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Resource Package #4: Financing and Sustaining CHW/P Roles in Medi-Cal Services

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21 A Project of the California Health Care Foundation

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Introduction

About the Project and Resource Package

As California aims to improve the quality of life and health outcomes for its residents, particularly Medi-Cal members, one strategy is to better integrate community health workers and *promotores* (CHW/Ps) into health care coordinated by managed care plans (MCPs) and providers. According to the American Public Health Association, a community health worker is a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison, link, or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."[1] *Promotores de salud*, or *promotoras*, are a subset of community health workers who serve Spanish-speaking communities and are characterized as lay health workers with the ability to provide culturally appropriate services informed by their lived experiences.[2] CHW/Ps have been employed across public health, medical, and behavioral health settings with different job titles and in a range of roles. CHW/P roles are covered in depth in the first resource package of this project, *The Role of CHW/Ps in Health Care Delivery for Medi-Cal Members*. Currently, most CHW/Ps work for federally qualified health centers, public health agencies, or health plans, but increasingly hospitals and health systems are exploring CHW/P programs.[3] CHW/Ps have an extensive history within community-based and social service organizations serving communities that are most likely to experience inequities. In some organizations, job positions for unlicensed professionals may include shared roles with those often performed by CHW/Ps, such as case management, engagement, health coaching, health care and housing navigation, employment services, and outreach. However, in different settings these professionals may not use the titles of community health workers or *promotores*, which is frequently the case with behavioral health and social service providers. For this resource package, unlicensed professionals performing these roles – including but not limited to those formally titled community health workers or *promotores* – will be described as the community-connected health workforce to emphasize their shared characteristics and broad importance across multiple sectors. This term, community-connected health workforce, is also used to elevate the value of this workforce.

Medi-Cal MCPs and their partners, such as federally qualified health centers, hospitals, or community-based organizations, can implement effective, evidence-based CHW/P programs to advance health equity and improve outcomes overall. To do this successfully, it is important to facilitate training and ongoing skill- and capacity-building opportunities for CHW/Ps, their supervisors, and organizational leaders.

This project aims to advance the role of CHW/Ps in the future of Medi-Cal, within the context of the California Advancing and Innovating Medi-Cal (CalAIM[4]) initiative. It seeks to enhance Medi-Cal MCPs and their partners' readiness to implement effective, evidence-based CHW/P programs that advance health equity. To advance this goal, the project is producing four resource packages — informed by stakeholders — containing resources and tools that support CHW/Ps' integration into programs for Medi-Cal enrollees. The packages cover the following topics:

- Roles of CHW/Ps in improving care delivery for Medi-Cal members[5]
- Training for CHW/Ps and their employers[6]
- Data collection and outcome measurement related to CHW/Ps
- Financing and sustaining CHW/P roles in Medi-Cal services

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The resource packages will be released as they are developed. In September 2021, these four resource packages will be adapted into a comprehensive toolkit, with updates related to the CalAIM initiative. A comprehensive stakeholder engagement process, including a health plan council, advisory council, and stakeholder group, is helping to inform resource package content. Insights from project stakeholders — including CHW/Ps — were gathered through interviews and feedback provided through the stakeholder process and are incorporated into the resource packages. For this resource package, a list of contributing stakeholders is included in the Acknowledgments section.

CalAIM is designed to better meet the needs of California residents, and acknowledges nonclinical interventions that effectively address health-related social needs and reduce racial health disparities. Two CalAIM components are particularly relevant for CHW/P programs: (1) a requirement for an enhanced care management (ECM) benefit to address clinical and nonclinical needs of individuals with complex health and social needs; and (2) authorization for MCPs to deliver in lieu of services (ILOS), which are cost-effective alternatives to covered services that improve health, such as housing navigation services. As the CalAIM proposal is finalized, and MCPs develop plans for these services in the community, MCPs are uniquely positioned to include CHW/P programs as key components in their strategies. The final toolkit will be designed to support MCPs in leveraging CHW/P programs within this context.

As CalAIM prepares to serve as the vehicle for care management (via ECM) and innovative service provision (through ILOS), it is valuable to understand the experiences from predecessor programs — the Health Homes Program and Whole Person Care pilots. In these models, MCPs partnered with community-based care management entities and Whole Person Care partners to employ CHW/Ps. This resource package features case examples drawn from the Health Homes Program and Whole Person Care pilots to illustrate lessons for MCPs and their partners.

The primary audience for this resource package is Medi-Cal MCPs. This resource package can also inform MCP partner organizations that develop CHW/P programs to serve Medi-Cal members. The implementation approaches and considerations detailed in this resource package focus on how MCPs can most effectively leverage an organizational and financial commitment to integrate CHW/Ps and the community-connected health workforce. This resource package provides a framework for MCPs, partners, and CHW/Ps to share perspectives and solutions.

