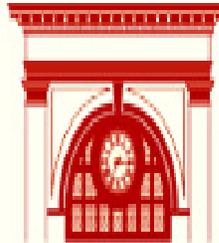


Community Health Workers:

*Building a Diverse Workforce
To Decrease Health Disparities*



Curriculum Development and Sustainability **Roundtable Series**

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The Transcultural Community Health Initiative

Building a Diverse Workforce With Community Health Workers

Rhode Island Foundation Roundtable Series

Feb 17 - May 17, 2004

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ACKNOWLEDGEMENTS: TCHI would like to thank Brown University and the Rhode Island Foundation (RIF) for their support in making this Roundtable Series possible. Thanks also to the presenters—Caroline Campos, Durrel Fox, Janet Isserlis, Adrianna León, Yvette Mendez, Christine Russell, Dr. Peter Simon, Donna Williams— and to the individual participants and participating organizations that sent representatives. Thanks to all who contributed to editing the presentations and work group summaries. And finally, a special thanks to Beverly Guay from the RIF; to the undergraduate students, Cate Oswald and John Ly, whose tireless efforts assisted in the organization of the Series; and to Valerie Wilson for inspiring the production of the monograph.

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Executive Summary

The Transcultural Community Health Initiative (TCHI) is a participatory research initiative developed at the Center for the Study of Race and Ethnicity in America at Brown University which strives to enable community-driven solutions to disparities in health. The overall goal is to decrease health disparities in Rhode Island through developing community health worker (CHW) training programs in community-based organizations, i.e., minority health promotion centers. Part of the initiative's work is to develop a strategic plan for the development of these training programs.

Between February and May of 2004, with the sponsorship of the Rhode Island Foundation, TCHI held a Roundtable Series in which over 30 different organizations participated. The Roundtable Series had two objectives—the development of a strategic plan for the creation of a core curriculum for CHW training programs and the creation of action steps to facilitate placement of CHW program graduates in paid positions. This is part of a national strategy to attain the recognition of CHW as a valid profession and a mechanism to create sustainable paid positions and placement for people who complete the programs.

While the concept of CHWs is not new, the focus for this initiative is to use the CHW as an innovative approach to decrease health disparities and to create another starting point for building diversity in the health care workforce. This approach will create healthy and strong communities through local capacity building and social mobility enhancement with the creation of the CHW programs. Working on many levels, the initiative builds networks which will improve educational options, labor force options, community organization, advocacy, and health literacy as it provides an additional approach to creating a diverse health professional workforce. It is envisioned that once the CHW training program is in place, it would provide a profession that could either stand alone or be part of a career ladder for diverse under-represented communities.

The most significant success of the Roundtable Series was the impressive level of participation, with over thirty community organizations coming together to collaborate in the roundtable. The roundtables have also created a new level of recognition of the value of community health workers and the part they can play in integrating the community into the health care system. And finally, working together has provided the clarity to determine the most appropriate persons and organizations to assist in this process.

The Roundtable Series concluded with an initial blueprint for a strategic core curriculum development plan for the CHW training programs. It also succeeded in identifying several people from various participating organizations who will develop reimbursement mechanisms to ensure the program's sustainability.

Introduction and Background

In Rhode Island, access to health care is widespread compared with other states in the nation. However, health disparities based on race and culture mirror, and in some cases are worse than, those in the rest of the country. These disparities persist despite access to insurance, the availability of health care centers and institutions, and health promotion efforts to encourage greater access to care (see Table 1 and 2.)

The preliminary data presented is binary and secondary data from a national and state comparison of the general population to racial and ethnic populations of Hispanic, African-American or Black and Asian/Pacific Islanders. Native Americans' statistics were gathered but not presented here. Comparisons include access, in terms of health insurance and utilization of health services; health indicators, in terms of chronic disease and infant mortality and low birth weight outcomes; socioeconomic status and residential segregation indices (Tables 1 – 5.)

Table 1. Access to Care

Access to Care

	General US Population		Hispanic		African American		Asian/Pacific	
	National (US)	Rhode Island (RI)	US	RI	US	RI	US	RI
Percent reporting usual source of care none or ER (1996)	8%	9.8%	14%	14.8%	13%	11.5%	8%	15.1%
Percent Report having no health insurance (1996)	24%	10%	46%	23.5%	30%	18.3%	21%	24.7%

Commonwealth Fund, RI Health Interview Survey, 1996, RI Hospital Discharge Data, RIDOH Office of Health Risk Assessment

In Table 1, in 1996, for most Rhode Islanders except African Americans there is a higher percent who had no usual source of care or they use the ER for their care. This is despite the fact that, compared to the rest of the nation, for almost all there is a moderate difference in those stating that they had no health insurance with the exception of Asian Americans. An important contextual comment here is that these broad quantitative categories do nothing to describe the different groups and contextual factors within these categories that may explain the differences from the national statistics. For example the Asian population in Rhode Island is comprised of a number of refugee immigrant populations—Cambodian, Hmong, Vietnamese and Loatian. Their historical circumstances of migration differentiate them from East Indian and Japanese populations in the rest of the nation.

Table 2. Health Status Indicators

Health Status Indicators

	General US Population		Hispanic		African American		Asian/Pacific	
	National (US)	Rhode Island (RI)	US	RI	US	RI	US	RI
CHD (2001) cases per 100,000	187	206	154	93	236	254	---DNC/DSU---	
Stroke death (1999) cases per 100,000	62	50	47	DSU	83	105	---DNC/DSU---	
Diabetes rate (2000) per 100,000	45	58	66	94	76	201	34 (Asian) DSU	
Diabetes related (2000) deaths per 100,000	77	87	98	DNC	137	195	---DNC/DNC---	
Infant Mortality (1996) per 1,000	7.3	7.3	6.1	5.8	14.2	12.1	5.2	5.8
Low Birth wgt (1991-1996) % <2500gms	7.4	6.3	6.8	6.8	13.1	10.8	7.1	7.7

---DNC- did not collect, DSU- did not meet criteria for reliability---
 Combined CDC and RIDOH Maternal Child health data bank

It is with Table 2 that we start to see how, in Rhode Island, access to health care is widespread compared to other states in the nation. However, health disparities based on race and culture are similar to, and in some cases worse than, those in the rest of the country. The presumption is that access should lead to better health outcomes. But this is clearly not the case. Also of note is that while the racial and ethnic populations bear the greater burden of poor health outcomes, the RI population as a whole fares worse in health outcomes when compared to the rest of the nation.

To help redress this situation, Dannie Ritchie, M.D, M.P.H, an assistant clinical professor of family medicine at Brown Medical School and a research associate at Brown’s Center for the Study of Race and Ethnicity in America, has assembled an advisory board of community health leaders, community-based organization representatives, faculty members from Brown University and other colleges, physicians, state and federal public health officials, state health care officials and advocates to spearhead the Transcultural Community Health Initiative (TCHI).

TCHI was conceived as a participatory research initiative to enable community-driven solutions to disparities in health. The overall goal is to improve the overall health of Rhode Island by decreasing health disparities. The principal objective is to create a series of CHW training programs for community members so that they become active health promoters serving as liaisons between underserved communities, health care providers and other health and human resources. These programs will be developed in conjunction with community-based organizations—health centers in Rhode Island’s core cities—and each program will be designed to address the particular needs of the community in which the center operates. The training program choice will evolve from the community organizations’ local assessment to determine the best program for the specific community it serves.

Initial steps of the initiative's work are to form a larger coalition to develop a strategic plan for the development of the training programs. Between February and May of 2004, with support from the Rhode Island Foundation, TCHI held a Roundtable Series attracting the participation of over 30 different organizations. There were two objectives. The first was to develop a strategic plan for the creation of a core curriculum for CHW training programs. The other was to develop action steps to facilitate placement of CHW program graduates in sustainable paid positions. It is envisioned that once the CHW training program is in place, it would provide a profession that could either stand alone or be part of a career ladder for diverse under-represented communities.

The roundtables also served a number of strategic purposes. One was to educate the larger Rhode Island community about the issues and rationale for taking a concerted and collaborative approach in addressing health disparities and diversification of the health work force. Another goal was to learn from the community at large about concurrent efforts in existing programs both locally and across the region and country in order to collaborate with and/or model them. And finally, the roundtables hoped to create recognition of the community health worker (CHW) as a profession worthy of validation, and to view the CHW model as the appropriate vehicle/mechanism for integrating under-served, under-represented racial and ethnic populations into the solution to the problem of health disparities.

In order to achieve the objectives of the roundtable and those mentioned above, three general meetings were held and two work groups were formed. In the general meetings, Dr. Dannie Ritchie presented the rationale and theory for TCHI. Health disparities were linked to the social determinants of health, and discussion centered on how, in any population, disparities in socioeconomic status and segregation lead to isolation and disparate resource allocation.

A number of speakers were invited to present information on their programs. Christine Russell, executive director of East Connecticut Area Health Education Centers (AHEC) community college program described the national efforts to promote the professionalization of CHWs and detailed the CHW education courses, including those offered at the community college. She emphasized the importance of entry-level positions leading to a career path in providing viable economic options for under-served racial and ethnic populations allowing them to improve their circumstances and build capacity for their community.

A number of Rhode Island programs that use community health workers or outreach workers discussed their programs. Presenters included Dr Peter Simon of the RI Dept of Health (DOH), Division of Family Health discussing INSEARCH (Increasing South East Asians Receiving Comprehensive Health Services). Also presenting were Caroline Campus, project director of the Center for Hispanic Policy & Advocacy (CHisPA); Adrianna León, Rhode Island D O H, project director of the Rhode Island Parent Information Network (RIPAN) Parent Consultant Programs; Donna Williams, program manager, Sojourner-House and WomenCares; and Yvette Mendez, Neighborhood Health Plan Of RI (NHPRI, project manager Su Salud.

The issue of literacy was presented in two different contexts. Adult education and the development of a curriculum to ensure success was discussed by Janet Isserlis, assistant director of literacy resource at Brown University's Swearer Center. This presentation was augmented by Brenda Dann-Messier, president of Dorcas Place, an adult literacy agency. The link of literacy to health care access was presented by Dr. Dannie Ritchie.

Work groups were formed and these met in between the general roundtables. One group focused on curriculum development and the issues of community health workers. The other studied the issue of utilization, reimbursement and sustainability. The summary reports of these meetings were presented in the last general meeting. Also during the last general meeting Darrell Fox, chair of the

Massachusetts Community Health Workers' Network (MACHW), gave a presentation on the history and rationale for the formation of local and national CHW associations. He also emphasized the importance of involving CHWs in the process of curriculum development. The following sections represent the discussion in the Roundtable Series with their conclusions and recommendations.

Background and Rationale for TCHI

The rationale and theory for TCHI was presented by Dr. Dannie Ritchie. In addition to the disparities in access and health indicators already presented in tables 1 and 2, this rationale includes the theories on social determinants of health as well as data on the socioeconomic status and segregation presented during the Roundtable Series.

The diversity of the American population is one of our nation's greatest strengths. Yet one of our greatest challenges is reducing the profound disparity in health status among America's racial and ethnic minorities. For example, 17 percent of Hispanics and 16 percent of blacks say they are in fair or poor health, compared with 10 percent of non-Hispanic whites.¹ Black males have a life expectancy of 68.3 years, compared with 74.8 years for white men. Black female life expectancy is 75 years, compared with 80 years for white females.² Hispanics are nearly twice as likely to have diabetes as non-Hispanic whites. Having a usual source of care is an indicator of adequate access to preventive and other health services. About 30 percent Hispanics (of any race) and 19 percent of blacks report that they have no usual source of care, compared to 17 percent of non-Hispanic whites.³ These statistics only tell part of the story, but clearly, the burden of disease falls more heavily on minority communities in the United States today.

Access to care in Rhode Island is widespread compared to other states in the nation; but health disparities based on race and cultures are similar, and in some cases worse, than the problems in the rest of the nation. These disparities persist despite access to insurance, the availability of health care centers and institutions, and health promotion efforts to encourage greater access to care.

