Expanding the Community Health Worker Program at Island Health Care on Martha's Vineyard

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"We consider CHWs as expert listeners who get to know patients holistically and provide flexible support based on the person's needs and preferences. This support often arises, not from the doctor's office, but back in communities where CHWs plant urban gardens, battle evictions, or even play basketball with patients."
Island Health Care

TABLE OF CONTENTS

I. Situation Analysis
  A. Overview of Island Health Care and their CHWs
  B. Problem Statement
  C. Why CHWs?
  D. Elaboration of the Issues with the CHW Program
  E. Prior Experiences with CHW Programs
II. Logic Model
III. Goals, Objectives, and Workplan
IV. Management Structure
V. Monitoring and Evaluation
  A. Monitoring Plan
  B. Evaluation Plan
VI. Budget Narrative
VII. Sustainability
VIII. Cape Statement
IX. Appendixes
  A. Appendix A. Gantt Chart
  B. Appendix B. Budget

Acronym List

ACO – Accountable Care Organization
CHW – Community Health Worker
CY – Calendar Year
CP – Community Partner
EHR – Electronic Health Record
HIPAA – Health Insurance Portability and Accountability Act
IHC – Island Health Care
IMPaCT – Individualized Management for Patient-Centered Targets
NACHW – National Association of Community Health Workers
PCP – Primary Care Provider

EXECUTIVE SUMMARY

This executive summary provides an overview of Island Health Care (IHC) and their Community Health Workers (CHWs) program. IHC is a federally qualified health center located in Martha's Vineyard, Massachusetts. The center is dedicated to providing high-quality, patient-centered care to all individuals, regardless of their ability to pay. IHC’s CHWs play a vital role in understanding the unique health needs of the island population, ensuring access to necessary care, and addressing social determinants of health.

The need for CHWs in Dukes County, where IHC is located, is evident due to various flagged health issues. The county has higher rural death rates compared to urban areas, mental health crises with high suicide and depression rates, and a rise in substance use disorders. IHC's CHWs have already made a positive impact by connecting disadvantaged patients to resources, providing emotional support, and advocating for increased resources for the CHW program. Previous CHW programs have also demonstrated improved clinical outcomes, cost savings, and better management of underlying social and behavioral factors. In a cost savings analysis, researchers found that a team of CHWs saved Medicaid $1.4 million dollars, making the investment into the expansion and integration of a CHW program a possible way to save if not even generate income in a clinic.

The current CHW program at IHC faces several challenges, including a lack of standardized operating procedures, inefficient communication with clinical staff, and difficulties in documenting patient services and outcomes. To enhance and expand the CHW program, we plan to streamline CHW training, integrate CHWs within clinical care teams, increase collaboration between CHWs and care providers, and implement a system to monitor patient outcomes related to CHW-delivered care. Addressing these issues is crucial to achieving the goals of the CHW program and improving patient health outcomes.

To achieve the program's goals and objectives, we propose a three-pronged approach to improving the current CHW program at IHC: the implementation of a comprehensive training program for CHW, integration within patient care teams, and the establishment of data collection and management process to analyze patient outcomes. A detailed workplan with action items is provided for each of these objectives in the attached proposal. To accomplish this, we are requesting $1.1 million dollars to implement the expansion of IHC’s CHW program. This program will increase IHC’s CHW workforce, improve CHW-delivered care, and ultimately, improve health outcomes in Dukes County. In 2022, the CHWs of IHC had an impressive 535 patient encounters, showcasing their commitment and dedication to providing quality healthcare. With the ongoing support and implementation of sustainable measures like transitioning to capitation funding, IHC and their CHWs are poised to amplify their impact and secure a thriving future for the expanded CHW effort

I. Situation Analysis

A. Overview of Island Health Care and their CHWs

Island Health Care (IHC) is a federally qualified health center located in Martha's Vineyard, off the coast of Massachusetts. IHC is dedicated to delivering high-quality, patient-centered care to all individuals, irrespective of their ability to pay. Community Health Workers (CHWs) are an integral part of IHC's approach to addressing the unique health needs of the island population and ensuring access to necessary care. The CHWs of IHC promote access to care, assist patients in navigating complex health systems, and address social determinants of health, such as poverty, housing instability, and food insecurity. Furthermore, CHWs are seen as expert listeners who take a holistic approach to patient care, providing flexible support tailored to individual needs and preferences.

B. Problem Statement

Currently, IHC has a CHW program, but it suffers from a lack of standardized operating procedures, inefficient communication with clinical staff, and difficulties in documenting patient services and outcomes. The organization aims to enhance and expand this program by streamlining CHW training, integrating CHWs within clinical care teams, increasing collaboration between CHWS and care providers, and creating a system to monitor patient outcomes, especially with regards to the CHW program.

C. Why CHWs?

Island Health Care is located in Dukes County, Massachusetts, which is home to approximately 21,000 residents, of which, 51.5% are male and the majority (24.4%) are greater than 65 years old. The county ranks relatively high in overall health but falls behind in modifiable risk factors/behaviors compared to other counties in Massachusetts.

Several flagged health issues (where Duke's Country has an increased burden relative to other counties in Massachusetts) are summarized below:

High Rural Death Rates: From 1999-2019, death rates within rural areas of the county are 20% higher than those in urban areas. The rate had increased 14% from the previous reporting period. These death rates can be attributed to the fact that rural residents of Dukes County are at greater risk from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke.

