of primary care, the increase in community health worker workforce in the context of shift to medical home and accountable entities, and a broadening of the role in the context of the Rhode to Equity has brought us full circle to an important moment to better support and sustain the role and leadership of CHWs as part of investing in health equity. The CHW Strategy Team, acting as an organizing vehicle to bring CHWs and their applications, the work developed through workgroups within that process, created the conditions of readiness for the road mapping process we are engaging in today. In the words of Dannie Ritchie, “The issue with CHWs was about having the community have a consistent vehicle to amplify community resident concerns, understand assets, bring resources back into the community.” This is a moment when there is readiness of context, community, and opportunity to take the next step forward in investing in community health workers as a sustained strategy to improve health equity in Rhode Island.

Supported by the CHW Strategy Team, after an initial design day, four design strands were fleshed out to advance the road mapping process. These were:

- 1) Growing the role, agency, and leadership of community health workers
- 2) Workforce development for CHWs and their supervisors
- 3) Payment and sustainability
- 4) People and place-based coordinating infrastructure

Measurement and evaluation recommendations follow description of each of these roadmaps.

D. Four Roadmaps

I. Growing the role, agency, and leadership of community health workers

The roadmap design process began by developing a shared understanding across groups about what was meant by a community health worker in Rhode Island. Because this workforce had been part of many different pilots over decades, the understanding of the role had evolved over time. As a result, there were many definitions of a community health worker in use in the state by different agencies which led to differences in training, supervision, payment, and engagement in policymaking. The importance of creating a common working understanding of the role was an important priority for community health workers in the state and those who supported the role, agency, and leadership of CHWs.

An initial scan of definitions revealed several working definitions used by different groups within the state:

“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 (APHA)

The Rhode Island Certification Board expanded on and strengthened this definition:

“Community Health Workers are frontline public health workers who are trusted members of the community they serve. This trusting relationship enables them to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural responsiveness of service delivery.

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

An important role of the Community Health Worker is to advocate for the socioeconomic, environmental, and political rights of individuals and their communities. Community Health Workers often link people to needed health information and services. Community Health Workers address the social and environmental situations that interfere with an individual or community achieving optimal health and well-being. Community Health Worker’s may have various titles as it is used as an umbrella term.”²

The Rhode Island Department of Health adopted the CDC definition and made it contextually relevant to COVID:

“Community health workers (CHWs) are frontline public health workers who are trusted members of the community they serve. This trusting relationship enables the worker to serve as a link between health/social services and the community to facilitate access to services and improve service delivery. Public health crises, such as COVID-19, worsen existing health disparities. CHWs are well-positioned to reach communities hit hardest by COVID-19, stop the spread of COVID-19, and move toward health equity.”

¹ American Public Health Association <https://www.apha.org/apha-communities/member-sections/community-health-workers>

² Rhode Island Certification Board [RICB’s CCHW \[ricertboard.org\]](https://ricb.org/ricertboard.org)

The Bureau of Labor Statistics uses a more limited definition of the role, which is more focused on navigation and service delivery. However, EOHHS in the Rhode to Equity initiative, invested in a far more expansive version of the role, which included embedding the community health worker into the role of civic capacity-building and system change to address upstream and root cause drivers of health outcomes.

Participants in the roadmap process universally agreed to embrace the full scope of the role, from service delivery to relational connection to civic capacity building to policy and advocacy. It was acknowledged that not every agency would be able to identify reimbursement mechanisms for the full scope of the role—or that every community health worker should have to embrace the full span of that role, but there was real agreement to identify pathways to embrace, support and build policy and payment around the full scope of the role. In addition, participants agreed on a place-based orientation, with room for some community-health workers to focus on specialization based on groups of people who had something in common (for example, children with special needs, older adults) that would transcend place. The group then turned to key principles of how this could happen.

Key principles identified by CHWs and their partners to support advancement of the role, agency, and leadership of CHWs as part of this process included:

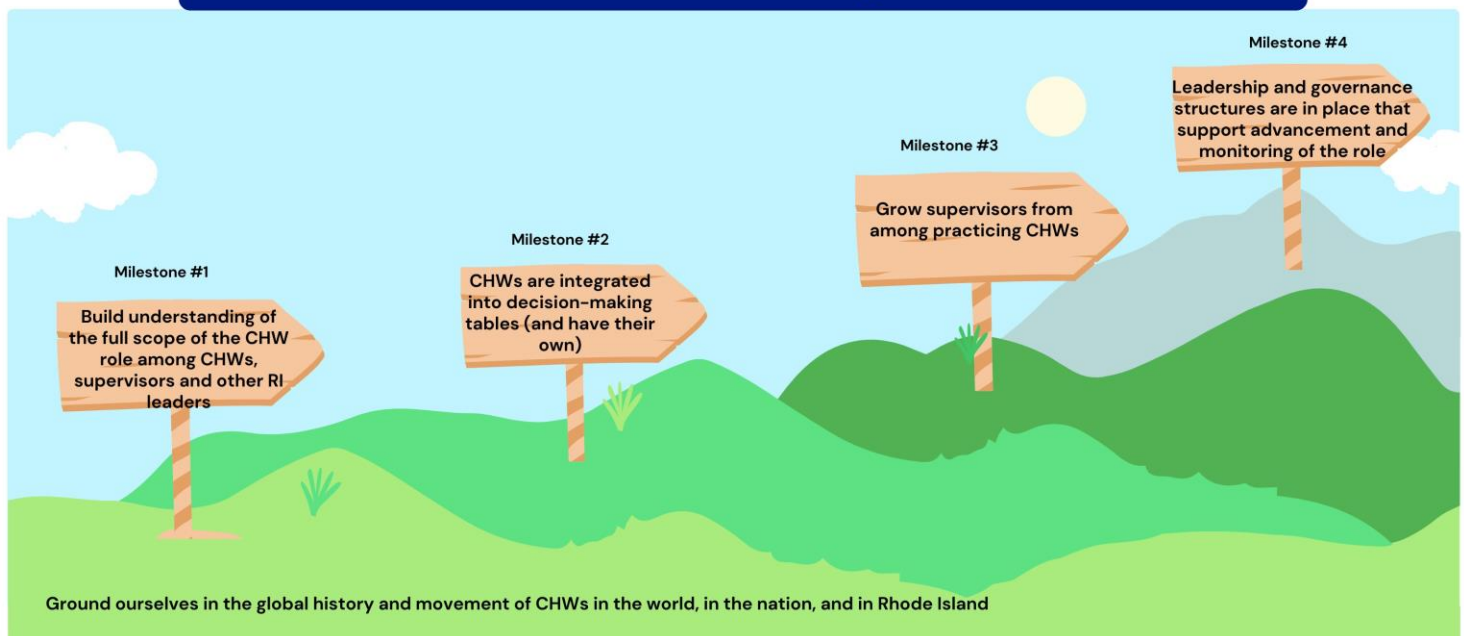
- **Agency and leadership of CHWs in determining the future of CHWs** – “nothing about us without us is for us” – CHWs should have a role in decision-making related to their future.
- **Whole person orientation** – that CHWs are most effective when they can address the whole person and whole family, in the context of the community; the construction of their work, training, and payment should reflect and support that.
- **Relationships are central and valued** – a central value that CHWs brought were their relationships—both as trusted guides with clients/patients and with organizations and groups within the community. This work of relational and civic connection and capacity building needed to be understood and valued.
- **Advocating for big system change to address all of the conditions needed to improve health and well-being** – While CHWs could and do act as navigators of a system that is siloed, disconnected and misaligned to meet the needs of patients and community members experiencing the system, they have just as important a role to play in changing the system so that it works better for everyone.
- **Acceptance and appreciation of the role by others** – It would be insufficient for CHWs to understand this scope and principles. Building on a deep foundation of experience of how CHWs can function in the world, in the nation and had for decades functioned in full scope in Rhode Island, it was important to build a deeper understanding of the full scope of the role and its value by CHW allies, employers, and many others.

An important caveat was that the role, agency and leadership of CHWs should be advanced in a coherent way with other parts of the peer-based workforce, such as doulas and peer mental health and addiction specialists. The development of a coherent plan across these agencies was felt to be essential.

The following four roadmaps emerged from a synthesis of several design sessions, interviews and ratings of different ideas based on importance, feasibility and timeline over a three-year period.

Key Roadmap Recommendations

1. Growing the role, agency, and leadership of CHWs



Build the foundation

1.0.0 Ground everyone—especially CHW supervisors, sites and employers--in the global history and movement of community health workers in Rhode Island, in the nation, and in the world.