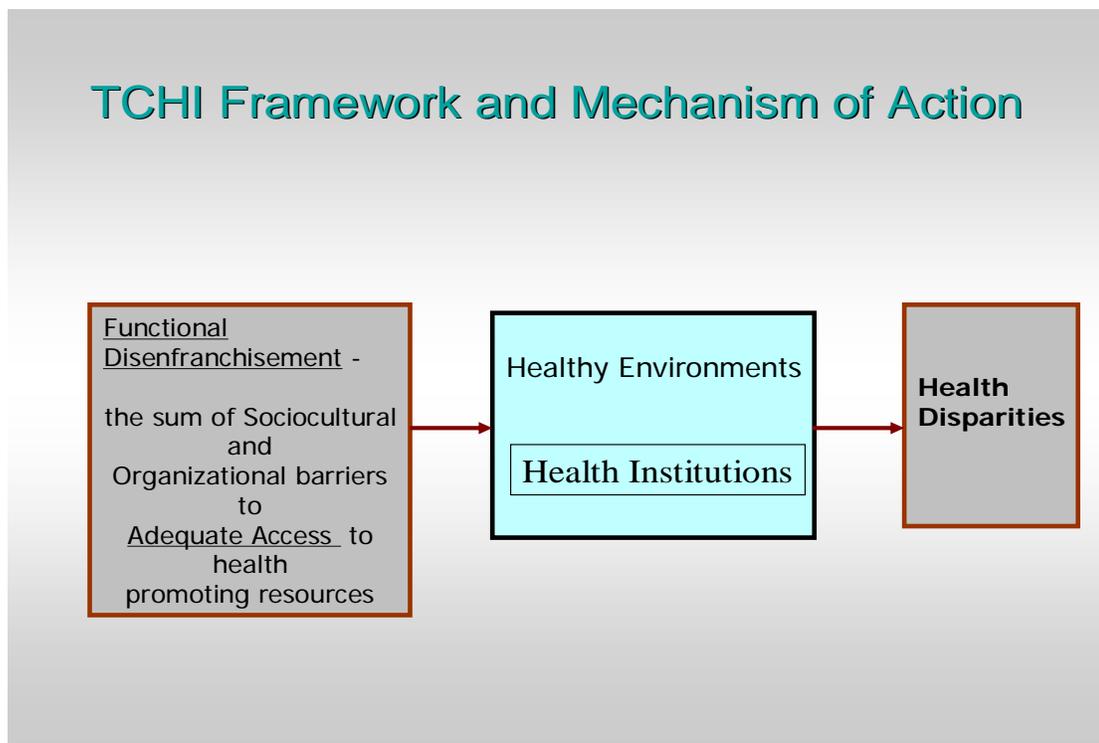
In light of the persistence of health disparities, TCHI argues for an understanding of the issue from a multilevel/multidimensional approach or ecological framework. While we have reviewed a few sources for and explanations of the ecological framework^{4 5 6}, the one we found to be the most succinct for our purposes is the definition given by Lantz *et al* 2001⁷. Here the ecological framework is described as an approach where “individuals are recognized as existing within larger social, political and economic contexts, which shape factors that both promote and negatively influence health behaviors and health status.”

The central reason for health disparities is that Rhode Island's racial and ethnic communities, like those in the rest of the nation, experience functional disenfranchisement.¹ That is, despite access to insurance and even health care centers and institutions, minority populations tend to be discouraged by long-term discrimination and economic privation which undermines the functional involvement of individuals in the health care system and differential access to health-promoting resources (i.e., education, housing, employment.)

ⁱ “Functional Disenfranchisement” is a term developed in the policy analysis papers on the Family Van at the Kennedy School of Government.

The use of the term functional disenfranchisement was developed from a health institution’s perspective. Hamblin and Oriol (unpublished manuscript, oral report) see functional disenfranchisement “...[as] the unease of the outsider looking into a fast paced world that cannot hear their whole story or begin to address the holes that a lifetime of deprivation has created in the ability to manage the business of life.”ⁱⁱ In 1995, this term was further developed by Callahan and Caughey to be recognized as the sociocultural and organizational barriers beyond insurance that limit access⁸. Here sociocultural barriers to access “...comprise a major deterrent to the provision of appropriate health care services for many individuals. These barriers include hostile provider or staff attitudes, language incompatibility between patients and physicians, and differences in cultural...beliefs and preferences”. Where “...organizational barriers in health care delivery system are inadequate capacity (inadequate number of clinics and appointment slots, long waits for appointments and a general shortage of physicians) [and] lack of coordination of services...”

Figure 1. TCHI Framework and Mechanism of Action for Health Disparities

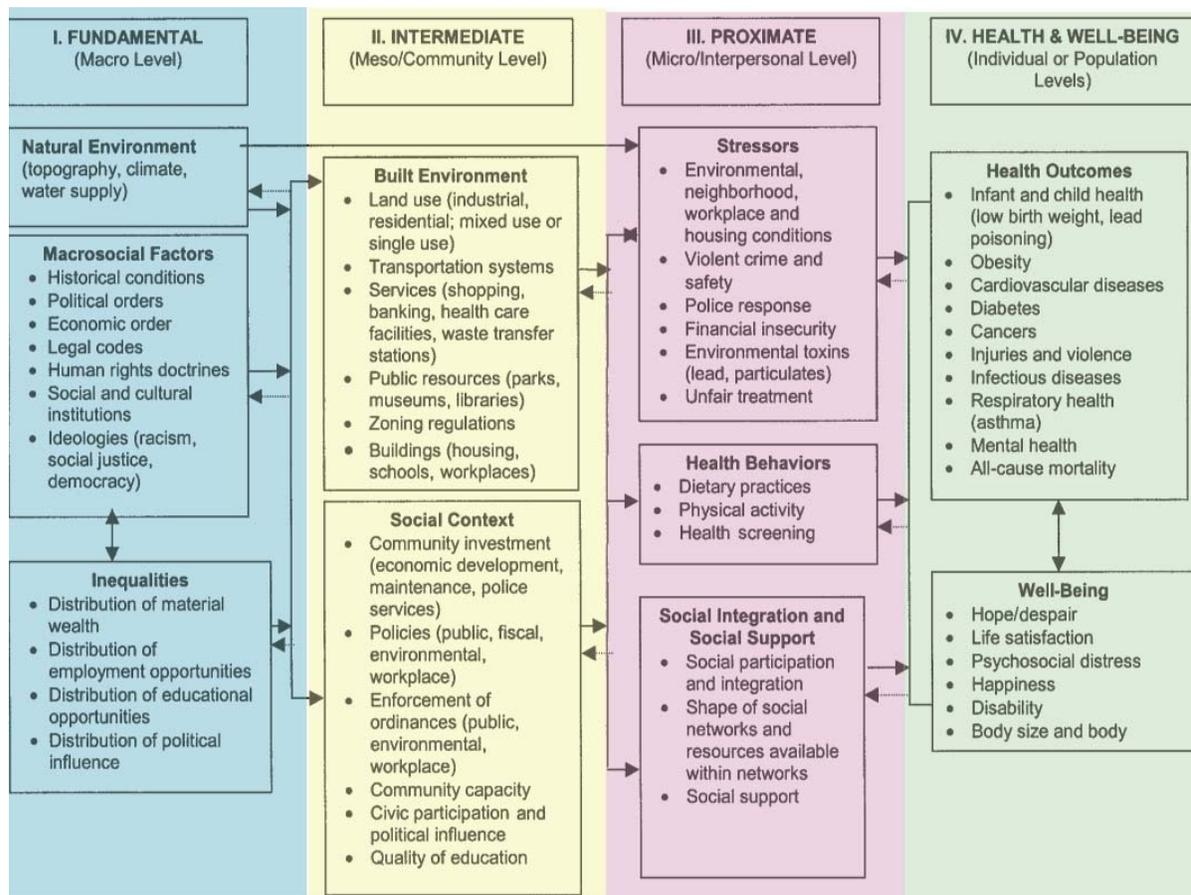


TCHI’s ecological perspective strives to understand and elucidate the social forces that “play a central role in structuring the social and economic disadvantage faced by ethnic minority groups”⁹. We extend this meaning to include the lack of access to health promoting resources (see Figure 1.) This work understands the social context as determinants of health. In figure 2, a logic model

ⁱⁱ Hamblin, R and Oriol, N. 1992. Mission statement for The Family Van of Boston’s Beth Israel Hospital. The Boston Family Van is now part of the Department of Community Development at Harvard.

developed by Schulz and Northridge^{10, 11} incorporates the social variables that impact health outcomes. While this model incorporates social variables that may impact health, it can also highlight the limited area that proximate interpersonal level behavioral risk factors occupies, which most health promotion efforts focus on. This may explain much of what may be responsible for the limited effect of many health promotion efforts (see Merzel and D’Afflitti for more discussion on reconsidering health promotion¹².)

Figure 2 Social Determinants of Health



Source Schulz and Northridge 2004

Socioeconomic Disparities and Residential Segregation Indices

Both research on socioeconomic status (SES) gradient by Kawachi, Kennedy *et al*^{13 14} and others^{15 16 17 18} as well as that on segregation indices by Morello-Frosch and Jesdale¹⁹ demonstrate that wide population gradients and moderate segregation negatively influence the health of the whole population, not only those with the least power. Such research emphasizes that populations who are seemingly in better socioeconomic positions suffer poorer health outcomes if they live in a social environment where there are wide socioeconomic gaps or disparities and/or widespread segregation. It is our contention that by creating interventions that decrease disparities in general, the whole population will benefit with improved health overall.

With the literature pointing to disparate health outcomes as a product of socioeconomic gaps and segregation we gathered preliminary data to see if this might have any bearing on the health indicators for RI. Tables 3 – 5 contain some of the data we compiled on socioeconomics and segregation in RI as viewed against national statistics. Table 3 represents the result of the 1990 census data for Hispanics, African Americans and Asians. Native American data has been gathered but was not presented in the roundtable series.

Table 3. Socioeconomic Status 1990

Socioeconomic Status

	General US Population		Hispanic		African American		Asian/Pacific	
	National (US)	Rhode Island (RI)	US	RI	US	RI	US	RI
Percent living below poverty	12.4%	6.8%	27.1%	29.0%	26.5%	23.0%	10%	26.5%
Percent unemployed	4.8%	7.5%	7%	13.5%	7.8%	12.6%	4.1%	10.7%
Median family income	\$35,000	\$39,172	\$29,608	\$20,516	\$29,404	\$25,367	\$44,460	\$27,867
Percent 25 and older with HS diploma	84%	72%	55%	46.8%	70%	65.9%	87%	59.6%

source: 1990 Census

Table 3 demonstrates that in 1990 RI overall had a better income status compared to the rest of the nation in terms of median family income and % living below poverty. However in terms of % unemployment and those obtaining a high school education, RI fared worse. For the racial and ethnic populations, they tended to fare worse comparatively across all levels than the rest of the nation. Here is the first evidence of there being a wider difference, gradient or gap in SES consistent with the theory mentioned earlier by Kawachi and Kennedy.

This pattern repeats itself in Table 4 except for the fact that the percent living below poverty has increase for both the nation and RI. In this table, RI overall is now much closer to the rest of the nation but is substantially increased for racial and ethnic populations. Also of note is that the percent unemployed is less for RI. Based on this preliminary analysis one can wonder if this reflects an increase in the working population living at or below the poverty line.

Table 4. Socioeconomic Status 2000

Socioeconomic Status

	General US Population		Hispanic		African American		Asian/Pacific	
	National (US)	Rhode Island (RI)	US	RI	US	RI	US	RI
Percent living below poverty	11.30%	10.20%	21.4%	43.0%	22.7%	38.0%	10%	26.0%
Percent unemployed	6.0%	5%	9%	21.0%	10.2%	14.8%	3.9%	12.6%
Median family income	\$42,409	\$44,311	\$33,103	\$22,851	\$ 29,177	\$24973	\$52,285	\$36,473
Percent 25 and older with HS diploma	80%	78%	64%	62%	80%	68%	89%	59.0%

source: 2000 Census

Residential Segregation Indices

As previously mentioned, the work by Morello-Frosch and Jesdale draws a correlation between moderate levels of residential segregation and poorer general population health. Residential segregation serves as one of the most visible representations of differential access to resources. Having previously introduced how SES constructs are formulated, we also looked at how the constructs of residential segregation are formulated. The trend has also been to understand the complexity of residential segregation by looking at the phenomena of hypersegregation. Hypersegregation is a multidimensional phenomenon, which is calculated to produce indices. Most indices are calculated between 0 –1 with 0 being not segregated and 1 being completely segregated. An index of 0.6 has become the convention to indicate moderate segregation. A moderate level of residential segregation on any one dimension can have deleterious socioeconomic consequences, but as high levels of segregation accumulate across dimensions, the negative effects increase²⁰. The next area on which that we collect census data was RI residential segregation.