Mental Health Crises: Dukes County has the highest crude rate for suicide in the state, and the occurrence rate for depression is 20%.

Rise in Substance Use Disorders: While Massachusetts usually has low numbers of opioid-related deaths, Dukes County has seen a rise in these deaths. Furthermore, the county also reports that adult binge drinking constitutes 26% of alcohol SUD in 2021, and 57.65% of Martha's Vineyard Community Services' Off-Island detox referrals are for alcohol use. Martha's Vineyard has no on-island detox programs for people with substance use disorders.

Dukes County has an extremely high need for services that address the aforementioned issues. Island Health Care, specifically their community health workers (CHWs), have taken on the challenge of addressing these major issues in Dukes County. In addition to the primary care that Island Health Care provides, CHWs reach out to especially vulnerable patients to add an additional level of care that revolves around social determinants of health. The crucial duties of the CHWs include resource navigation, emotional support, referrals, clinical team assistance, assistance in completion of applications for housing and government assistance programs, peer recovery coaching, public health outreach, advocacy, care management, and care coordination. So far, the CHWs of IHC have connected vulnerable patients to resources such as food banks, provided emotional support to patients who have suffered loss of loved ones, and advocated for increased resources for the CHW program.

D. Elaboration of Issues with the CHW Program

Several issues impact the goals of expanding, integrating, and improving CHW-delivered care. The center now has only **one** community health care worker. Currently, CHWs are recruited from the surrounding community and enter the position with varying degrees of experience and skills. More CHWs need to be recruited to IHC to initiate the expansion of the programs. Another issue is the need for a streamlined training plan to support the expansion of the CHW role. A standardized training program must be developed in order to formalize the CHW job description and recruitment process. Furthermore, since there is extreme need for these services in Martha's Vineyard, IHC's CHWS are spread thin and work with both IHC and non-IHC patients. This decreases the bandwidth of all of the IHC CHWs, limiting them from attending training or being integrated into care teams.

Another challenge is the need for a formal process for CHWs to increase collaboration with healthcare providers. Currently, there are gaps in understanding from providers about the role of a CHW. The lack of knowledge and cooperation within care teams hinders their abilities to fully contribute to patient care and outcomes. Furthermore, the absence of formal guidance and workflows for screening, referral, and follow-up care poses a significant challenge for CHWs. CHWs must be integrated within primary care at IHC, so that the skill sets of all staff are optimized to their highest potential. With clear integration and collaboration, it becomes easier for CHWs to provide consistent and comprehensive patient care.

Additionally, IHC needs a system to track patient data and ensure patient confidentiality, which is crucial for accurately monitoring patient services and outcomes. Patient data, especially outcomes related to CHW-delivered care, is crucial in adjusting workflows and protocols. This data will also determine the success of IHC's CHW program and its impact on the center and the community.

Addressing these issues is essential to achieving the goals of the CHW program. Streamlining the training plan, integrating CHWs within care teams, establishing collaborative processes to support patients and health providers, and implementing robust data management systems will enhance the effectiveness and impact of CHWs in delivering care to patients.

E. Prior Experiences with CHW Programs

Community Health Workers are crucial in determining health outcomes, especially when the CHW program has been standardized. One recent trial implemented Individualized Management for Patient-Centered Targets (IMPaCT), a standardized community health worker intervention that addresses unmet social needs for disadvantaged people. The randomized clinical trials of IMPaCT have shown that when CHWs do grassroots and socially focused work, they can actually improve clinical outcomes, such as glycosylated hemoglobin, body mass index, tobacco cessation, mental health assistance, and quality of care and reduced hospitalizations.