Milestone 1 Build understanding of the full scope of the CHW role among CHWs, supervisors and other Rhode Island allies and leaders. A few recommendations to consider:

- 1.1.1 If CHWs are to lead, they will need to be able to own the full scope of their role and engage in building a pipeline of CHW leaders and mentors that serve as a support system for other CHWs. This support system needs to be supported and funded, as it has been in Rhode to Equity and HEZ-supported CHWs.
- 1.1.2 Connect the pipeline of CHW leaders to the leadership of other peer professionals, such as addiction specialists and doulas. This will require ways in which CHW training and supports create an enabling environment for facilitative leadership.
- 1.1.3 CHWs cannot change their role and scope alone. The support of others—especially those with access to decision-making tables and resources to shift the role is deeply needed. The work of CHWARI and the CHW Strategy team and other groups were instrumental to building the will for change and getting CHWs here. Other supports, including EOHHS, HEZ leadership, the Employer Alliance and others are essential allies in strongly reinforcing that the full scope of the role is supported and resourced. Rhode to Equity lay a strong foundation for the role that

CHWs could play in systemic change. Building on that could be a good opportunity and support long-term evolution and sustainability.

Milestone 2: CHWs are integrated into decision-making tables

- I.2.1 While leadership can be practiced from anywhere by anyone, real equity in the process requires a seat at important decision-making tables.
- I.2.2 There are important opportunities to both strengthen existing leadership tables where CHWs have opportunities to lead, like the CHW Strategy Team, as well as integrate into other tables where CHW leadership matters. This should absolutely be the case for any matter that directly impacts CHWs—for example, EOHHS tables related to workforce or CHW payment.
- I.2.3 The ability to activate CHW allies, such as the ones above, to both create the space and the enabling supports (payment, time, accompaniment) for CHW leadership to be successful can serve as a major win-win for both groups. Health Equity Zones and other population and community health equity initiatives are natural opportunities to grow this leadership connection, in addition to specific ad hoc structures and initiatives.
- I.2.4 Engagement of CHWs and their allies at national tables that seek to advance the CHW role should be emphasized. CHWARI's engagement of CHWs in the National CHW Association is a bright spot for this.
- I.2.5 Any significant and sustained leadership role should include a plan and budget for payment of CHWs commensurate with the pay received by other leaders at the table. The expertise CHWs bring needs to be valued, with a living wage serving only as a minimum standard. A donor advised fund—with CHWs acting as the advisers--could be established at the state level and contributed to by entities across the state, from foundations to agencies, as a lived experience fund.

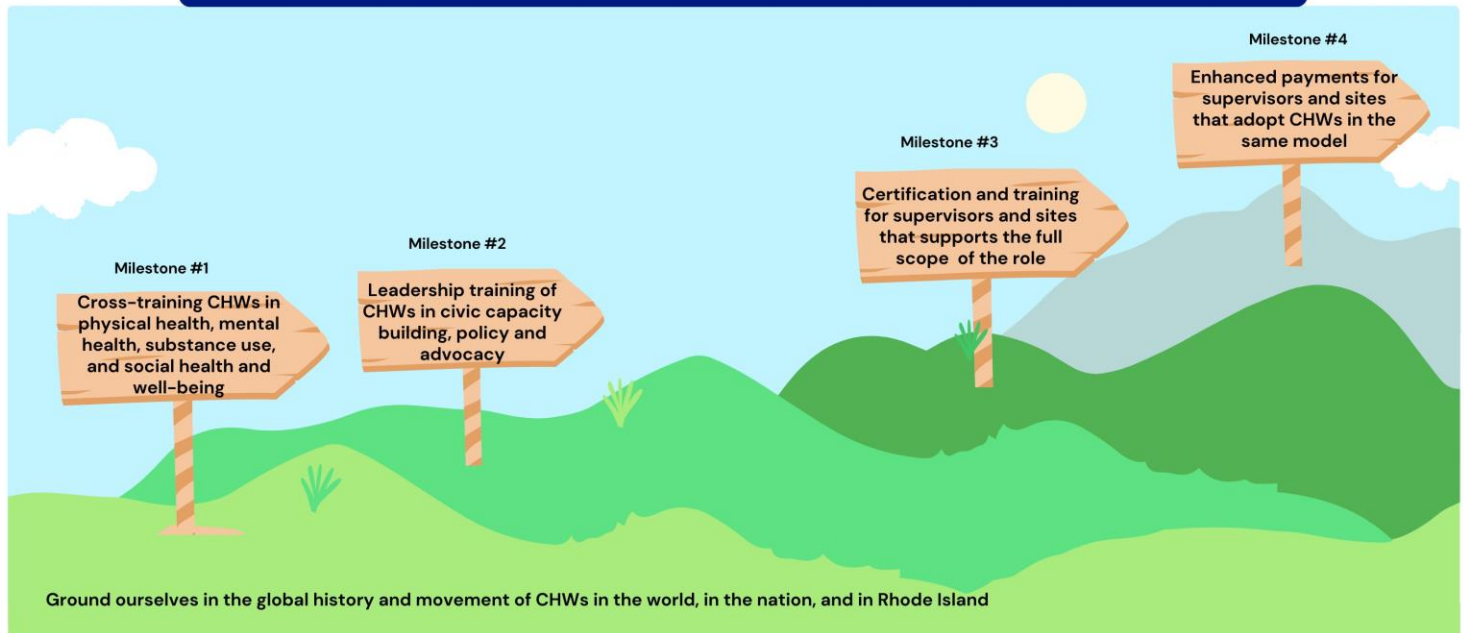
Milestone 3: Grow supervisors from among practicing CHWs