It should first be noted that residential segregation was initially constructed as a comparison of the white and black populations in urban areas, but it has grown to compare against other racial and/or ethnic populations. In general, when residential segregation is used in research, the dissimilarity index is what is most often used. This is a proportional summary representing how much redistribution it would take across segregated communities to make the populations equally distributed. There are about 20 more ways that segregation is measured, but Massey and Denton, in 1986, noted that all of the measures fall into basically five dimensions:²¹ 1) unevenness in the distribution of blacks and whites compared to the region overall; 2) isolation, or average probability of contact between blacks and whites in the neighborhood; 3) clustering of black neighborhoods together; 4) centralization, or proximity of black neighborhoods to the central city rather than the suburbs; and 5) concentration, or density of the segregated group

compared to other groups. Dissimilarity or unevenness refers to the number of people needed to move in an area. Isolation/exposure, or interaction index, has two components. One is a measure of the likelihood that a person of color will come in contact with a white person, versus the likelihood that he will come in contact with another person of his own color. This is sometime termed social exclusion. The third dimension, centralization measures nearness of a community to the urban center. This is subject to the changing dynamics of urban economic conditions such as urban de-industrialization. Concentration measures the density of the non-white community or compactness of the circumscribed area that they live in. Lastly there is clustering, which measures the number of adjacent racial ethnic groups concentrated in an area. Although most public health research has used unevenness in the distribution of blacks and whites compared to the region overall as a measure of segregation, isolation is actually more associated with socioeconomic status and neighborhood quality.

Table 5 is what was presented at the Roundtable Series. Of the preliminary data compiled, the dimensions of dissimilarity/unevenness, isolation/exposure and concentration were presented. The national comparison Hispanic, African American, and Asian was made with RI.

Table 5. Residential Segregation 2000

Residential Segregation, 2000: National Median and Range/ Rhode Island for Hispanic, Black, and Asian and Pacific Islanders

Segregation Indices	Race/Ethnicity		
	Hispanic	Black or African American	Asian and Pacific Islander
National Median	0.371	0.501	0.337
UNEVENNESS			
Range	<i>0.112 - 0.754</i>	<i>0.188 - 0.846</i>	<i>0.135 - 0.582</i>
ISOLATION			
Providence MSA Median	0.676	0.600	0.437
Interaction Index (xPy*)	0.870	0.680	0.950
	<i>0.048 - 0.993</i>	<i>0.173 - 0.995</i>	<i>0.168 - 0.993</i>
CONCENTRATION			
Relative Concentration Index (RCO)	0.422	0.646	0.522
	<i>-1.370 - 0.904</i>	<i>-0.810 - 0.934</i>	<i>-0.23 1- 0.842</i>
	0.854	0.802	0.560

Source: U.S. Census Bureau, Housing and Household Economic Statistics Division
Providence-Fall River-Warwick, RI-MA MSA

The results demonstrate that for most racial and ethnic populations RI is more segregated and that the racial ethnic groups in RI experience segregation across two or more dimensions.

Mapping the Divide

With the advent of geocoding and block census tracking, the possibility now exists to map much of the demographic data on SES and segregation in a more accurate visual context. The Providence Plan is the main organization charged with census consolidation. Their most completed work has been done on Providence. Viewing this one municipality concretely demonstrates the concepts and data previously presented. It adds a new dimension to the abstract numerical data tables which then allows us to see the stark divide between racial and ethnic populations. The maps in Figures 3 through 5 demonstrate the racial and community segregation, income segregation, and education segregation.

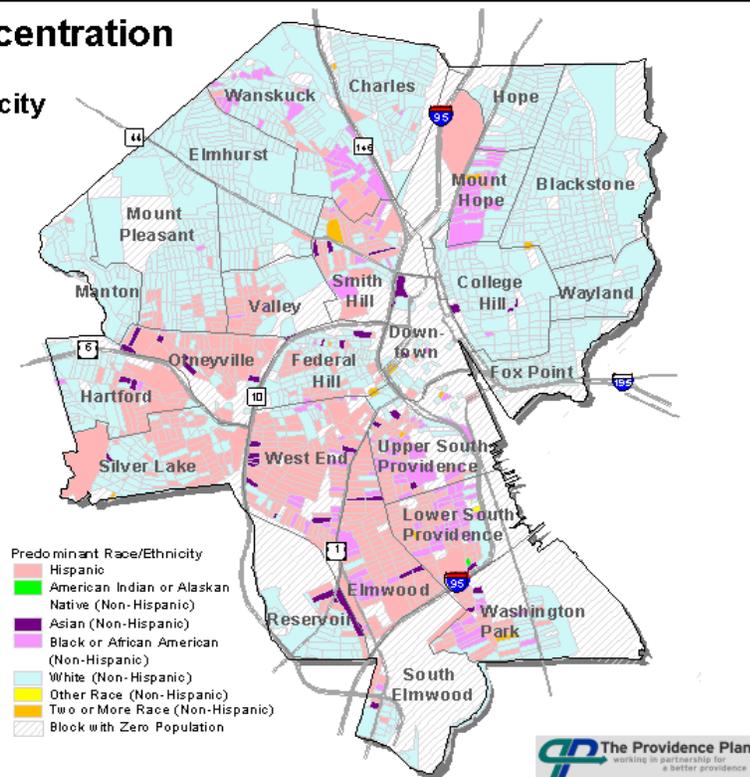
RI Demographic Maps

Fig 3 Providence Rhode Island Race and Ethnic Residential Population Segregation

Racial/Ethnic Concentration

**2000 Census Blocks by
Predominant Race/Ethnicity**

Providence, RI



With the discussion of hypersegregation presented in Table 5, from this map in Figure 3 one can get the visual impact of the concept of isolation/exposure. And though the quantitative data of clustering (measure of adjacent racial and ethnic populations) was not presented here, visually it is evident.

Figure 4 demonstrates the income differential/income dispersion of SES in Providence. It is clear that the racial and ethnic income disparity presented in Table 4 maps onto the segregated residential communities. Also of note in this graph is the marked difference between the overall median family income of \$32,058.00 in Providence, which is well below that of RI and nationally.

Figure 4 Providence Rhode Island Income Differentials / Segregation

Median Family Income, 2000

Providence, RI Neighborhoods

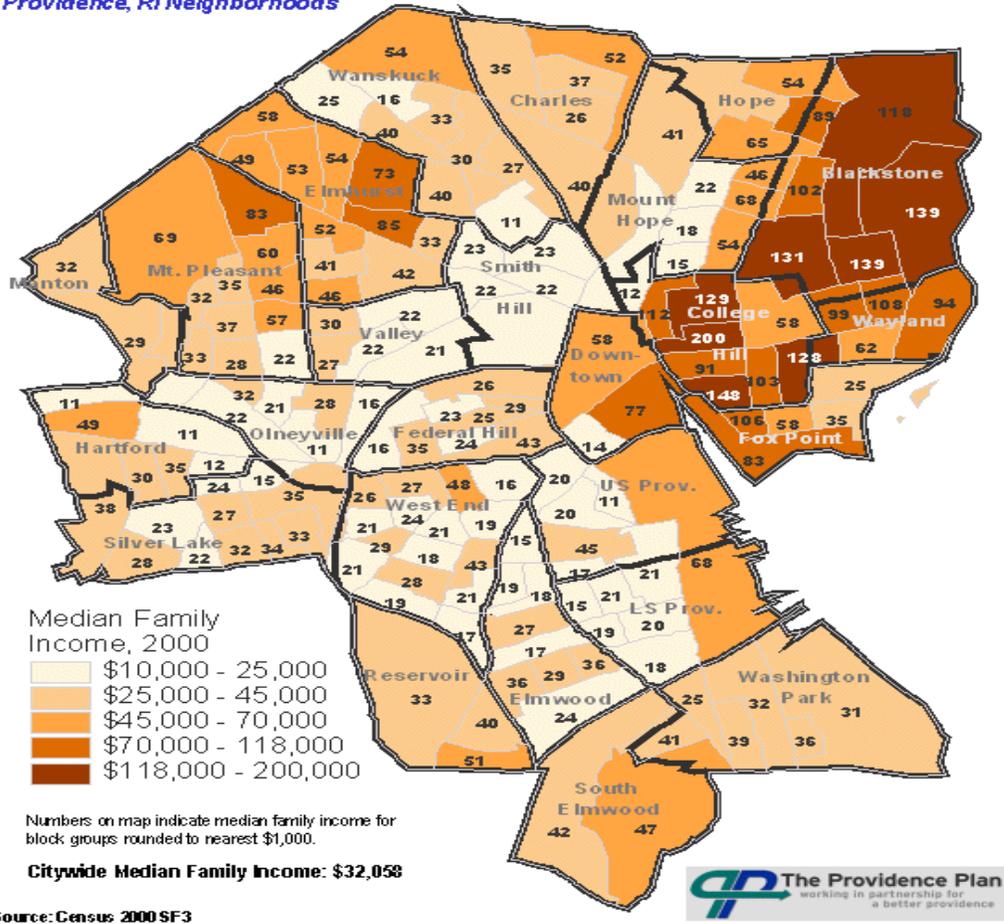
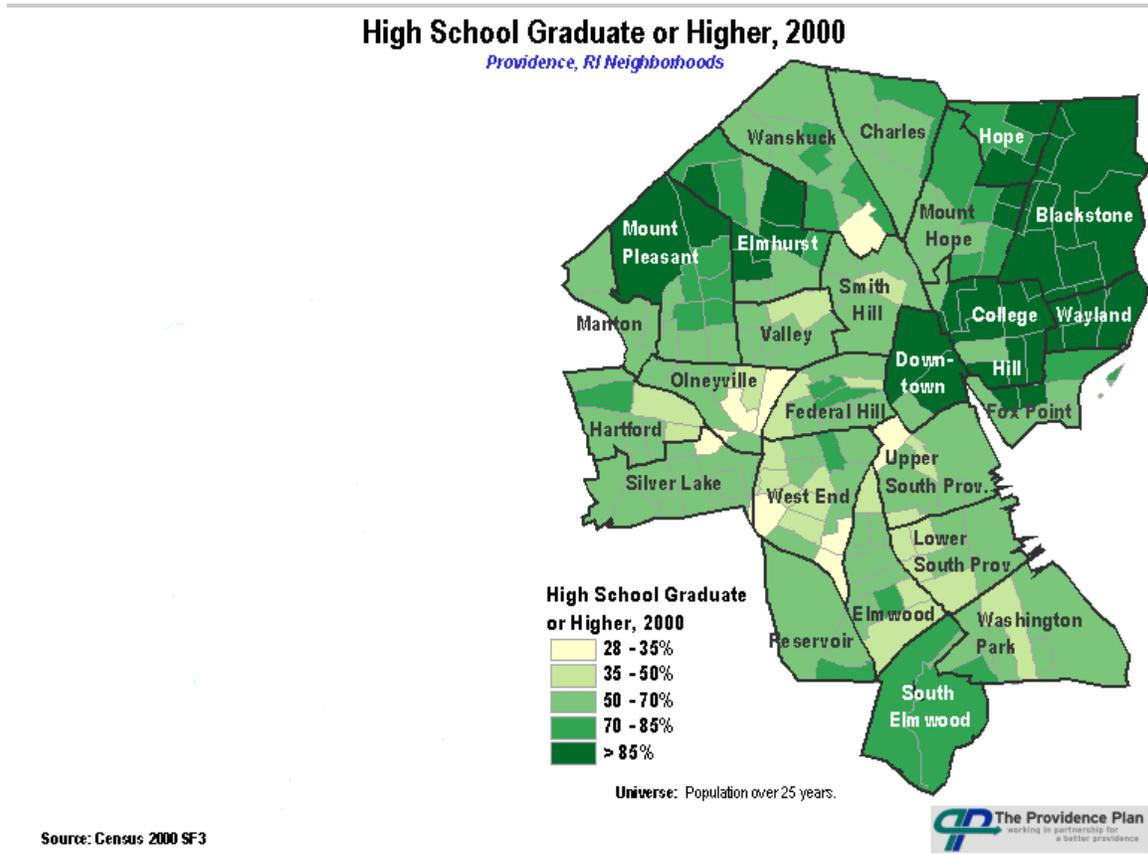


Figure 5 demonstrates the differential education dispersion of SES in Providence. It looks at the percent with a high school or higher education. These map reflect the same racial and ethnic education disparity presented in Table 4, which reports those with a High School education. Again the disparities maps onto the residential segregated communities.