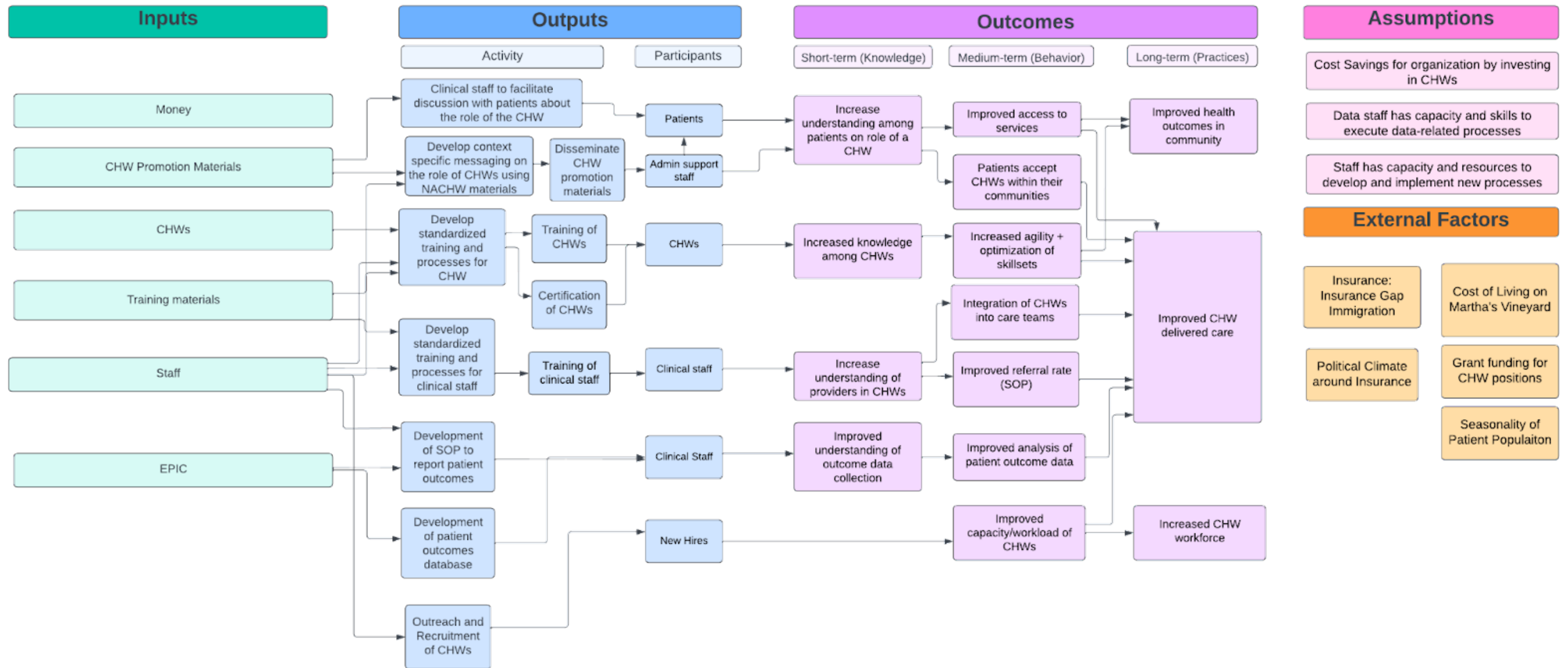
CHW programs are also part of a huge cost-savings initiative to decrease inefficient medical spending. In 2022, the United States government spent $747 billion dollars on Medicaid, which covers over 89 million people. Some of this spending may be inefficient because it is used to treat illnesses as they manifest themselves, instead of addressing the underlying social and behavioral factors that cause illness. In the trial randomizing IMPaCT, the study arm with the standardized CHW program had both fewer and lower-cost admission, with a total inpatient cost of $2,267,900.10 compared with $3,681,206.88 in the control arm. When outpatient costs were factored in, the total cost of care was $2,450,881.80 for the intervention arm and $3,852,189.78 for the control arm. A robust CHW program resulted in a 38 percent reduction in cost, and after calculating the return on investment, researchers found that every dollar invested in the CHW program would return $2.47 to an average Medicaid payer within the fiscal year.

II. Logic Model

The logic model illustrates the link between the program resources, activities, and outcomes. The diagram highlights how each of the primary components of the monitoring and evaluation activities, including program assumptions, resources, activities, outputs, outcomes, and external factors, will influence one another to attain the intended outcomes. The logic model will guide monitoring and evaluating the CHW expansion program to understand if the planned implementation activities were successful.

The inputs for this program include the resources and people necessary to support the implementation of the project. Program outputs and associated activities include the strategies and steps planned to be implemented throughout the project to achieve the desired outcomes. The outcomes for this program describe the intended effect this project will have on the IHC organization and the focus population for this program. The assumptions included in the logic model represent our beliefs about the program and how the program will work. This program's external factors cover outside aspects that may influence how the project functions. *To view a larger version of the logic model framework, refer to Figure 1.*

Figure 1: Logic Model



III. Goals, Objectives, and Workplan

Program Goal: Utilize current infrastructure to expand the Island Health Care CHW program and better integrate it into patient care, leading to improved health outcomes within the Edgartown IHC community. Please refer to the Gantt chart in Appendix A for activity timelines.

A. **Objective 1: Implement a comprehensive training program for CHWs (IHC specific training + 18 core competencies) by the end of the first year**
   a. By the end of the first year, IHC admin/support staff will have implemented a "path to CHW Certification" protocol for new CHW hires interested in obtaining a state certification
      Action Items:
      i. *Conduct and compile research on existing CHW training programs by year 1*
      ii. *Present options for CHW training programs to current CHW and IHC Clinical Staff by year 1*
      iii. *Finalize training program selection and purchase necessary software by year 1*
      iv. *Develop a training protocol and tracking protocol (if not included in software by year 1*
      v. *Push the new training program into use by new IHC CHWs by year 1*
      vi. *Train all new CHW hires through the new IHC CHW training program by by the end of year 3*
      vii. *All CHWs will complete curated trainings by the end of 2026*

B. **Objective 2: Within 18 months, clinic staff will standardize the integration of CHWs into patient care teams.**
   a. By the end of the 2nd year, all patient-facing IHC staff will have been trained in the CHW-matched patient referral process.
      Action Items:
      i. *Hold meetings with patient-facing IHC staff to gather CHW-related feedback.*
         1. *Create PCP-directed list of objectives for CHW responsibilities*
         2. *Standardize referral workflows based on CHW-related feedback (from aforementioned meetings)*
         3. *Train PCPs on new, standardized referral workflows*
      ii. *Develop training for PCPs (to integrate CHW into primary care team workflows based on NACHW guidelines)*
         1. *Train all PCPs*
   b. By the end of the 3rd year, CHWs will be incorporated into the primary care teams for 75% of IHC patients referred to CHW services.
      Action Items:
      i. *PCPs will include CHWs into primary care teams per referral guidance*

C. Objective 3: Establish a HIPAA compliant data collection and management process to analyze CHW-matched patient outcomes by the end of the 2nd program year.