- I.3.1 Develop a professional development pipeline that supports current CHWs to become CHW supervisors.
- I.3.2 Align supervision competencies based on the span of role that is being supervised.
- I.3.3 Develop and implement training and certification for supervisors and sites to support the full scope of the role. More about this will be discussed in the Roadmap 2.

Milestone 4: Governance structures are in place that support advancement and monitoring of the role

- I.4.1 It will become essential over time to identify a majority CHW table where there is significant decision-making, oversight and accountability related to CHW and peer workforce and initiatives within the state—a table that monitors CHW well-being, the implementation of the roadmap, and helps sets new standards.
- I.4.2 Agencies like the Rhode Island Department of Health and Executive Office of Health and Human Services could model use of such a body as part of developing and monitoring CHW-related initiatives.

2. Workforce development for supervisors and CHWs



Build the foundation

- 2.0.0 Ground everyone—especially CHW supervisors, sites and employers—in the global history and movement of community health workers in Rhode Island, in the nation, and in the world.
- 2.0.1 Connect work with CHWs with the field of peer recovery to share learning, achieve a consistent and fair approach and leverage lessons learned from implementation of peers to support advancement of CHWs.

Milestone 1 Cross-training CHWs in physical health, mental health, substance use, and social needs

- 2.1.1 Cross-training of CHWs in physical, mental, social health and well-being – To support a comprehensive role in service delivery, cross-train peers and community health workers in mental health and social support navigation. The training for this already exists in RI. This would be an opportunity for enhanced payments or certification for both independent and site-based CHWs who could support the full scope of the role.
- 2.1.2 Build in professional development opportunities and funding to support CHWs—both at sites and those that are independent—to pursue enhanced training.
- 2.1.3 Balance imperatives for training with associated use of the training—and appropriate payment and restructuring of work to carry out the role well.

Milestone 2 Leadership training of all or selected CHWs in civic capacity building, policy and advocacy

- 2.2.1 Engage and support community health workers who have skills in civic capacity building, policy, advocacy and system change to help develop a curriculum to support this work.
- 2.2.2 Build exposure during core training to the full scope of the community health worker role.

- 2.2.3 Develop and implement stepped-up training for community health workers at any stage of their career journey who show real interest and aptitude in embracing a broader span of CHW roles, including civic community-building, organizing, coordination, leadership, quality improvement and policy change. The training CHWs and their teams received during Rhode to Equity, for example, led to a different level of integration of CHWs as leaders in that initiative. This could be built upon and expanded over the next several years.
- 2.2.4 Develop a system of continuing education and opportunities to practice these types of leadership skills to grow a pipeline of leaders in health systems to address health equity. This knowledge needs to be practical and applied, not theoretical. CHWARI has already demonstrated what that could look like in the planning of the recent CHW conference. In the future, engagement in planning a conference like that or engagement in an improvement activity in the community could serve as credit toward a practicum that supports certification in the development of these skills.
- 2.2.5 Embed core approaches to addressing underlying community conditions, building community partnerships and addressing root causes into this training so that CHWs can serve as subject matter experts in these areas, adding lived experience and implementation know-how together to serve as a critical community and state resource.