Figure 5 Providence Rhode Island Education Differentials/Segregation



Making the Link

It is clear those populations with the least socioeconomic and political powers bare the greater burden of disease. However the research done on socioeconomic status gradient by investigators such as Kawachi, Kennedy *et al*^{22 23} and segregation indices by Morello-Frosch and Jesdale²⁴ demonstrates that populations who are seemingly in a better socioeconomic position suffer poorer health outcomes if they live in a social environment where there are wide socioeconomic gaps or disparities, and/or are greatly segregated. The preliminary secondary research data for Rhode Island bears out the finding in the literature. That is, as Tables 3 and 4 illustrate, RI is wealthier compared to the rest of the nation, but has a greater socioeconomic divide and urban residential segregation. Table 2 reveals that RI, on a whole, bears a greater burden of disease compared to the rest of the nation.

The preliminary data collected for RI appears to validate the literature presumptions of poorer health due to great socioeconomic disparities and segregated conditions. What these finding also reemphasize to us is that access to health is not only access to health institutions through insurance and/or transportation, but also access to health promoting resources (i.e. education, housing and employment) and healthy environments. It is the purpose of TCHI to continue to investigate and elucidate the social context or determinants of health, to then begin a process to promote community capacity building in order to assist in leveling the playing field, and thus, promote the health and well-being of Rhode Island as a whole.

The TCHI Participatory Intervention

As previously mentioned, access to care in Rhode Island is considered one of the best in the nation, but health disparities based on race, culture, and class are similar to, and in some instances worse than, those in the rest of the nation. We contend that this is due to the fact that Rhode Island's racial and ethnic communities, like those in the rest of the nation, experience functional disenfranchisement. That is, under-served racial and ethnic communities' differential access to health-promoting resources and functional involvement in the health care system is not sufficiently supported by insurance, health institutions, or current health promotion efforts.

In light of the empirical evidence of health disparities in RI, and in an effort to improve the health status of Rhode Islanders, the Transcultural Community Health Initiative was conceived. It seeks to implement a project to promote neighborhood groups' capacity to build health care connections and programs to increase a diverse health care workforce.

We believe that the best way to address functional disenfranchisement is to collaborate, to coordinate, and to support the health activities that communities provide for themselves by themselves and to build the technical capacity within the communities to develop a diverse health care workforce. Such infrastructure enhancement will create opportunities for community members to be more proactive in providing input into community health care issues and developing solutions which meet their particular community health needs.

The principal objectives of TCHI are as follows:

- To build the technical capacity of existing community-based organizations and/or groups in order to build social capital to address community health care issues
- To coordinate with a number of contemporaneous efforts across Rhode Island's core cities in building capacity for training health care workers in existing community infrastructures
- To build diverse community health workforces that can define their health issues and create interventions.

The approach that TCHI takes is a community-based participatory action research framework. This involves an active community/academic collaboration in order to create community-driven plans. The collaborative partnership involves the community, which extends from the under-served community populations and organizations to coalitions with larger institutions and agencies. It also includes a multidisciplinary group of academic faculty, students, and public health officials. We believe that this will allow for us to build on each other's strengths in order to facilitate the goals of the initiative; provide the expertise in data collection, analysis, tracking and evaluative processes; identify resources for the purpose of forming a larger coalition which would channel resources into communities; and bring organizations with similar missions together to increase effective and efficient community capacity building.

An advisory board was formed that consisted of community-based organization representatives, an interdisciplinary group of faculty members from Brown University Medical School and other colleges, and state/federal public health officials. With an ecological framework—recognizing social determinants in the context of health—and taking on a participatory research design to achieve our goals and objectives, TCHI adopted the following Mission Statement and Core Principles.

Mission

Building and developing community has a health-enhancing influence. Through the act of capacity building of under-represented diverse communities, we will further the discourse on how social forces shape disparate health outcomes. This will further inform the channeling of resources and advocate for change to promote the social well-being and health of Rhode Island.

Core Principles

To provide a channel for political empowerment of disenfranchised communities by power sharing, TCHI maintains five core guiding principles of Humility, Empowerment, Access, Relationship, and Social Justice (**HEARS**) to achieve its mission.

■ Humility

- To recognize the limitations of our knowledge and perspectives—whether academicians, policy makers or community organizations—in addressing complex social forces
- To maintain a focus that allows us to develop mutually beneficial and non-paternalistic advocacy partnerships with communities on behalf of individuals and defined communities.

■ Empowerment

- To work with communities to reach their full potential in communicating and addressing the solutions to health disparities
- To provide a channel for political empowerment of disenfranchised communities by power sharing

■ Access

- To broaden the concept of access to address the fact that what limits access is more than a matter of adequate insurance and transportation
- To recognize that the verbal and nonverbal communication to under-represented populations, on a societal and systemic level, has greater importance in the equation of health outcomes.

✚ This should include, but not be limited to, a focus on communication in terms of literacy, English proficiency on the part of the patient, and cultural appropriateness on the part of the provider in the medical encounter.

■ Relationship

- To advocate for health promotion as a function of building relationships of trust and mutual respect
- To promote sustained partnership through the collaborative efforts of building community

■ Social Justice

- To recognize that there is a direct relationship between poverty, discrimination, wealth and health outcomes
- To recognize that health disparities are the outcome of social inequities and social injustice
- TCHI maintains the focus that health disparities are a matter of social injustice, which is an ethical and moral imperative to be addressed.

The following subcommittees were formed with the listed responsibilities:

- Policy/Community – charged with identifying core principles, coalition partners, community organizations, community organization selection process, and resource identification
- Education – charged with developing and executing a plan to create a core education/curricula development and skills trainers
- Analysis/Plan – charged with identifying and developing the concepts, outcome measures, methods of measurement, types of data collection, and the responsible parties for data collection
- Funding – charged with identifying mechanisms and organizations to fund the initiative.

One of the principle objectives is to build a community of diverse community health workers in order to provide a mechanism for communities to be more integrated in the discussions of how to improve their community's health. While there are a number of models and names for community health workers such as interpretive service programs, cultural brokers, health advocates, peer advisors and educators, community health representatives, parish nurses, and even paramedics and case managers, this initiative's vision is to develop and create a curriculum that is more consistent with health advocates or cultural brokers within community-based organizations.

Definitions of Community and Community Health Workersⁱⁱⁱ

TCHI's initial working definition for Community:

- used to imply that members sharing relatively distinctive lifestyles, and with which there is a sense of identity and belonging, shared values, norms, communications, and helping patterns
- and/or communality amongst networks, i.e., a community of interest.

And Community Health Workers:

- used to imply an indigenous outreach worker who is trusted and respected in his or her community and who serves as a bridge between peers and health care professionals.

To form community health worker programs as a mechanism to enhance a core of community participation that will assist in the process of assessment and design of interventions, the following objectives, strategies and outcomes were envisioned: (Table 6.)

ⁱⁱⁱ Both definitions have been modified since the Roundtable Series

Table 6 Objective Strategies and Plan

To build diverse community health workforces that can define their health issues and create interventions		
Objectives	Strategies	Outcomes
<p>Develop a core curriculum for all health worker programs.</p> <ul style="list-style-type: none"> Identify core curriculum certification training programs for community health workers to produce consistency and accountability. Establish core competencies and skills. Establish programs which will be fundamental to all types of health workers and that can be adapted to what the community members want. (“Take marching orders from...”) <p>Establish culturally appropriate curricula, in a culturally sensitive manner and implement best practice health promotion strategies.</p> <ul style="list-style-type: none"> Address the issue of language barriers including basic literacy skills. Recognize the verbal and nonverbal communication to under-represented populations. Create a pipeline of mobility to be able to move on to other professional opportunities. 	<p>Conduct an assessment of existing models as possible resources for curriculum development.</p> <p>Encourage peer-to-peer outreach, both formal and informal.</p> <p>Incorporate preparatory training for test taking skills leading to any needed certification/ licensing.</p> <p>Assess literacy and math skills in the participants’ primary language.</p> <p>Provide programs that will be taught in dominant language of the US and primary language of the communities in order to increase access.</p> <p>Perform community assessments to assure input from different sectors so that communities won’t be left out due to language barriers or cultural practices.</p>	<p>Be the bridge to advocate for health care consumers within the health care system.</p> <p>Link the community to the institutions by creating options to work both in the community and in the health institutions.</p> <p>Link between traditional healing practices and western/main stream medicine approaches.</p> <p>Produce CHWs that provide access to care for the functionally disenfranchised via outreach and/or as a resource.</p> <p>Produce standardized certificate programs.</p> <p>Create a cross-cultural training program that would aid in a more holistic health perspective.</p> <p>Create career ladders to connect greater access and opportunities with the health professions.</p> <p>Promote development capacity of a emerging population of workers in a seamless system.</p>

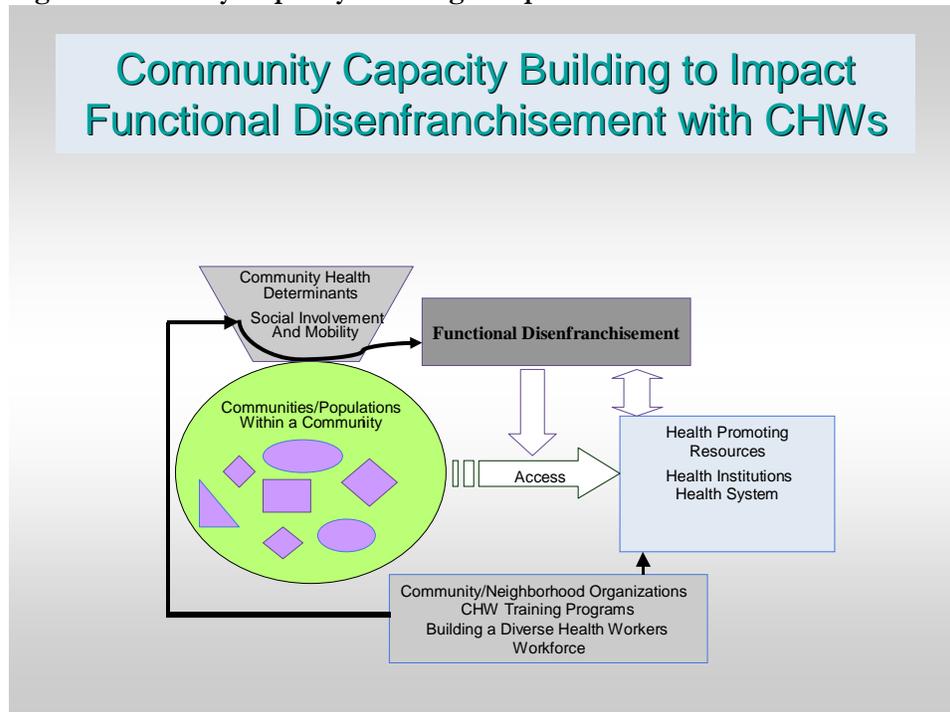
The literature that discusses the CHW framework models consistent with the TCHI ideal being considered is as follows: Parker *et al*'s lay health advisors in their Community Academic Research Partnership through the University of Michigan in Detroit²⁵; CHWs as cultural brokers who act as links for the disenfranchised immigrant^{26 27}; CHWs as integral to the health care industry²⁸; and finally one of the faith-based community health workers²⁹. All of these examples are variations on the same theme—increasing availability to health care and promotion through community members—and identify slightly different points of access.

One of the first minor objectives is to design a CHW core curriculum. This curriculum is to have the capacity to be enhanced and modified, which will provide community organizations with a choice of CHW training programs which will be offered to community members and will accommodate different community identified needs. These CHWs will provide the mechanism and opportunity for community driven solutions. The community organization’s choice or modification of training program will evolve from a community assessment to determine the best fit program for the community it serves. It will additionally tap into under-utilized community resources by providing entry into the health workforce at various levels, thus creating an opportunity to enlarge and diversify the health care workforce

The framework for community assessment consistent with the TCHI model is represented in the literature of Kretzman and McKnight³⁰ and Goepfinger and Baglioni³¹. These examples challenge the status quo of needs assessment models that cast under-served and under-represented communities from a deficit model perspective. This literature suggests shifting the framing of these communities to one with needs but also assets to be tapped into.