Action Items:

i. *Determine variables for evaluation (including referrals)*

ii. *Standardize a process for collecting CHW-matched patient outcomes data*
   1. *Train CHWs and patient-facing staff to collect data using new standardized process*

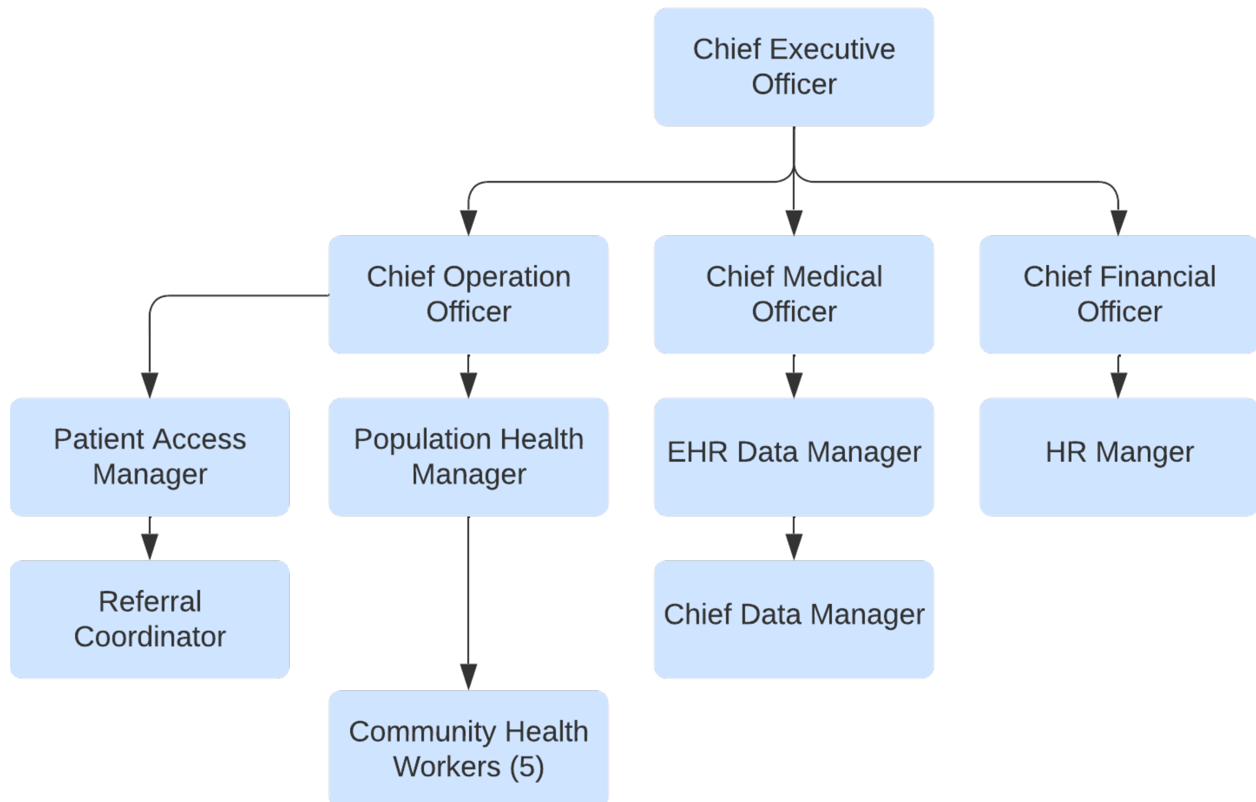
iii. *Choose a HIPAA compliant database*
Ex: REDCap
   1. *Integrate database into existing IHC infrastructure*

iv. *Create a data management process to extract and clean EHR data from Epic*
   1. *Train data-related staff on data management process ongoing creation of data management process*
   2. *Deposit standardized data into database*

v. *Analyze CHW-matched patient outcomes data*

vi. *Develop standard data analysis report template*
   1. *Report CHW-matched patient outcomes data bi-annually*

IV. Management Structure



V. Monitoring and Evaluation Plan

The "Integrated and Expanded Community Health Worker (CHW) Program" is IHC's first iteration of a CHW program in Martha's Vineyard. CHWs are critical in promoting access to care, assisting patients in navigating complex health systems, and addressing the social determinants of health, including poverty, housing instability, and food insecurity. With the increasing recognition of the CHW role in healthcare systems, there has been a concerted effort to integrate CHWs into the healthcare team at IHC. This pilot program will focus on expanding and integrating CHWs into the primary care function at IHC and in the health system for Martha's Vineyard. In consideration of this information, the main objectives of this program are to address the following barriers: the lack of standardized procedures, guidelines and workflows, challenges in documenting patient services and outcomes and communicating efficiently with primary care providers.

A. Monitoring Plan

The goal of implementing this program is to utilize existing local resources, including funding provided by donors, to improve patient health outcomes, increase CHW workforce and enhance CHW delivered care in Martha's Vineyard. The implementation plan encompasses training activities, outreach and recruitment, establishing patient referral guidance, and utilizing a

community-focused approach to promoting access to care and improving patient health outcomes.

The overall approach for monitoring is to help track and assess the results of the CHW expansion program. The purpose of the monitoring plan is to provide an approach for monitoring activities according to objectives and the availability of resources. For the monitoring plan, three indicators were identified to determine the extent of how well processes implemented through this program are working. Monitoring of indicators in Figure 2, will be primarily in the form of reporting outputs and based on the target values to ensure the effectiveness of the pilot program to make positive long-term changes to CHW program activities.