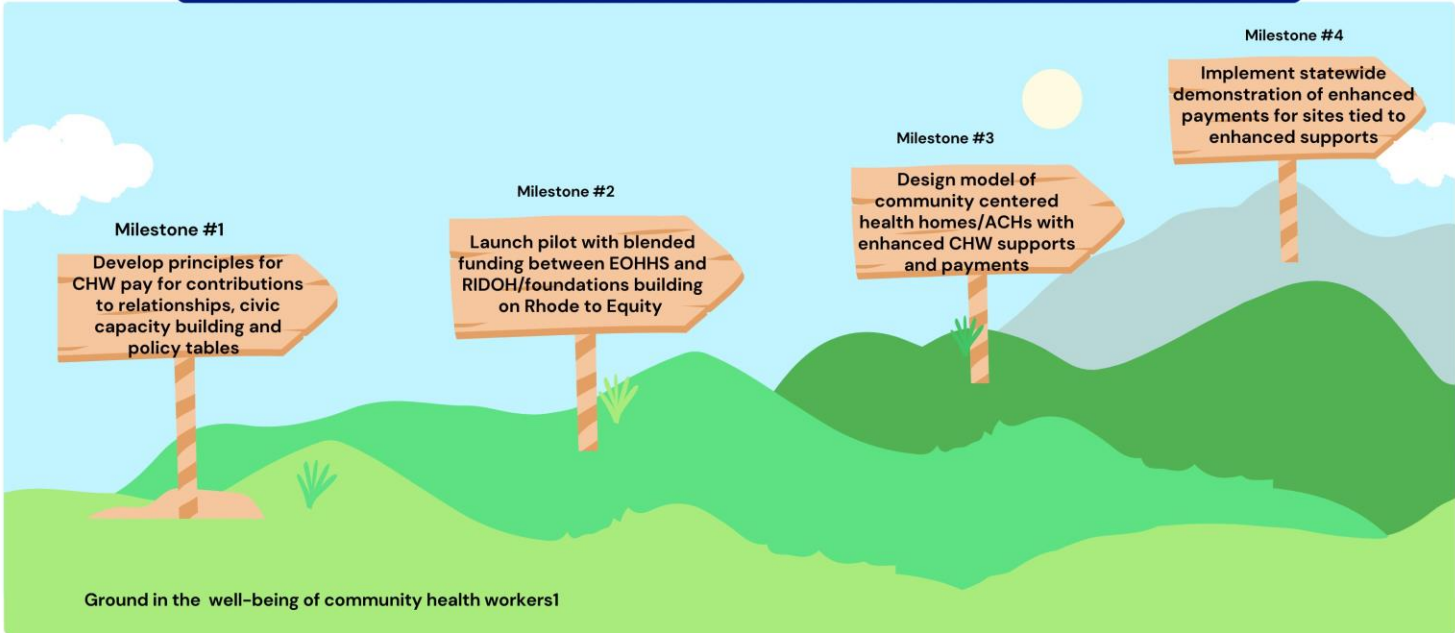
Milestone 3 Certification and training for CHWs, supervisors and sites that supports the full scope of the role

- 2.3.1 Engage with the Employer Alliance to build understanding, competencies and systems among employers and supervisors to better support the full scope of the role and the well-being of CHWs in general as a critical workforce.
- 2.3.2 Building on the model of health homes in the state, which include policies, supports and ongoing supervisory training for sites that engage peers, develop policies, competencies, trainings, and evaluation systems for supervisors of community health workers. These should include both the service delivery and the civic capacity part of the role—but could represent two different credentials based on the span of the role that is being used.

Milestone 4 Enhanced payments for supervisors and sites that offer enhanced supports for CHWs

- 2.4.1 Building on the health home model of payment tied to site-based credentialing, develop a mechanism of enhanced payment through RIDOH, EOHHS and other agencies that have policies, systems and supports in place to create an effective environment for community health workers to grow and contribute.

3. Payment and sustainability



Build the foundation

Ground in the well-being and sustainability of community health workers. As a group commonly recruited from communities experiencing inequities, these frontline, resourceful community leaders are often stretched in the work and in caregiving in their family and community. While extraordinarily resourceful, the risk of burnout in the work can be high and often CHWs lack the generational wealth to give more of their time that is uncompensated. An investment in community health workers, on the flip side, is a direct investment in health equity, often for a whole family and community.

Milestone 1 Develop principles for CHW pay that aligns with the full scope of their role, from whole person care to relationship-building, to civic connection and policy and system change work.

- 3.1.1 Plan to pay at least a living wage (minimum bar) and ideally, a wage that fully values their contribution depending on their expertise, qualifications and demonstrated competencies. An assessment of these competencies should include ways in which lived experience, not just formal education, may have contributed toward skills needed for the work. In addition, the presence of certification should not preclude people with important lived experience in less formal roles to be compensated (for example, as part of improvement processes).
- 3.1.2 Understand how the requirements of time, energy and resources of the different parts of the role might be different and develop a payment scale accordingly.
- 3.1.3 Account for the importance of relationships across all these roles and value the work of relationship development.
- 3.1.4 Assure benefits and protection, as well as spaces to debrief and cope with the experiences they are encountering every day as part of building long-term renewal.