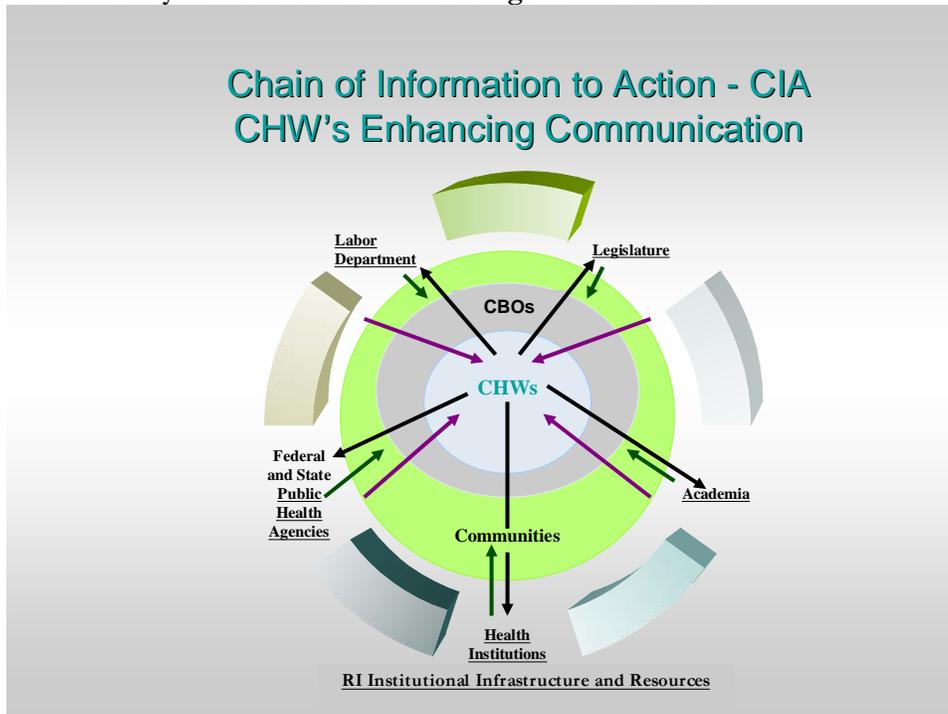
Figure 6's schematic demonstrates the idea of how these training programs would act within communities to affect functional disenfranchisement through social mobility and community participation. It is envisioned that these training programs would primarily provide service from community based organizations (CBOs, which could also potentially include health centers)

Fig 6 Community Capacity Building's impact on Functional Disenfranchisement



By applying his or her unique understanding of the experiences, language and culture of the communities he or she serves, CHWs have the potential to provide several functions. They can be a wraparound service that overcomes logistical and cultural barriers to care, contribute to continuity of care, and/or be the voice of the community and part of the community integration in the health care team. But overall community health workers as a voice for their community will assist in the evaluation of the needs and assets of their community bringing needed resources into the community. In this way CHWs can enhance their community by being both the navigator for community members and the ambassador for the community (see Fig 7).

Fig 7 Community Health Workers Enhancing Communication



Invited Speakers Presentations

As part of the Roundtable Series, a number of regional and local speakers were invited to present their programs and efforts. The following is a summation of their presentations.

Community Health Worker Curricula Models

Catherine Russell, Executive Director, East Connecticut's AHEC community college program presented "The Future of Outreach in New England." Outreach worker is a term used interchangeably with CHWs. She started by discussing who outreach workers are and what they do. According to her description, they are a broad range of frontline health and human service professionals who serve as liaisons between under-served populations and formal health care and human service delivery systems. She noted that outreach workers are often indigenous to the communities they serve and operate as "culture brokers." In addition, because they are trusted, they can serve as effective conduits of information, resources, services and advice on how to access services.

She noted that her institution, the Eastern AHEC, along with Northwestern AHEC, completed an Outreach Workers Survey in the late 1990s. The NW AHEC survey results were very consistent with, or, in many cases, nearly identical to, the findings of Eastern AHEC. She then presented the results of their Eastern Connecticut survey. Their results revealed that the single largest barrier to wider employment of community health outreach workers (CHOW) was budget constraints. On-the-job training was the most widely used training. Eighty percent of employers were interested in having their workers receive additional training and are willing to consider releasing employees from work to

attend. The preferred type of training was half-day sessions, followed by a large forum, full day, and finally evening sessions were last. The sources of funding were predominantly federal, followed by state grants, county/city funding, and other sources.

There are a wide variety of services provided by the outreach workers. These range from general case management and general social service (the major area to topical target population, i.e., youth violence,) to categorical medical (STD/HIV, learning disabilities, MCH and immunizations.) CHOWs serve many different functions in different contexts and work for a wide range of employers. Outreach workers on the whole are well educated, but not necessarily trained for their work. They are modestly paid and few employers offer opportunities to career advancement.

Employers reported that they would like to offer their employees additional training. They also expressed frustration with limited funding and, to a lesser extent, the lack of standardization and formalization of the profession.

These trends set the backdrop and begin to set the agenda for the advancement of the profession. Recent social trends which indicate growing economic disparity and social fragmentation are increasing the need for outreach workers. Nationally there is a trend to provide training and certification programs for outreach workers and community health workers in order to:

- provide consistent core competency training
- provide a clear understanding of roles and skills
- provide recognition of outreach workers as front-line health care professionals
- provide peer support and networking opportunities
- develop a training/certification program with local colleges that will meet the needs of outreach workers, supervisors, and employers
- provide an entry-level ladder for individuals that will offer a family-supporting wage, benefits, and a career path.

She gave the following examples of regional and national CHW career tract programs and standards of practice.

The Connecticut's CHOW (Community Health Outreach Worker) is a 31 credit program offered at Three Rivers Community College. The credits can be applied toward an associate's degree in human services, nursing, education, liberal arts, or science; and it serves as a path to a bachelor's degree in either arts or sciences and eventually a master's degree in social work or public health.

The San Francisco Community Health Worker Certificate (Level I) and a Community Health Worker Specialty Certificate (Level II) provides a performance-based approach to curriculum. These are offered at the City College of San Francisco, which provides a certificate that carries 17 units of credit and a "Career Track" train for workers. Credits earned can be used to complete an associate's degree at City College. Additionally, twelve units can also be applied to satisfy requirements for a bachelor's degree in health education at San Francisco State University. The San Francisco Department of Health accepts certificate completion as a minimum qualification for civil service health worker positions.

The University of Arizona offers a certificate program called **Jump Start** at in Arizona Community College. It is a core competency-based program of 16 credits based on Lee Rosenthal *et al.*'s National Community Health Advisor Study³². This curriculum also recognizes the indigenous nature of this

worker and the non-traditional characteristics of the students. It is responsive to and depends upon non-traditional community-based partnerships that support the preparation and utilization of outreach workers.

In Massachusetts, **Community Health Education Centers (CHEC)** has developed a nationally recognized certificate program structured to include six core courses and a minimum of seven health modules. CHEC has developed a nationally recognized certificate program structured to include six core courses and a minimum of seven health modules.

Rhode Island Outreach Model Programs

Catherine Russell helped to define and overview the national move towards the career pathways/tracks that CHW training can offer. What follows below are the number of presenters that provide or have provided programs that are consistent with what could be considered RI CHWs.

INSEARCH

Dr. Peter Simon, Department of Health (HEALTH), Division of Family Health (DFH) Programs, presented lessons learned from INSEARCH (Increasing Numbers of Southeast Asians Receiving Comprehensive Health Services). INSEARCH was funded by MCHB's Genetics Branch in the late 80s and early 90s and recently was included in an MCHB funded March of Dimes project to review best practices in bridging cultural barriers to western genetics and other preventive maternal and child health services.

The purpose of INSEARCH was to assist providers and the new refugee Southeast Asian communities to create culturally appropriate services for mothers and children, and to address the cultural and linguistic barriers to understanding such genetic conditions as thalassemia and other hemoglobinopathies experienced by resettled Southeast Asian families. PAOU staff were trained to address comprehensive maternal and child health needs of these groups and were not solely trained to assist with genetic counseling for hemoglobin disorders.

The lessons learned were:

- Specially trained bicultural/bilingual community health workers were needed to serve as culture brokers as well as interpreters and are a necessary component of a health care team if it is to deliver culturally competent care.
- Successful bridging of cultural barriers to health care services requires increased knowledge of the culture of both the patients and providers.
- Learning styles are also culturally bound and teaching needs to be sensitive to both style and content.
- A provider cannot assume that having the knowledge of the name of a medical procedure or an explanation imparts an understanding of the principle behind it.
- Communication with patients requires concepts and words that can be translated into the concepts and words of the other culture.
- Flexibility in our methods is also important; we must be open to adjust our approach as we learn new information.
- Successful efforts to overcome cultural and linguistic barriers to health care are likely to be frustrated when service capacity is limited.
- Traditional needs assessment skills used by Title V agencies need to include qualitative methods of assessment of health beliefs, attitudes and practices.

ChisPA

Caroline Campos, Project Director, CHisPA, gave a presentation of the history and programs there. CHisPa is the Center for Hispanic Policy & Advocacy, formerly known as the Hispanic Social Services Association was founded in 1986. CHisPA provides advocacy, community information and referrals as well as an alternative high school. They also provide direct social services to community members with assistance in different areas of adult education such as a financial literacy program. In July 1995 the Promotores de Salud/Health Promoters programs was created as an effort to prevent health related issues affecting the Latino community.

Their promotores conduct outreach and provide vital health information on different topics, such as HIV/AIDS prevention, cancer, heart disease, diabetes, tobacco, and access to health care. They are teachers, advocates and friends. They belong to the community. They understand the needs of the client. They speak their own language. They are in a continuing training process to improve their knowledge.

Parent Consultant Program

Adriana León, Project Director for RI Parent Information Network (RIPIN) Parent Consultant Program at Rhode Island Department of Health, Division of Family Health (DFH) discussed the Parent Consultant Program. The purpose of this program is to ensure that consumers are integral to planning, implementing and evaluating (DFH) programs. The program trains parent consultants to be effective advocates for families and informed spokespersons for the Maternal and Child Health programs such as Immunization, Lead Prevention and Education, Adolescent Health, and WIC (Women Infants and Children Nutrition Program). Training provided to parents includes leadership development, how the legislation process works, how to run focus groups, facilitation skills, effective advocacy skills, and individual program skills depending on placement.

Parent involvement in this program started in 1988 when two parents with special needs children began volunteering as expert resources to DFH staff. In 1990, funds from Title V became available, and Rhode Island increased the number of parents and began to pay them for their dedicated involvement as parent consultants. The DOH contracts with RIPIN for the management of the Parent Consultant Program.

Objectives:

- Identify and build opportunities for consumers to participate in the design, implementation, and evaluation of the MCH programs.
- Strengthen partnerships between families and the DFH, and between families and communities across Rhode Island.
- Train parent consultants to be effective advocates for families and informed spokespersons for the MCH programs.

Supporting activities for parents and mentors include individual meetings with parents and mentors, biweekly parent consultant meetings, quarterly mentor meetings and training and parent recognition events.

Parent Consultant roles. Parent Consultants play various roles according to each of the programs' priorities. These roles mostly involve the fields of:

- policy development
- program assessment
- program planning

- outreach and education
- quality assurance

They note that their accomplishments have and continue to be:

- program strengthening through diversity and family centered practice
- accepting that consumers are experts
- advancing community connections
- providing career opportunities for parents

Sojourner-House

Donna Williams made a presentation about the nonprofit organization Sojourner House and its program, WomenCares. Sojourner House was founded in 1976 by Brown University students who were concerned about domestic violence. With a domestic violence focus, they have formed and continue to provide multi-purpose services including peer education support groups, a gay/lesbian support group, a latina women’s group, youth groups, prison/training school support, child advocacy (helping children understand trauma,) elderly abuse prevention and safety, as well as community outreach and education. It provides community resources such as an emergency shelter and court advocacy.