B. Evaluation Plan

The overall approach for evaluation is to help assess the results and the impact of the CHW expansion program. The purpose of the evaluation plan is to outline an approach for evaluation activities that tie in with our objectives and utilize the resources available at IHC. For the evaluation plan, four indicators were identified to determine the extent of how well met the target outcomes were. Evaluation of indicators in Figure 3, will be primarily in the form of reporting short-term, medium-term and long-term outcomes based on the target values to ensure the effectiveness of the pilot program to make positive long-term changes to CHW program activities. Lastly, the evaluation plan aims to use the aforementioned monitoring indicators at the midpoint and final evaluation.

Figure 2: Monitoring Indicators Matrix

Construct	**Indicator**	**Rationale**	**Definitions**	**Calculation**	**Target value**	**Sources of data & Method**	**Who Uses the Data/How Data is used & frequency of data collection**
Adherence to training schedule	Utilization of training SOPs	Utilization of training SOPs helps to understand the extent to which CHWs proactively complete their assigned trainings in a timely manner	Utilization of training SOPs refers to the process outlined in a standard operating procedure based on recommended core competencies indicated by NACHW and IHC specific training.	Numerator: Total # of CHWs at 100% compliance Denominator: Total # of CHWs	100% compliance records for all CHWs employed by IHC	Review of CHW training records collection and reports	Population health manager will conduct the audit to assess the adherence to assigned training schedules. Audit will be completed on a quarterly basis. Recording will be completed on a monthly basis.
Disseminate CHW promotion materials to referred patients	Amount of materials distributed	In order to increase the understanding of a CHW's role and move towards acceptance of CHWs within the community, CHW promotion materials will be distributed as a part of conversations with patients who are referred to CHWs. Amount of materials distributed to referred patients will allow us to ensure this is happening.	The percentage of materials distributed by clinic staff which will be assessed by looking at the number of materials compared with the number of materials remaining.	# referred patients / # materials given* * # materials given calculation: # promotion materials printed - # of materials remaining	100% of referred patients receive the CHW promotion materials	Audit of patient referral records and inspection of number of health promotion materials remaining at the clinic	Population health manager audits patient records and counts of promotion materials to assess if patients were told about the CHW role every 6 months.
Outreach and recruitment of CHWs	Amount of time spent on outreach and recruitment activities	Assess how much time is being actively spent on outreach and recruitment activities to ensure that new CHWs are being recruited	The amount of time spent on outreach and recruitment activities will be measured as combined hours among current staff being put into recruitment efforts	Hours spent on recruitment and outreach activities per week	2 hours per week	Program time tracking log from recruitment staff will be added up	Human resources manager and human resources coordinator will inspect the program time tracking log to determine how many hours per week was spent on recruitment and outreach efforts on a monthly basis.

Figure 3: Evaluation Indicators Matrix

Construct	Indicator	Rationale	Definitions	Calculation	Target value	Sources of data & Method	Who Uses the Data/How Data is used & frequency of data collection
Knowledge of CHW competencies and IHC community specific issues and priorities	Post-training test score	Tests conducted post-training will help determine to what extent CHWs completed training have mastered the knowledge of the role of CHWs and an understanding of the local community.	Test score refers to the proportion of CHWs that passed their examination with an 80% or greater.	Numerator: The amount of CHWs that passed their test. Denominator: Total of CHWs enrolled in training	100% of CHWs trained with a passing training test score	Audit of CHWs training records and test scores	Population health manager audits the CHWs training records and test scores to assess if the CHW has mastered the knowledge of CHW competencies and IHC community specific issues and priorities. Data will be collected daily and data reporting will occur quarterly.
Adherence to referral guidance and workflows	Referral rate	Assess the referral rate that clinical staff are making of patients to CHWs to see if there is any change towards integration.	The referral rate is measured by comparing the referral rate at baseline to current referral rate after training for clinical staff.	((Referral rate afterwards - referral rate at baseline) / referral rate at baseline) * 100 *referral rate = the number of referred patients divided by the total number of patients	25% increase in referral rates compared to baseline	Audit referral records data to calculate referral rates and percent change.	Chief Data Information Officer, COO, CMO, Chief Quality Officer, Referral Coordinator and Population Health Manager will audit the referral records to assess the referral rate that clinical staff are making of patients to CHWs to see if there is any change towards integration. Frequency of data collection to occur on a daily basis. Reporting to occur on a quarterly basis.
Quality of patient outcome data collection	Data collection of patient outcome data	To assess the new SOP to report patient outcomes and establish a supporting database to collect patient outcome data.	Data collection of patient outcome data will be measured by comparing the patient records at IHC to a similar federally qualified health center.	% of patients you would expect to have outcomes documented by the CHW.	100% of patient outcomes at IHC match a similar federally qualified health center	Audit patient records data to calculate percent change in patient records.	Chief Data Information Officer, COO, Chief Quality Officer, EHR Data Manager and Population Health Manager will audit the patient records to assess the new SOP to report patient outcomes and patient outcomes database. Frequency of data collection to occur on a daily basis. Analysis to occur at baseline, mid-point, and end of project.
Improved health outcomes in community	1.Blood pressure control 2.Mental health crisis	To assess changes in health outcomes within the community, there will be an analysis on some key health issues such as blood pressure and depression. These key health issues will be used as a generalized measure for health outcomes.	Blood pressure control: Blood pressure control will be measured by incidence of high blood pressure within Dukes County. Mental health: Mental health will be measured by the depression occurrence within Dukes County.	Blood pressure: # new cases of high blood pressure Mental health: # new cases of depression / total population	Blood pressure: reduce high blood pressure cases by 5% Mental health: reduce depression rates in the county from 20% to 15%	Assess high blood pressure and depression data from county-level health data	COO and Chief Data Information Officer will analyze substance use and depression data as a generalized assessment of health outcomes within the community. Frequency of data collection to occur on a daily basis. Reporting to occur every 6 months.