- 3.1.5 Any significant and sustained leadership role should include a plan and budget for payment of CHWs commensurate with the pay received by other leaders at the table.
- 3.1.6 A fund should be established at the state level and contributed to by entities across the state, from foundations to agencies, as a lived experience fund that supports the contribution of people with lived experience to improvement processes.
- 3.1.7 Following the example of Washington State, a policy should be passed that contribution of people with lived experience to improvement processes cannot be counted against eligibility requirements for benefits.

Milestone 2 Launch pilot with braided or blended funding between EOHHS and RIDOH/private foundations to support a cohort of CHW positions that are both involved in service delivery and in leadership roles.

- 3.2.1 By developing and launching a pilot in this next year, building on the role of CHWs who have been engaged in Rhode to Equity, for example, where 0.5FTE is paid through service delivery and 0.5FTE is paid through public health and foundation funding to support broader civic connection, community health equity, civic capacity building, policy and advocacy, the state would be able to demonstrate a mechanism to sustain investment in these roles while creating a model that could be built upon as part of a long-term investment.
- 3.2.2 Engage with foundations in the state, payers and their foundations, etc. especially those who have already invested in community health workers, to build these types of blended roles into their planning.
- 3.2.3 Partner with United Way to use core operating grants that are intended to advance racial justice to support the leadership of community health workers and other peer professionals and deepen their literacy and leadership as a resource in these issues.

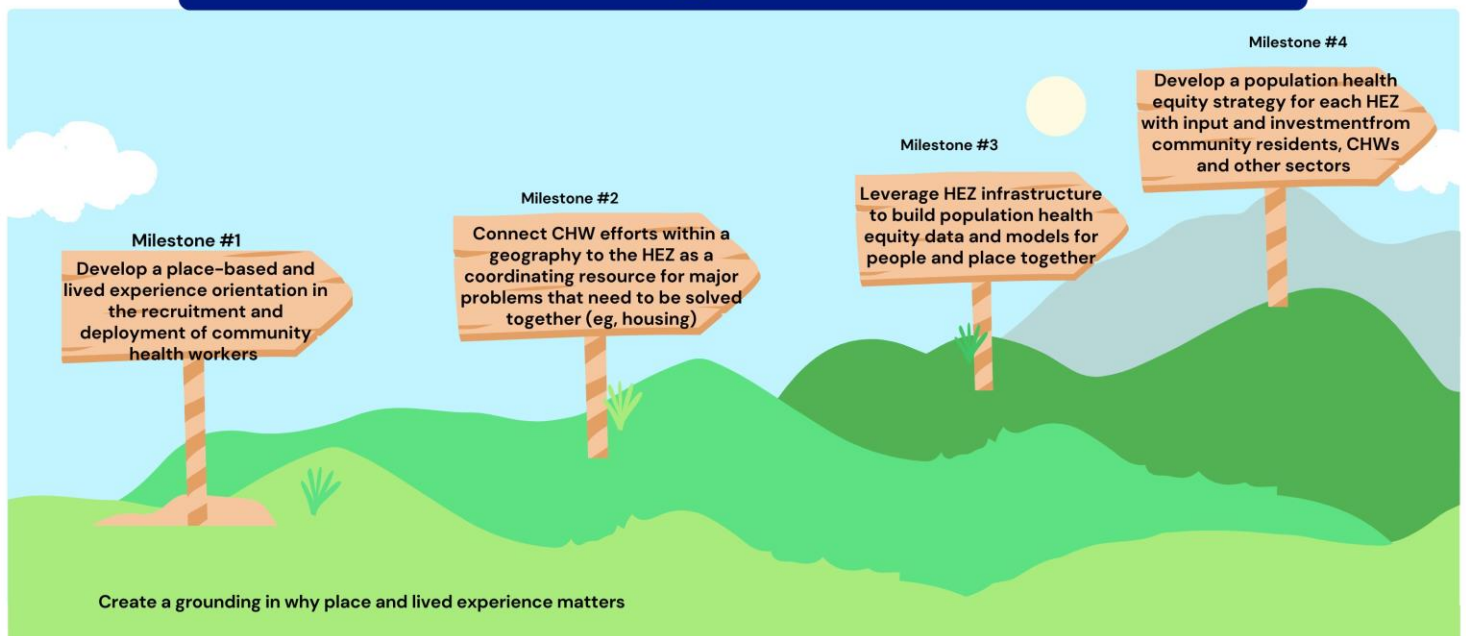
Milestone 3 Building on the model of integrated health homes which have policies, practices, training requirements and certifications in place for sites that are credentialed to have peers, develop a model of community centered health homes or accountable communities of health for accountable entities that host community health workers and other peers.