Another special program is their WomenCares (Women Creating Awareness, Respect, Empowerment and Support) program. It provides support and advocacy as well as harm reduction to abused women at risk for HIV/AIDS. This program trains outreach workers in graduated levels, starting with a 10 session entry level program and ending with a public advocacy training course. These courses were developed by the initial outreach workers who felt and saw a need to expand their roles and duties to be more effective advocate for abused women.

Sojourner House is funded in part by the United Way, and the WomenCares program is funded by HEALTH. Many of their services are dependent on donations from various community partners and volunteers. In the WomenCares program outreach workers are paid a stipend during training and on the job.

Su Salud

Yvette Mendez from the Neighborhood Health Plan of Rhode Island (NHPRI) and Su Salud project manager discussed the Su Salud Project—“Improving patient-provider communication.” NHPRI’s Su Salud is part of the Robert Wood Johnson Foundation’s Hablamos Juntos National Initiative. This program was devised to standardize medical interpreters’ services in order to break down communication barriers which compromise care in order to improve health care services to Latino patients. Su Salud is one of ten health demonstration sites selected to work with the project to help design and test innovative approaches in an effort to create best practices. Handouts about the National Initiative were distributed, and a presentation of NHP’s approach and their timeline was given. The use of medical interpreters in dual roles is one of the objectives of the NHP approach, and the use of CHWs in this dual role is open for continued exploration.

In her presentation, Ms. Mendez provided useful information on an innovative project at Neighborhood Health Plan of Rhode Island which works to reduce health care disparities that often result from language barriers through the use of increased access to interpreter services. This session included descriptions about specific interventions such as:

- why family and/or friends should not be used to interpret in a medical encounter

- how to increase the availability and quality of interpretation services for Latino patients who speak little English
- how to develop and provide useful informational materials in Spanish
- how to develop and implement a claims reimbursement system to reimburse health care providers for the cost of providing trained interpreters
- why there is a need for standardization in the field of medical interpreting.

Why Family/friends or other untrained persons should not be interpreters Medical interpreting has gained attention in the United States with the increase in the foreign born population and a growing body of evidence linking disparities in health outcomes to language barriers. The Civil Rights Act of 1967 prohibits discrimination due to national origin. Federal requirements for equal access mandate federal programs to pay attention to language barriers that may prevent those who speak little or no English from accessing public services. Looking for expedient and practical solutions, doctors, hospitals, and other health organizations turn to heritage communities³³ for help. Many medical interpreters are heritage speakers—persons who learned their native language at home not in school.

With demographic changes, doctors and hospitals are challenged with an increasing number of patients who speak little or no English. Unable to communicate, doctors and hospitals rely on family and friends, or others who may be nearby, to interpret. Many health organizations hire bilingual employees for patient contact positions in order to help patients in their own languages.

Important information between a doctor and patient can be lost in the interpretation. In one study, untrained interpreters were found to make an average of 31 errors per encounter. The use of untrained bilingual staff and family members as interpreters can have implications for patient-provider communication. The most common include:

- omission – where an important piece of information is left out by the interpreter
- false fluency – where words or phrases that do not exist are used by the interpreter
- substitution (13%) – a word or phrase is replaced with another word or phrase of a different meaning
- editorialization (10%) – the interpreter’s opinion is added to the interpretation
- addition (8%) – a word or phrase is added by the interpreter³⁴.

There is a misconception that bilingual individuals without training are adequate interpreters. Unfortunately, the people most affected by interpreting lack the skills to judge its quality. They assume the person providing the interpreting is doing an adequate job. This may create misplaced sense of security that effective communication is taking place.³⁵

Fundamental ethical aspects of healthcare between providers and patients are compromised when people who have not received healthcare interpreter training are asked to interpret. These include, among others, the loss of confidentiality, potential misdiagnosis, and potential invalid informed consent. These consequences increase healthcare costs and liability, and lead to poor health outcomes.

Intervention

The goal of the Su Salud project has been to increase the number and quality of medical interpreters through the development and implementation of a community based medical interpreter training program. Kaiser Permanente’s National Linguistic & Cultural Programs will provide consultation and technical assistance which will replicate an existing health care interpreter training program and train local college instructors to offer this training. Rhode Island will develop the first college level

health care interpreter program in the state based on Kaiser Permanente’s curriculum. We believe that an increased availability of quality interpreting will result in better access to healthcare for limited English proficient (LEP) patients.

As a health plan, Neighborhood Health Plan of RI, through the Su Salud project has developed and is piloting a qualification and claims reimbursement system to reimburse health care providers for the cost of providing trained interpreters. Through this claims reimbursement, the Su Salud project will collect data to demonstrate the positive financial and improved health outcomes that result from providing a trained and qualified interpreter in health care settings.

Standardization

Through the development of interpreter services standards, we are able to establish a consistent set of standards of practice by which interpreter services may be measured. Such standards are important to the delivery of quality patient care. These standards may then be used for a variety of purposes, including training, job descriptions, performance evaluation, and may eventually become the basis of interpreter qualification.³⁶

Literacy Link Adult Education

The issue of literacy and adult education was presented in two different contexts. One was in the context of adult education and the importance of addressing this issue in developing a curriculum and training program in order to ensure success. This was presented by Janet Isserlis, assistant director, Literacy Resources/RI, Swearer Center, Brown University, and her presentation was augmented by Brenda Dann-Messier, president of Dorcas Place, an adult literacy agency. The next discussion explained the link of literacy to health care access and the social context of low health literacy. This was presented by Dr. Dannie Ritchie.

A key point established in the development of the curriculum objectives for TCHI was that the issue of literacy in reading and math needed to be addressed in order to maximize the best levels of successful completion rates for adults from disenfranchised populations, and a mechanism needed to be offered to develop these skills. Janet Isserlis presented issues of Rhode Island adult literacy. The context for the presentation was set with a review of the RI SES demographics on education and racial ethnic populations in RI (see table 3).

Ms. Isserlis started with a call-out and record session where she prompted the participants to state what they thought about when talking about connections between adult literacy and health.

The following were the responses the participants gave:

<ul style="list-style-type: none"> • navigation • communication • networking • medical terminology • understanding instructions 	<ul style="list-style-type: none"> • following directions • barriers to job advancement • safety/health • day to day functioning 	<ul style="list-style-type: none"> • access • training/feedback to care givers • managing household
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What this exercise illustrates is that there is not *one* monolithic literacy, but rather a range of literacies. There is print literacy, as people who use print comfortably understand it (words, instructions, information are communicated in writing); but beyond that there are multiple literacies.

Here it is also important to keep in mind that there are specialized languages and literacies, often with particular conventions and expectations, e.g., writing prescriptions, reading a graph, reading a bill, writing a check or money order, reading/writing a meeting agenda, deciphering maps, or taking a number at a supermarket. What we do to make sense of the world may or may not explicitly include encoding and decoding print. In order to do this we need knowledge of the world (in which these conventions are utilized) as well as the ability to ‘read’ a sound/symbol system.

Brenda Dann-Messier, from Dorcas Place, the adult literacy center added to the discussion and talked about the state of literacy in Rhode Island. Rhode Island has New England’s highest level high school dropout rate. But even a high school degree does not assure literacy. The National Adult Literacy Survey (NALS) breaks out adult literacy abilities into five levels (1 = low to high =5). Results from this report place RI as having the highest percentage of adults at a literacy level 1 in the NW region. The figures used in RI are that 47% of RI adults fall into levels 1 and 2, meaning they are unable to balance a checkbook or read a newspaper article. The point stressed is that one should not be lulled into believing that a degree indicates preparedness; and the reverse is that lack of a degree may not indicate lack of preparedness. It is important be open to other than traditional indicators of preparedness, to meet adult learners where they are, and to address the very probable need for literacy training in curriculum development.

Additionally, it is important to be aware that although NALS is often quoted when noting our nation’s problems in the area of literacy, it is a study that was developed in the early nineties and has methodological problems. The issue is that many standardized tests use pencil/paper and written questions to assess adults’ ability to “function” in the world. One major problem with these tests is that they ask test takers to consider a common task, such as using an ATM, which is frequently accomplished as a series of steps rarely described in writing. One may be able to insert one’s card, punch in a PIN code and withdraw cash without necessarily being able to write or describe this sequence of events. Asking adults to respond in written language to describe tasks they do daily is an inaccurate and incomplete measure of the ways in which they actually do use written words. However, this currently is the data available for use when discussing literacy and the need for funding in the area of literacy program development. This funding is needed to address the issue of adults who have either been failed by the K-12 system and/or are grappling with English language. The survey is currently being revised for re-implementation.

Literacy Link to Health Care and Access

With the emphasis of TCHI on the social determinants of health, and the SES data revealing that there are a disproportionate amount of racial and ethnic populations being failed by the K-12 system—part of whom could be grappling with the English language—it is clearly understandable that this population would also have a problem with low health literacy (one of our many specialized languages.) So there is the issue of literacy in the context of adult education; but there is the additional social context in RI of the greater burden within the racial and ethnic population.

For this discussion, *In Plain Language*³⁷, a video produced by Harvard’s School of Public Health, Health Literacy Study, and the National Center for the Study of Adult Learning and Literacy (NCSALL), was presented. Using the NALS data, the video explains that low literacy rates indicate that many people are unable to connect two facts in a newspaper’s sports article. Ms. Isserlis emphasizes that this issue is therefore not only comprised of the skills of reading and writing, but is also about navigating the world we live in through coded symbols.

Through this video, the communication divide was made more apparent. The video demonstrated the assumptions made by medical institutions giving patients questionnaires to fill out and the ways that people compensate in order not to expose their lack of literacy. For example, they might answer

“no” to the entire questionnaire, figuring they won’t be asked about it. Why are medical institutions giving out questionnaires in the first place? What is it in the structure of our organizations that would lack adequate personal attention and set patients up to give erroneous information? This speaks to ways in which we are structured organizationally not to communicate, and demonstrates how miscommunication can be multiplied due to a simple lack of attention to issues of literacy.

An additional impact we must be cognizant is of how low literacy limits employment opportunities, which, in turn, limits health care through limited access to insurance, and thereby a person’s ability to take care of his or her health.

TCHI would not only provide opportunities, which will address literacy, but with the development of community health worker programs for under-served populations, it can be a means to assist folks with low literacy as well as low health literacy. For those who may have great difficulty asking for the assistance they need in the health care system, TCHI community health worker programs in community-based organizations should create a safe place for those needing assistance to seek out and find a community health worker who can provide that assistance.

National Movement for the Recognition of CHW

Durrel Fox is a CHW who is working on both the Boston and National levels in the areas of sustainability, CHW leadership building, and association formation. He is the Chairman of the National Community Health Workers Association, the Massachusetts CHW Network (MACHW) Chair of the BOD and Policy Committee, and the Chair of APHA CHW SPIG (Special Interest Group). He is a CHW for the New England HIV Education Consortium and the Boston HAPPENS Program and he is on the Advisory Board of CSHO (Center for Sustainable Health Outreach.) He presented the background and current status of the development of a nationwide CHW association development. In a presentation concerning the most recent details about the CHW movement, he started with the definitions of CHW and included a few of the milestones and key organizations involved.

He noted that, for at least 10 years, the field of community health work has been redefined, expanded, and has increasingly become more advanced and organized. He then gave the current MACHW Network 2001 Strategic Plan definition of a CHW which is as follows:

- A Community Health Worker (CHW) is a public health professional who promotes full and equal access to necessary health and human services by applying his or her unique understanding of the experiences, language, and culture of the communities he or she serves.

He then went on to elaborate on the development of the use of the term “Community Health Worker” to describe a large array of outreach workers. He stated that back in 1992 there were many small training, education, and support networks of CHWs in many areas of the country. Most were developed around a specific health topic/area. At that time only a few of these networks even used the term CHW. Also in the 90s there were a few national groups that were linking CHWs to each other and with their allies, partners, and supporters. Those groups include Healthy Mothers Healthy Baby, National Association of CHRs, and the New Professionals (now CHW) SPIG of APHA.

He reported that local groups of CHWs also began to gather on a regular basis for training and support. Most of these groups were formed around categorical health topics, as was most funding. But a key point is that many began to cross-train from within due to demands from the field that had many overlapping CHW topics.

He explained that a group of allies and partners (Lee Rosenthal, *et al*) worked with CHWs to compile the National Community Health Advisor Study that sought to chronicle and map the field while defining core roles and competencies of CHWs across the country. Also many of them became involved with formulating the National Lay Health Workers/Promotores Network.