VI. Budget

The budget set forth in this narrative explains the major allocation of funds for the expansion of the Community Health Work Program at Island Health Care. This budget is for three years of programming with deliverables at different time periods. See Appendix B for more budget details.

A. Salaries

a. Recruiting CHWs are crucial to the expansion of the CHW Program and IHC. All CHWs will be spend their time dedicated to this program, and these individuals will be covered by grant funding throughout the entire program
   i. CHW Salaries: $25/hour x 40 hours/week x 52 weeks = $52,000
      1. Years 2 and 3 adjust for inflation.
      2. IHC currently pays their CHWs $25/hour.
   ii. Proposed CHW Hiring
      1. Year 1: 2 CHWs
      2. Year 2 and 3: Addition of 2 more CHWs (at least one working remotely)

B. Internal Employees

a. This program incorporates participation from other major players within IHC. Since our program integrates activities that align with current job descriptions and program goals, these participants will add value to the program without adding cost to the budget.
   i. Chief Data Information Manager
   ii. Chief Operating Officer
   iii. Chief Medical Officer
   iv. Chief Financial Officer
   v. Population Health Manager
   vi. Patient Access Manager
   vii. Chief Quality Officer
   viii. Human Resources Manager
   ix. Human Resources Coordinator

C. Fringe Benefits

a. 21% is the IHC fringe benefit rate (information received from CEO and Population Health Manager).

D. Travel and Per Diem

a. Domestic Travel
   i. This program necessitates that CHWs can interact with IHC patients outside of the center. These interactions may improve CHW-delivered care and patient health outcomes. Since these travel costs are directly related to the program, gas costs associated with work-related travel on the island will be reimbursed.
   ii. Year 1: $0.65/mile x 10 miles traveled (max distance CHW travels) x 166 patients (# of patient CHW served in 2022) = $1079 per CHW X 2 CHWs = $2158
      1. $0.65/mile = current IHC reimbursement rate set by federal standardS

iii. Year 2: 3 CHWs (midpoint of 30% increase in referral by end of program) = $3,366
iv. Year 3: 4 CHWs (midpoint of 30% increase in referral by end of program)
1. $0.65/mile x 10 miles traveled (max distance CHW travels) x 191 patients (# of patient CHW served in 2022) = $4688

E. Other Direct Costs

a. These are other costs that are anticipated with this program:
b. Translation of Materials = $900
    i. IHC already has a Brazilian Portuguese medical translator (Julia Santos) available to translate written materials, such as recruitment and information brochures. However, the budget included will cover translation into other languages, such as Spanish and French.
    ii. $0.40/word translated x 450 words in average brochure x 5 brochures = $900
    iii. https://www.costowl.com/b2b/translation-services/translation-service-medical-cost/
c. Large photo-copying and printing jobs: $2000 dollars for recruitment and information brochures
d. Training Costs: $0
    i. 80-hour Community Health Worker Core Competency Course equips participants with the practical tools necessary to help lead their patients to greater engagement in health care, improved adherence to treatment, and better health outcomes. This virtual course focuses on increasing the overall capacity of CHWs. The workshop is built upon the 10 core competencies as defined by the Massachusetts Board of Certification of Community Health Workers.
        1. Participants will have no out of pocket costs. Individuals who are currently employed at a MassHealth ACO or Community Partner (CP), or an associated entity, are eligible to apply.
        2. https://www.centerforhealthimpact.org/wp-content/uploads/2023/04/CHW-ARPA.pdf
        3. https://www.centerforhealthimpact.org/training/chw-core-competency-course/
        4. Core Competency and Course Eligibility form:
            a. https://forms.office.com/pages/responsepage.aspx?id=CZPxt3ZUoUOZZ1T2HQavhDT-wSXRx1NHsasyVMDLGr9UOUZJUFNVSlFGVzkwQ0tNVTlJWThUTE1OMy4u
e. Certification Costs: $35/CHW x 4 CHW + inflation adjustment = $151
    i. Application fee for MA: $35
    ii. Work Experience Pathway to Certification (4,000 hrs)
    iii. Two years of CHW work and can apply for MA certification
f. Swag for Events
    i. $500 is budgeted for the first year of the program to purchase items to give out at recruitment and outreach events
g. Food for Events

i. $50 is budgeted for food to be given out at recruitment and outreach events, which would occur every other month

VI. Sustainability Plan

As part of the sustainability of the IHC program, we plan to focus on the following key areas utilizing IHC and local resources: recruitment, retention, and outreach, effective marketing of the CHW role within the Martha's Vineyard community, utilizing existing resources, continuous improvement for data collection, outcomes, analysis and establishing a reliable funding model for the CHW program.

Recruitment and Retention

In order to maintain the expansion of the CHW program after three years, IHC will continue to host and lead outreach and recruitment activities that will prioritize recruiting people from within the community of Martha's Vineyard. Outreach and recruitment activities would include hosting events at schools and churches, and other venues to engage community members of interest. The inclusion of retention as part of the sustainability plan for IHC is to focus on the engagement level of the CHWs, improve organizational outcomes, and continue to build partnership and trust within the community.