- 3.3.1 EOHHS already plans to convene a table next year to look across the board at peer professionals as part of the next wave of health system transformation. One opportunity will be—whether it is called this or not—to build on the model of PCMH and integrated health homes that credential sites for demonstrating certain capacities and competencies and supporting them with enhanced payments. Embedding expectations around how health care entities integrate, support and create a healthy environment for the growth of community health workers and other peer professionals as part of creating internal equity as part of an overall health system transformation model could lead to sustained and integrated change. A similar mechanism could be used for accountable entities that work in communities, built from models in Vermont, California and North Carolina.
- 3.3.2 The Rhode Island Department of Health can make a significant investment in community health infrastructure through the public health infrastructure grant over the next five years. Embedding community health workers into a process to support a deep approach to health equity in public health departments, leveraging their current leadership in implementing frameworks and tools like Pathways to Population Health equity represents an opportunity for both.

Milestone 4 Implement statewide demonstration of enhanced payments for sites that relates to the way these sites invest in community health workers with support for the full span of the role and are connected to communities as part of wider multi-sector, community-led processes to advance health equity.

- 3.4.1 Building on the experience of the state both in Rhode to Equity and the pilots noted below, EOHHS should work to develop an enhanced payment model for sites that fully invest in community health workers and partner with key stakeholders in their community.
- 3.4.2 In addition to demonstration resources, the federal match could be used in unrestricted ways to invest in this type of approach and potentially to address upstream community conditions.
- 3.4.3 Over time, develop a fund pooled across entities (a donor advised fund with community members acting as donors engaged in participatory budgeting for example) to invest in resources that sit in the middle and/or suffer from the wrong pocket problem.
- 3.4.4 Regardless of the above, EOHHS and RIDOH should use their regulatory authority to assure that sites hosting peer professionals and community health workers have policies, practices, a fair wage, appropriate supervision and benefits in place to assure that community members acting to improve health equity are not themselves being harmed. The CHW governance structure should be involved in evaluating and monitoring this.

4. Place and people-based coordinating infrastructure



Build the Foundation:

Create a grounding in why place and lived experience matters. Place encodes structural legacies, root causes and civic relationships and infrastructure in a way that shapes our health outcomes—as data from the RWJF Commission demonstrated, the place where you live, work, learn, play and pray can change your life expectancy by 10-25 years. Because many assets, policies and relationships are local and place-based, community health workers from a place bring a wealth of knowledge and expertise to the table that is often undervalued. Similarly, lived experience brings unstated understanding of context, barriers and opportunities that would be difficult to come by. Community health workers bring both place and people based lived experience to the table.

Milestone 4.1: Develop a place-based and lived experience orientation in the recruitment and deployment of community health workers as much as possible and makes sense - Community health workers that are sourced from and serve a particular geography tend to be far more effective because they have and can build trusted relationships and have a long-term perspective about the community. The same is true for people with lived experience of a particular identity or experience. This deep lived expertise of place and experience should be recognized by all actors as an essential part of appropriate hiring and recruitment to maximize the value community health workers can offer.

- 4.1.1 Integrate a lens of place and lived experience into the hiring and development of community health workers.
- 4.1.2 Build place and lived experience-based grounding in community change efforts (for example, understanding of asset mapping, structural requirements of place, history of lived experience)

Milestone 4.2 Connect CHW efforts within a geography to the HEZ as a coordinating resource for major problems that need to be solved through broader efforts. While community health workers are powerful catalysts for change in communities, they are not miracle workers. Some challenges—for example, the availability of affordable housing, requires the shared stewardship of a broader set of partners and actors across sectors to play a role. While this element is not unique to community health workers, Health Equity Zones offer a powerful mechanism for acting as this place-based coordinating infrastructure—that can also support coordination for groups more based on identity. They can also serve as a neutral entity that can receive braided and blended funding and offer shared stewardship and governance, building on the Advisory Council and other mechanisms already in place.

- 4.2.1 Integrate CHW leadership and coordination supports into HEZ infrastructure (while continuing a direct line connection across HEZs and groups with an independent CHW governance body)
- 4.2.2 Create regular opportunities for CHW leadership to bring the perspectives and experiences of CHWs to strategy conversations at the level of the HEZ.
- 4.2.3 Integrate CHW presence and learning about the role into HEZ conversations.

Milestone 3 Leverage this place-based coordinating infrastructure and the leadership of CHWs to solve challenging community problems, like lack of affordable housing.