Another pivotal point came in 1998 when the Bureau of Primary Health Care hosted a national outreach conference in DC which brought over 600 CHWs together to discuss milestones in the field and strategies for the future including:

- sustainable funding
- how to become more efficient/effective
- reimbursement
- advocacy
- policy
- credentialing and certification

Also discussed in this conference was how to link CHWs on a regular basis and how to sustain these linkages so CHWs could teach, support, and learn from each other across the country and world.

He noted that CHWs are at a place where they have become more savvy regarding advocacy, policy, training, funding, and support. It was concluded that they need to, within their own ranks, (but not excluding allies and partners) develop a national group that can link the local, state, and regional networks/associations; set standards and funding guidelines; inform and unify CHWs across the country on a regular basis; research and work toward setting the national agenda for all CHWs no matter the health topic, areas of expertise, length of service, race, creed or nationality. However, at this point in time at least 2 states—Texas and Ohio—and a few cities are developing, or have developed, standards or requirements for CHWs without CHWs having leadership or decision making roles.

He gave details of recent meetings which were held to discuss the formulation of a national organization to create a link to other CHWs and to achieve the following:

- peer support
- provide support, training, and networking opportunities
- development of leadership skills
- assist in the integration into health and human service systems
- promote CHWs as key public health professionals
- advocate for public policies that support and sustain CHWs.

He presented the MACHW Network as an example. He discussed some of their history and their infrastructure including the creation of a steering committee, development of subcommittees, development of a strategic plan, and MPHA selection as a fiscal agent.

He discussed some of the network development barriers and solutions including problems with engendering statewide CHW participation due, in part, to the diversity of region and the logistics of meeting. Also there are the issues of state budget cuts and insufficient public policy support which affect MACHW funding and infrastructure development.

The solutions he described included outreach to CHWs, advocacy work with CHW policy development, and the development of grant writing skills in order to apply for and be competitive in

the grant application process. Also important was fostering collaboration, by which he meant convincing others that this process builds a stronger movement than staying isolated and competitive amongst each other.

To achieve this they held regional meetings. They applied for grants to several organizations including Rural Health, Harvard Pilgrim, Blue Cross/Blue Shield, March of Dimes, and Progressive Technology to assist in their infrastructure building and training programs (Advocacy, MCH, Popular Education and TOT). They acquired an advisor to CHW training programs; created collaborative training opportunities; described core competencies; designed a web site; and held conferences as well as local, state, regional, and national workshops.

Key to the success of the MACHW Network was the development of health policy & legislation, active CHW involvement in advocacy, policy updates and information dissemination linking CHWs to advocacy coalitions, CHW advocacy trainings, the recommendation to have the MPHA as fiscal agent, and developing a memorandum of agreement. Also, what played an important part was their ability to identify additional funding sources and opportunities as well as in-kind resources. Among the lessons they learned were that creative strategies must be developed to involve CHWs in advocacy; supportive partners are a crucial component for sustaining a CHW network; the board of directors and subcommittees must have active members, ongoing outreach and that recruitment for new CHW members must be a priority; and lastly, sustaining CHWs is directly linked to sustaining MACHW.

Work Group Summaries

CHW Core Curricula Development Summary

Three work group meetings were held between the second and third general meetings on March 16 and April 30, 2004. As a result of the first round table meeting, we started to become aware of the regional and national workings on behalf of defining and sustaining CHWs. Dr. Ritchie and a student, John Ly, attended the annual Unity 2004 conference, “Community Health Workers: Changing Health Care Delivery.” This is a national conference for and about CHWs sponsored by the Centers for Sustainable Outreach (CSHO), which is a collaboration between the University of Southern Mississippi and the Harrison Institute for Public Law of Georgetown University, www.usm.edu/csho/history.html. From that conference, they brought a large amount of resource material and information to help guide the process.

To begin the TCHI program, objectives for the curriculum to be developed were established as follows:

- Develop a core curriculum for all health worker programs.
- Establish culturally appropriate curricula, in a culturally sensitive manner, and implement best practice health promotion strategies.
- Create a pipeline of mobility and allow movement to other professional opportunities.

TCHI rationale for the development of core curricula was consistent with beliefs held on the national level, namely that one of the important barriers to the expanded use of CHWs is “the lack of a standard definition and conceptualization of who community health workers are and what they do.”³⁸ The definition that we started with was that the term CHWs is used to imply an indigenous outreach worker who is trusted and respected in his or her community and who serves as a bridge between

peers and health care professionals. It became clear as our process evolved and the various definitions nationally began to change that CHWs have roles beyond the health care system involving links to human services. Since the baseline TCHI definition did not include these, it would have to be modified.

One important early step towards developing a standard definition is the development of a recognized standard for CHWs and a definition of the core roles for CHWs. At the conference we met with Lee Rosenthal and others that had worked with CHWs to compile the National Community Health Advisor Study mentioned during Christine Russell's presentation and completed in 1998³⁹. This study chronicled and mapped the field while defining core roles and competencies of CHWs across the country. What follows are the core roles described and competencies as defined by the advisory board.

Core roles and competencies

Core Roles (what CHWs do)

- cultural mediation between communities and health and human service systems
- informal counseling and social support
- provide culturally appropriate health education
- advocate for individual and community needs
- assure that people get the services they need
- build individual and community capacity

Core Skills

- communication skills
- interpersonal skills
- knowledge base
- capacity-building skills
- advocacy skills
- teaching skills
- organizational skills

It was agreed in the group that these skills can be taught; but what is most important, especially for recruiting, is that a CHW have a high EQ (emotional quotient) as opposed to IQ. This conclusion is consistent with the quality competencies for CHWs described by the National Advisory Board. But while having this work as a guide and building block to inform the work group and larger RI community, it is important that the purpose of the TCHI curriculum be to establish a program that can be modified to address various community needs and health focuses.

The groups were asked to consider the models of various programs, including those from other states. Strategies for successful program completion were discussed and considered. These included remedial skills support and stipends. The various points of entry were considered, along with a discussion of how the program could be developed as part of a pipeline or career path. Literature, handouts, and websites were presented to the work group describing the larger community models of CHW programs leading to certification along with some existing college level programs. One discussion presented procedures and policy considerations for credentialing. We began to realize that there are existing models which RI could adapt in order to achieve the long term goal of creating such a program. It was concluded that to create a program for under-served and under-represented communities, the first step would be to create an entry level program that would provide an on ramp for the under-utilized and unrecognized talents in our selected communities.

The following action steps were devised to create the core curriculum:

- Develop a curriculum with the use of *Core Curriculum Guidebook for a Community Health Worker Basic Certificate Program*.⁴⁰ From the University of Arizona Area Health Education Centers.
- Inventory CHW-like programs in RI:
 - Conduct an assessment of what models exist.
 - Compare local models to current standards: CHW roles and training.
 - Consider these as possible resources for curriculum development.
- Identify CHW core roles for RI.
 - Identify areas to highlight for a RI-specific core while maintaining the core principles of TCHI.
- Examine potential partnerships to provide adult learning support such as DORCAS Place and Genesis Center.

The first steps were taken in this process by creating a matrix and documenting some of the programs that participated in the Roundtable Series.

Table 7 Program Examples: WomenCARES, CHisPA

Program	Mission	Education Requirements	Core Competencies	Training	Services
WomenCARES	WomenCARES (Women Creating Awareness, Respect, Empowerment & Support) provides support and advocacy as well as harm reduction services to abused women at risk for HIV.	No H.S. diploma required - Partnership with DORCAS Place to provide training for those who are illiterate	- Knowledge of domestic violence - Willingness to want to make a difference - Able to make at least a one-year commitment	- Different levels of training - Initial training includes 10 core sessions that cover: domestic violence, HIV/AIDS, health education/outreach, communication, group facilitation, organization, material development - each session is 90 mins - Total = 15 hrs	psychoeducation/support groups - street outreach - individual advocacy - community education programs - prevention case management - peer based advocacy - youth services
CHisPA - Promotoras	Promoting a healthy, safe Latino community. The goal is to serve, assist and educate.	- Basic skills - No H.S. diploma	Bilingual - Collaborative (able to work as part of a team)	Initial training for promotoras happened in 1995 - current outreach workers are trained in specific health topics	Conduct educational workshops in Spanish on health issues and how to prevent diseases at community workshops and at “home parties” - Outreach the Latino community through participation in community events and ChisPA Informa - Provide Social Services

CHW Reimbursement/Sustainability Strategies Work Group Summary

As with the CHW core curriculum work group, three work group meetings were held between the second and third general meeting meetings on March 16 and April 30, 2004. Here too the annual Unity 2004 conference, “Community Health Workers: Changing Health Care Delivery” attended by Dr. Ritchie and John Ly provided valuable information and resource material to help guide the process. The remaining resource materials not presented from the prior section ranged from resource guides for applying for Medicaid waivers (explained further below) to current compendiums on CHW put out by the Kellogg Foundation⁴¹, policy statements by the American Public Health Association⁴², www.family-health-fdn.org/apha_statement.htm, and summary of state legislation efforts to recognize CHW.

In terms of the TCHI board objectives CHW are conceptualized as providing service or goods within a larger social context:

- decreasing health disparities
- building the adult workforce
- building a diverse health workforce
- providing a link for engagement
- providing a link for continuity
- building community capacity

The overarching issue of sustainability of the CHW workforce made it necessary to define the direct services the CHW would actually perform in an effort to separate this from the boarder social service context that the CHW would provide to the RI community. Because CHWs in many instances work in the health field, the most amenable model was an actual reimbursable health encounter. But because reimbursement codes are very narrowly defined, and because it was conceived that the CHW trained in the TCHI curriculum would be working in a community-based organization, it was necessary to think of models and how to broaden their “reimbursable” service role.

Essentially, the reimbursement strategies we defined were described by the following headings/considerations:

- LOOK, LEARN, and FIT Medical Model for Reimbursement – that is to hook on to the reimbursement models that already exist, i.e., current Medicaid services covered
- EXPLORE Medicaid waivers – as a mechanism to get skills for non-traditional services legitimized in order to broaden the definitions of the current reimbursement codes
- EXPLORE what models to use for the UNINSURED – i.e., family service payers – DCYF, DHS, DOH. This mechanism would be particularly important as the population that the CHW may be serving in CBOs may be uninsured.
- Health Plans/Insurance Coverage (other than Medicaid) – must consider that there are differences in what health plans recognize as a reimbursable service; also consider framing CHW service as medically necessary and cost efficacious.

These considerations to from a strategy are elaborated further below.

Medical Model for Reimbursement LOOK, LEARN and FIT

The rationale for the look, learn and fit model was the necessity of considering what reimbursement codes are currently used for the services that are similar to the work a CHW would be doing in order to ensure that what is being designed fits into those categories. It was explained that instead of defining the billing codes, the State Department of Health and Human Services (DHS) pays

accountable agencies to provide services outlined in a performance-based contract. **Most importantly, it must be remembered that while DHS may be interested in utilizing CHWs, the state is under fiscal budget constraints as well as a shift to a managed care/purchasing paradigm. And therefore, they have no plans to add new services or consultants to contracts. So that the most sustainable strategy may require reimbursement to be linked with programs that are already using a similar model (paraprofessionals) and pilot the initiative with them.** In other words, hook the program into current services instead of billing separately through a new program. Thus the strategy would be to look at organizations, projects, or programs already in existence and being reimbursed for the genre of services reimbursed. In this manner, CHW services would have to be attached to Medicaid eligible individuals within an organization already receiving Medicaid monies (i.e., working with NHPRI and/or other community agencies currently reimbursed by Medicaid will be more productive)

Examples of such programs are:

- **CIS Program** The Children’s Intensive Services (CIS) Program provides intensive community- based services to children at risk for out-of-home placements. The CIS program is geared towards preventing psychiatric or other residential placements, and is available for families who may or may not be involved with DCYF.
- **CEDARR** Comprehensive, Evaluation, Diagnosis, Assessment, Referral and Re-evaluation. This is a program for all children with special health care needs. Those who are Medicaid recipients can be eligible to receive the following CEDARR Direct Services— Home Based, Therapeutic Services, Therapeutic Child and Youth Care Services, Personal Assistance Services and Supports.
- **Collaborating with NHPRI who have Medicaid contracts** In this case, CHW placement is crucial because reimbursement codes are tied to these programs. Here also case management/outreach activities done by these programs in some instances may be similar to the projected CHW activities. Under RIte Care, the state pays the health plans to provide case management. Requirements differ under each individual health plan contract. Again, contracted plans differ in the services they have agreed to do making codes useless.
- **Parent Consultant Program** Another example of a block grant program paid for through Medicaid. Here the RI Parent Information Network (RIPIN) Parent Consultant Program jointly with the RI Department of Education (RIDE) and Rhode Island Department of Health holds this contract. The program trains parent consultants to be effective advocates and to be informed spokespersons for the Maternal and Child Health programs such as Immunization, Lead Prevention and Education, Adolescent Health, WIC (Women Infants and Children Nutrition Program) for families with children with special needs.