Retention of CHWs will help IHC to focus on delivering quality care and access to services to the focus population for the health care center. As part of the retention plan, IHC should consider incorporating CHW certification into their career development model for this role and increase salary over time as CHWs receive their certifications. IHC should also introduce a CHW recognition and incentive program to highlight the achievements of CHWs within the program.

Outreach and Effective Marketing of the CHW Role

IHC should continue to use promotion materials and communicate with patients regarding the role of CHWs in the community. These activities will help to strengthen the role of CHWs within Martha's Vineyard health system and build trust with the focus population of the health center. The effectiveness of these activities will help expand the reach of IHC with patients, improving the community's health outcomes over time.

Utilizing Existing Resources

The CHW expansion program would be expanding upon existing structures and activities at IHC by adding in additional elements and personnel to strengthen the program. Since IHC is an established healthcare center within the community, there are lots of resources available for this program to succeed. One main resource available to the CHW expansion program would be the staff members already employed at IHC who will be able to assist with the program expansion. In addition to main personnel such as the population health manager, this program would require assistance from other positions such as the Chief Data Information Manager and the Human Resources Coordinator.

Continuous Improvement for Data Collection, Outcomes, and Analysis

For this program, a data collection and outcomes analysis process will be implemented. Utilizing the data from *Epic*, IHC will standardize a process for managing CHW-matched patient outcomes data and will report their findings biannually. In doing so, we are able to base future

improvements to our program, referring to the outcomes data and ensuring CHWs are evolving as the needs in the community shift. Additionally, our improved data reporting collection process will allow for enhanced reports and data to bolster future grants and donor funding applications for this program. Future grants will allow us to employ individuals who are not able to become certified, due to multiple factors such as citizenship status or people not wanting to undergo a background check.

Establishing a Reliable Funding Model

With that being said, we hope over half of our CHWs become certified. By doing so, they would become eligible to get payments for CHW services through insurance. Recently, IHC has transitioned to a capitation payment model, and we hope that CHWs become a part of that capitation model in the future. The capitation model involves a fixed lump sum payment to healthcare providers for each enrolled individual, and this sum covers all necessary healthcare services within a specific time period, encouraging cost-effective care. The goal is to integrate certified community health workers (CHWs) into the capitation model, allowing them to receive their payments through insurance and further enhance the care they provide.

VII. Capability Statement

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About IHC

Island Health Care (IHC) is a federally qualified health center in Martha's Vineyard that supplies services related to the following:

- Primary care
- Mental and behavioral health
- Disease prevention and healthcare decision making
- Wellness coaching
- Guidance on benefits enrollment and utilization

Past Performance and Future Goals

- In CY 2022, IHC was on track to serve 3,000 unique patients for a total 9,000 visits. In CY 2023, they projected to raise those numbers to 3,500 and 10,500 respectively. CHWs specifically were matched with 166 of these unique patients in 2022 and accounted total of 535 encounters.
- Further down the line:
    - We project to serve 4,605 unique patients in CY 2024
    - Our organizational capacity has grown and evolved to include: more than doubling our Community Health Worker/Peer Recovery Coaches; a sustainable telehealth platform with supporting workflows and growth potential; new prospects for increasing our provider staffing including both Nurse Practitioner PCPs and a Psychiatric Nurse Practitioner; and finally, plans to expand our physical space are well underway to generally expand access to our primary care services.
- Implementing partner for covid testing of all island, partnered with QUEST (offered all testing for free) - staffed and ran it

What makes IHC Unique?

- IHC prioritizes recruitment, development, and retention of clinically and culturally competent staff
- IHC is one of the few organizations on Martha's Vineyard that serves the needs of the underserved and uninsured

Appendix:

Appendix A: Gantt Chart

Activities	Person Responsible	Resources	YEAR 1	YEAR 2	YEAR 3
			1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12
Objective 1: Implement a comprehensive training program for CHWs (IHC specific training + 18 core competencies) by the end of the first year					
Sub-Objective 1a: By the end of the first year, IHC admin/support staff will have implemented a "path to CHW Certification" protocol for new CHW hires interested in obtaining a state certification					
Conduct and compile research on existing CHW training programs by year 1	Population Health Managerr	Internet, Excel			
Present options for CHW training programs to current CHW and IHC Clinical Staff by year 1	Population Health Manager & Clinical staff	Internet, Excel			
Finalize training program selection and purchase necessary software by year 1	Population Health Manager & Clinical staff	Internet, Excel, Necessary Software			
Develop a training protocol and tracking protocol (if not included in software by year 1	Population Health Manager	Internet, Excel, Necessary Software			
Push the new training program into use by new IHC CHWs by year 1	Population Health Manager and CHWs	Internet, Excel, Necessary Software			
Train all new CHW hires throught the new IHC CHW training program by by the end of year 3	Population Health Manager and CHWs	Internet, Excel, Necessary Software			
Objective 2: Within 18 months, clinic staff will standardize the integration of CHWs into patient care					
Sub-Objective 2a: By the end of the 2nd year, all patient-facing IHC staff will have been trained in CHW-matched patient referral process					
1. Hold meetings with patient-facing IHC staff within the first 6 months of program to gather CHW-related feedback.	Population Health Manager & Clinical staff	Computers, materials, meeting space			
1a. Create PCP-directed list of objectives for CHW responsibilities	Population Health Manager	Computers			
1b. Standardize referral workflows based on CHW-related feedback (from aforementioned meetings) by first 18 months.	Population Health Manager, Patient Access Manager, Lead Referral Coordinator	Computers			
1c. Train PCPs on new, standardized referral workflows	Patient Access Manager, Lead Referral Coordinator, PCPs	Computers, materials, meeting space			
2. Develop training for PCPs (to integrate CHW into primary care team workflows based on NACHW guidelines) by first 18 months of program.	Population Health Manager, Patient Access Manager, Lead Referral Coordinator	Population Health Manager, Printing Services, NACHW materials			
2a. Train all PCPs	Patient Access Manager, Lead Referral Coordinator, PCPs	Computers, materials, meeting space			
Sub-Objective 2b: By the end of the 3rd year, CHWs will be incorporated into the primary care teams for 75% of IHC patients referred to CHW services					
1. PCPs will integrate CHWs into primary care teams per referral guidance	PCPS & CHWs				