For this kind of new relationship to feel real, it needs to be tested against a concrete problem that needs people to come together to solve. Across the board, people identified lack of affordable housing as a problem they would be motivated to work with others to solve. Housing also offers an important place-based lens into root causes and how these show up in an intersectional way in our practices and policies. This challenge requires coordination across sectors and the role of community health workers to both navigate and coordinate, for example, a point in time count, building a stories to system change process, the assessment of how much housing is available compared with how many people need it, and the development of a population health equity plan developed in partnership with the housing and community development sector.

- 4.3.1 Identify a common challenge to solve together—like housing or food insecurity.
- 4.3.2 Support the community health worker to become a facilitative change leader for the team—together with resource/system leaders and community members with lived experience of inequity.
- 4.3.3 Develop and implement an equity action lab or other improvement process that supports the community health workers to bring their leadership and skills to bear to solve a critical community challenge.

Milestone 4 Build a population health equity strategy for each HEZ with input and investment from community residents, community health workers and partners across sectors.

- 4.4.1 Use the development of a population health equity strategy (or the state health improvement plan) to build a virtuous cycle between community-driven input and leadership and long-term community outcomes.

Measurement and Evaluation Strategy

A measurement strategy will need to be developed to track progress on the roadmap and integrated into both evaluation and governance efforts. We look forward to seeing the outcomes of this process over the next 3-5 years. We recommend the following elements be included in the measurement strategy:

- 1) Well-being of the workforce:
 - a. An annual or Realtime survey to monitor the well-being, experience and burnout of the CHW workforce and other peer workers.
 - b. An annual survey of wages and compensation of community health workers (could be included in same instrument)
- 2) Core elements of CHW support systems are in place – Adapt the Program Functionality Matrix to become a CHW Compass which assesses the processes and systems in place at sites and within the state to support community health workers.
- 3) Health equity systems and supports
 - a. Expanded role of community health workers to address inequities in physical and social health outcomes and to address underlying policies and systems that create inequitable community conditions and root causes.
 - b. Expanded civic capacity exists in the community to address health inequities across sectors and in partnership with community residents experiencing inequities.
 - c. Improvement in health, well-being and equity indicators of patients and in the community

Next steps

We recommend that the partners who convened this roadmap process steward this roadmap to implementation. The CHW Strategy team will continue to serve as a place for coordination and accountability while implementation workgroups serve to move the work forward with relevant agency involvement. Agencies like EOHHS are already planning to convene processes to explore how to invest more deeply in community health workers as part of an integrated investment in health equity over the next year. By building a process that deeply involves and grows the leadership of community health workers and other peers with lived experience, and its recent experience building multisector capacity using approaches like Pathways to Population Health Equity, Rhode Island can chart a path forward toward a deep and strategic approach to health equity.

We are the Ones We've Been Waiting For

You have been telling people that this is the Eleventh Hour, now you must go back and tell the people that this is the Hour. And there are things to be considered...

Where are you living?
What are you doing?
What are your relationships?
Are you in right relation?
Where is your water?

Know your garden.
It is time to speak your truth.
Create your community.
Be good to each other.
And do not look outside yourself for your leader.

Then he clasped his hands together, smiled, and said, "This could be a good time! There is a river flowing now very fast. It is so great and swift that there are those who will be afraid. They will try to hold on to the shore. They will feel they are being torn apart and will suffer greatly. Know the river has its destination. The elders say we must let go of the shore, push off into the middle of the river, keep our eyes open, and our heads above the water.

And I say, see who is in there with you and celebrate. At this time in history, we are to take nothing personally, least of all ourselves. For the moment that we do, our spiritual growth and journey come to a halt.

The time of the lone wolf is over. Gather yourselves! Banish the word 'struggle' from your attitude and your vocabulary. All that we do now must be done in a sacred manner and in celebration.

We are the ones we've been waiting for.

--Hopi Elders' Prophecy, June 8, 2000

Read by Swanette Salazar, Ambar Delgado and Dannie Ritchie at the first CHW-organized Conference in RI

Acknowledgement and Appreciation – We wanted to thank everyone who contributed to this process, both community health workers, who made up over half of the contributors, members of the CHW Strategy Team, and many other CHW allies across the state. This is your roadmap. Thank you to the Rhode Island CHW Strategy team! This coalition has consistently created space for CHWs, allies, and policy leaders to advocate for systems that support the full scope of the CHW role. This commitment and passion will continue to drive the cross-sector engagement needed for RI to navigate through the milestones laid out in this Roadmap. In partnership, we can design accountable policies and practices that will promote the equity and well-being of communities and individuals.



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