EXPLORE Medicaid Waivers

Medicaid waivers are one mechanism which has been used to legitimize non-traditional forms of reimbursement. It must be kept in mind that you can only apply for a Medicaid waiver if you are a Medicaid agency. In Rhode Island, usually the designation of a Medicaid agency must come from the Health Department. But often when waivers are requested they include programs that are in partnership with other state agencies for the implementation (i.e., the Department of Education and Health Departments are a common partnership because of the overlap in some of the services that are provided to populations at schools.)

Because the population that TCHI CHW programs would be serving do not fit into narrowly defined categories that are covered by a possible partnering program, it was more important to consider thinking of mechanisms by which we might have the non-traditional services provided by CHWs legitimized or recognized. One means might be to broaden the definitions of the current reimbursement codes or contracted programs. Resource materials were brought back from the Unity Conference which described the possibility of applying for a Medicaid waiver⁴³. This would allow for a 3 – 5 year period in which to get a Medicaid reimbursement benefit category for a new non-traditional program. There are three different programs to apply for, but the Research and Development program would be most applicable for TCHI. DHS has avoided Medicaid waivers because of the time intensity and time to implement. However, Georgetown University's Harrison School of Law component of CSHO provides technical assistance in Medicaid waiver process, and could possibly be an option to getting assistance if this process is pursued. Partnering with Georgetown for assistance in pursuing other legislative initiatives is in progress.

The issue of broadening the definition of, or considering how to legitimize, non-traditional medical procedures or services remained a prominent theme. The way that a number of non-traditional services are being redefined as eligible for payment under Medicaid is to consider the service as medically necessary. Here “medical necessity” or “medically necessary service” means the following:

- medical, surgical or other services required for the prevention, diagnosis, cure or treatment of a health-related condition, including such services necessary to prevent a *decremental* change in either medical or mental health status.

Examples of programs or service that are not directly tied to the individual Medicaid recipient that have been legitimized as a benefit consist of:

- **LEAD** A statewide program to replace windows in lead-contaminated homes
The request for the funding came from the Department of Human Services after finding that children in the RIte Care program treated for lead poisoning frequently were re-exposed to lead due to a lack of lead-safe housing. Here window replacement in homes with high levels of lead—a non-traditional medical reimbursement procedure—was classified medically necessary, and Medicaid covered the costs as a preventative service.
- **RESPITE** Parents of children with special health care needs are given a time out not medically necessary for the individual, but the benefit to the individual is recognized and covered by Medicaid waiver. This has decreased unnecessary hospitalization for children. (Medicaid values prevention.)
- **Spanish Medical Interpreters** - Neighborhood Health Plan of RI, through the Su Salud project has developed and is piloting a qualification and claims reimbursement system to reimburse health care providers for the cost of providing trained interpreters.

For non-traditional services to be legitimized as a benefit, it was emphasized from the beginning of the work group session that there is the need to expand beyond the disease-based model. However, it was noted that these services still need to be defined as medically necessary and cost efficacious. With this in mind, one could consider the ability of the CHWs to recruit/outreach in order to increase access. This could be viewed as medically necessary and cost efficacious if it decreases the ER utilization and preventable hospitalization. It was suggested that the CHW should be considered part of a team of providers in the community and in the health centers. This would be the natural point for integrating communities into health care. The CHW would be considered as a consultation

service, which could be billable as either group time or one-on-one service. Activities could include health literacy topics such as basic living skills or how to navigate the health care institutions. It could be quite effective to partner with DHS and Neighborhood Health Plan of Rhode Island (NHPRI) who have been looking for mechanisms to reach populations that are eligible for Medicaid benefits but have not been accessing the program.

Models for the UNINSURED

The focus and efforts would not be limited to Medicaid populations because this would leave out a large sector of the functionally disenfranchised, under-served, under-represented population—the uninsured. Other programs that may address this population were discussed. For example, DCYF has family outreach workers who help prevent child abuse by providing role models and peer-to-peer education for parents. The possibility of linking with DCYF program themes that are consistent with TCHI objectives were considered. These include skills building in areas such as teaching budgeting and parenting skills (discipline.) This requires no formal education on the part of the peer advisor who has the advantage of being from the community. Agencies that use these workers bill DCYF for services. A potential disadvantage is that the agency defines training and curriculum.

Other programs to consider working with or as models are:

- Adolescent Self Sufficiency Initiative Run by the Urban League, this is a peer-to-peer education program funded with federal money through DHS for prevention efforts.
- Department of Elderly Affairs
- “One stop shopping” for the elderly initiatives
- Programs through the Department of Education that overlap with DOH, i.e.,RIPAN Parent Consultant (previously presented under the RI programs section)

Health Plans/Insurance

For those insured by various plans, the issues of recognition and reimbursement for the CHW was considered, particularly because of the variations of services recognized for reimbursement in different plans. Here again, emphasis is upon the need to present the service as medically necessary and cost efficacious. Thus empirical evidence and literature support the efforts to frame the initiative. It would be advisable to get a buy-in by the health plans. It was previously noted that there is scant literature on these issues. This is because, as described in the APHA policy statement, “while individual CHWs are doing innovative work, [there is a] lack of cohesion among CHW programs... [and] instability of funding for CHW programs...CHW evaluations are frequently poorly designed and implemented due to limited funds, inadequate skills, and the lack of time needed to show results, leading to difficulty documenting the contributions”⁴⁴. However, some evidence is starting to emerge. Brandeis University has just completed a study of elderly people of color on Medicaid with cancer which proved CHWs were effective through screening, navigating, and follow-up with greater retention rates; and trials are being designed to further the evaluation.

Work Group Summary Plan and Status

The work done was reported back to the general group on the 30th of April, 2004. The strategic plan that resulted from these meetings was to:

- continue to assess the current models concurrent with exploring broader definitions
- consider 1- 3 pilot organizations throughout Providence
- define CHWs as a consultant service that is medically necessary

- build upon model programs which are using CHWs
- develop a core for training CHWs using National Core Competency Standards for consistency in measurement and accountability
- create a curriculum from which community based organizations can then adapt/create other trainings to meet their needs.

Summary and Plans

TCHI was conceived as a participatory research initiative to enable community-driven solutions to disparities in health. The overall goal is to improve the health of Rhode Island overall by decreasing health disparities. The principal objective of TCHI is to create a series of CHW training programs for community members so that they become active health promoters serving as liaisons between under-served communities, health care providers and other health and human resources. Our plan is to design a CHW core curriculum that can be modified for the needs of different populations to address the health disparities in under-served racial/ethnic groups.

TCHI-RIF Roundtable Challenges

The Roundtable struggles with multiple challenges which are to:

- define and integrate CHWs as a recognized RI workforce
- address the issue of sustainability for this workforce. Consider mechanisms for sustainability of CHW training programs and for CHW placement when the training is completed. This requires the continued efforts to build the infrastructure to support the development of community health worker training programs and employment opportunities with sustainability.
- Maintain TCHI's integrity as a community driven plan which is not dependent on being either the classic proscriptive project, which is a top down design, and/or a categorical target population or disease.

Success of the TCHI-RIF Roundtable

The most significant success of Roundtable Series was the significant level of participation from community organizations. There were over thirty organizations that came together to participate in the roundtable and collaborate. It has also created a new level of recognition of the work and value of community health workers as a means for integrating the community into the health care system. The work has also identified the most appropriate persons and organizations to assist in this process.

Development of a Strategic Plan and Implementation Strategies

The strategic plans for developing a core curriculum consist of:

- creating an inventory of current community health worker programs in Providence and RI
- identifying assessment tools and curricula; compare these with the National Advisory Board's Core Competencies

- creating a community health worker network which will assist in advising the development of a core curriculum
- developing an entry level community health worker program that can be the basis for modular progression to more specific programs—i.e., HIV, diabetes or health advocacy—and which will have the ability to be transferred for credit recognition to a community college level curriculum.
- The Mount Hope area of Providence is one of the sites that we have identified in which to pilot the curriculum. We are currently working on creating a Community Outreach Partnership Center through Brown with the Community Health Worker Training Program as part of the development of this resource center.

The strategic plan for how to reimburse community health workers includes several mechanisms which require on going work but includes:

- working with DHS to define the community health worker as part of the team of providers and recognize them as consultants; working to include this definition in the contract language that DHS creates for their Medicaid service contracts partially as a means to enroll eligible persons.
- working with Georgetown Law School to acquire technical assistance in applying for a Medicaid waiver for the research and development of this identified role for community health workers.
- working with DCYF and the Department of Education to consider expanding block grant programs to use community health workers to increase health literacy, adult education opportunities and career entry; address the uninsured population; and improve child welfare.

Ability to raise additional Funds for the Initiative

The effort to fund the initiative is ongoing. The University of RI has become a collaborating party in this effort as well as Georgetown University. We are working in conjunction with University of RI to consider the formation of a Center of Excellence in Health Care Disparities. Georgetown has been involved with creating the national initiative for the recognition and sustainability of community health workers. They are attracted to the initiative because we are trying to build the infrastructure for sustainable programs and create an entry point for a career path.

A few potential grant opportunities have been identified, including the RWJF's local initiative partnership. As a result of the roundtable meetings there is the possibility of BC/BS considering funding the program. We are also working with RIH and Miriam Hospital to consider funding. We are still hopeful that the RIF will consider being the nominating sponsor for the initiative.

Round Table Series Agendas

I. February 17, 2004

9:00am – 12:00pm

Welcome and Introductions

Objectives

Overview of TCHI

Community Health Worker (CHW)

CHW Program Model Presentation

Caroline Campos, Project Director, CHisPA

Christine Russell, Executive Director,

East CT's AHEC Community College Program

Adrianna Léon, Project Director, Parent Consultant Program

Work Group Sessions

Curricula Development and Skills Assessment

CHW Utilization and Employer Network

→ Deferred for
General Group Discussion

Work Group Summaries

Next Meeting and Closing

II. March 16, 2004

9:00am – 12:00pm

Welcome and Introductions

TCHI Review

Model Program Presentation

Yvette Mendez – Su Salud, NHPRI

Donna Williams – WomenCares, Sojourner-House

Literacy Link Adult Education

Janet Isserlis – Literacy Resource, Brown

BREAK

Discussion

Work Groups

Summaries

Next Meeting and Closing

III. April 30, 2004

1:00pm – 4:00pm

Welcome and Introductions

Roundtable Objectives / TCHI Overview Review

Literacy Link to Health Care and Access

National Movement for the Recognition of CHW

Durrel Fox – Chairman of the National Community Health Workers Association

Break

Work Group Summaries

CHW Core Curriculum

CHW Reimbursement

Next Steps Discussion

Closing

Participants List

American Cancer Society
Cathedral of Life Christian Assembly
Community Health Services - Miriam Hospital
CCRI
CHisPA
DHHS Region I, Office of Minority Health
Dorcas Place Adult and Family Learning Center
Eastern Connecticut AHEC
Education Alliance (at Brown)
Hillside Avenue Family and Community Medicine
International Institute of Rhode Island
Neighborhood Health Plan of RI
New England HIV Education Consortium
NHPRI
Rhode Island Department of Health
- Office of Minority Health
- RIPIN
- Division of Family Health
RI Health Center Association
RI Hospital
Socio-Economic Development Center
Sojourner House
South Providence Development Corporation
South Providence Neighborhood Ministries
St. Joseph Hospital for Specialty Care
Swearer Center - Adult Literacy, Brown University
State of RI, Dept. of Human Services
The Genesis Center
The Rhode Island Foundation
URI College of Continuing Education
URI Community Research and Service Team

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- ⁴³ *Ibid* 41