Appendix A: Gantt Chart (continued)

Activities	Person Responsible	Resources	YEAR 1	YEAR 2	YEAR 3
			1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12
Objective 3: Establish a HIPAA compliant data collection and management process to analyze CHW-matched patient outcomes by the end of the 2nd program year					
1. Determine variables for evaluation (including referrals)	Chief Data and Information Manager, Population Health Manager, Chief Medical Officer, EHR Data Manager	Computers, EPIC			
2. Standardize a process for collecting CHW-matched patient outcomes data	Chief Data and Information Manager, Population Health Manager, Chief Medical Officer, EHR Data Manager	Computers			
2a. Train CHWs and patient-facing staff to collect data using new standardized process	Population Health Manager	Computers			
3. Choose a HIPAA compliant database	Chief Data and Information Manager, Population Health Manager, Chief Medical Officer	Computers, Chosen Data Repository			
3a. Integrate database into existing IHC infrastructure	Chief Data and Information Manager & EHR Data Manager	Computers, Data Repository			
4. Create a data management process to extract and clean EHR data from EPIC	Chief Data and Information Manager & EHR Data Manager	Computers, Epic, R-Studio, Data Repository			
4a. Train data-related staff on data management process ongoing creation of data management process	Chief Data and Information Manager & EHR Data Manager	Computers, Epic, R-Studio, Data Repository			
4b. Deposit standardized data into database	Chief Data and Information Manager & EHR Data Manager	Computers, Epic, R-Studio, Data Repository			
5. Analyze CHW-matched patient outcomes data	Chief Data and Information Manager & EHR Data Manager	Computers, Data Repository, & R-Studio			
6. Develop standard data analysis report template	Chief Data and Information Manager & EHR Data Manager	Computers, Data Repository, & R-Studio			
6a. Report CHW-matched patient outcomes data bi-annually	Chief Data and Information Manager & EHR Data Manager	Computers, Data Repository, & R-Studio			

Appendix B: Project Budget

PROJECT TITLE:	Expansion of Island Health Care's CHW Program										
			YEAR 1		YEAR 2		YEAR 3		PROJECT TOTAL		
	$/UNIT	UNIT	# UNITS	TOTAL	# UNITS	TOTAL	# UNITS	TOTAL	# UNITS	TOTAL	TOTALS
A. SALARIES											
US											
Community Health Workers (CHW) 1 (Field)	$1,000.00	Week	52	52,000	52	54,080	52	56,243	156	162,323	
Community Health Workers (CHW) 2 (Field)	$1,000.00	Week	52	52,000	52	54,080	52	56,243	156	162,323	
Community Health Workers (CHW) 4 (Field)	$1,000.00	Week		0	52	54,080	52	56,243	104	110,323	
Community Health Workers (CHW) 5 (Remote)	$1,000.00	Week		0	52	54,080	52	56,243	104	110,323	
Subtotal-Salaries			**104**	**104,000**	**208**	**216,320**	**208**	**224,973**	**520**	**545,293**	**545,293**
B. INTERNAL EMPLOYEES											
See Budget Narrative.											
				0		**0**		**0**		**0**	**0**
C. BENEFITS											
Fringe Benefits			21.00%	21,840	21.00%	45,427	21.00%	47,244		114,511	
Subtotal-Benefits				**21,840**		**45,427**		**47,244**		**114,511**	**114,511**
E. TRAVEL & PER DIEM											
Domestic Travel											
Ground Transport	$1,079.00	RdTrip	2	2,158	3	3,366	4	4,668	9	10,193	
Subtotal-Travel				**2,158**		**3,366**		**4,668**		**10,193**	**10,193**
J. OTHER DIRECT COSTS											
Translation of materials	$900.00	Month		0		0		0		0	
Photocopy/printing (large jobs)	$2,000.00	Year	1	2,000	1	2,080	1	2,163		6,243	
Certification costs	$35.00	Year	0	0	0	0	4	151		151	
Swag for events	$500.00	Year	1	500	0	0	0	0		500	
Food for events	$50.00	Month	6	300	6	312	6	324		936	
Subtotal-ODC				**2,800**		**2,392**		**2,639**		**7,831**	**7,831**
TOTAL DIRECT COSTS				**130,798**		**267,506**		**279,524**		**677,828**	**677,828**
OVERHEAD			**26.00%**	**34,007**	**26.00%**	**69,551**	**26.00%**	**72,676**		**176,235**	**423,643**
GRAND TOTAL				**164,805**		**337,057**		**352,201**		**854,063**	**1,101,471**