This fourth resource package, *Financing and Sustaining CHW/P Programs*, highlights

- ECM and ILOS roles in financing CHW/Ps
- Estimating financial requirements of a program, given program design, outcome measures, and priority populations
- Assessing community capacity to support community health workers, including local health needs, strategic goals of MCPs based on statewide goals, and core competencies of contracted partners
- Considerations from MCP and partner perspectives on partnership arrangements
- Infrastructure needs related to training, data collection and reporting, capacity to meet metrics, and supporting invoicing and payment requirements

Background and Context

The implementation of CalAIM, specifically through the ECM and ILOS benefits, provides a unique opportunity to finance and scale the integration of a community-connected health workforce, including community health workers and *promotores* (CHW/Ps), in health care interventions statewide.[7] While these new benefits provide an exciting prospect to expand and invest in CHW/Ps, it is critically important that MCPs, providers, and programs

158 with CHW/Ps align strategies and funding to best achieve program goals while strengthening the CHW/P
159 workforce. MCPs and programs with CHW/Ps operate with different funding models, cultures, and processes, all
160 of which need to be considered at each stage of the partnership. Successful programs that include CHW/Ps
161 require an understanding of the unique strengths and values of MCP and community-based organization (CBO)
162 partners, partner capacity and contracting abilities, as well as agreed-upon roles and structure to achieve overall
163 care management goals. The opportunity presented by CalAIM is to incorporate CHW/Ps within community and
164 healthcare settings, while providing the right kind of care. For example, a MCP may propose in its Model of Care
165 that return on investment (ROI) is proven where CHW/Ps can help members navigate appropriately; coach
166 members through health issues; prevent health issues from escalating; and, in many cases, coordinate with
167 individuals as they are discharged from the hospital, so they do not have a readmission.

168 **National examples of CHW/P programs**

Target population	State	Funding model	Impact
Adults with complex medical and social needs	New Mexico	1115 waiver-capitated rates	Molina reported a $4 return for every $1 spent.[8]
Latinx patients with depression and diabetes	California	Enabling services funding through HRSA (FQHCs)	After 12 months, improved psychological health, more likely to seek professional health for depression, hospital and ED use significantly reduced.[9]
People with serious mental illness	California	Grant funding	After 6 months, improved relationships with primary care providers. After 12 months, reduced ED use and improved confidence in self-care management.[10]
Obstetrics	Northwest Ohio	PMPM	236% ROI for every dollar spent on Community HUB model.[11]

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170 Examples of CHW/Ps Financed Through Whole Person Care Pilots and Health Homes Program and in 171 Other States

172 As MCPs consider developing partnerships with programs that have CHW/Ps to better serve patients eligible for
173 ECM and ILOS benefits, they can look to successful examples where CHW/Ps were integrated within the Whole
174 Person Care pilots and Health Homes programs. For example, across the state under the Whole Person Care
175 Pilot program, nearly all pilot sites used CHWs and/or peers in their program. Most significantly, these pilots
176 reported that CHWs and/or peers played a critical role in the success of their intervention.[12] Funding for
177 programs with a community-connected health workforce varies nationally and throughout California. Federal

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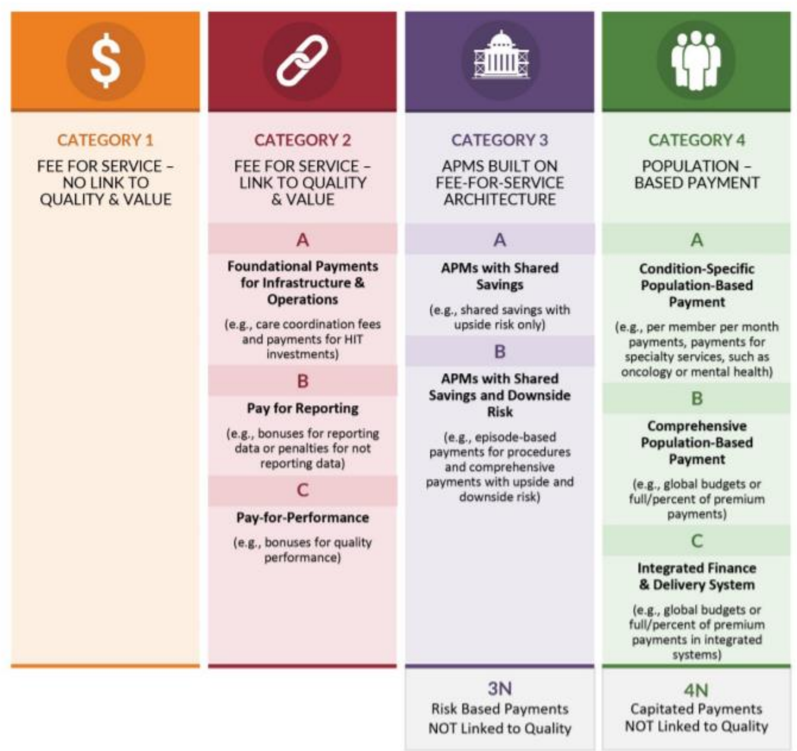
178 grants, Medicaid reimbursement, state funding, and foundation grants can all be used to fund a community-
179 connected health workforce, including CHW/Ps.

180 Nationally, many states are determining how to best use Medicaid funding to support programs with CHW/Ps in
181 health care delivery and expand this workforce. Different examples include (1) fee-for-service (as implemented
182 by Minnesota, Indiana, and California under behavioral health contracts); (2) 1115 waiver authority (Oregon and
183 New Mexico); (3) state plan amendments (Maine, Michigan, Missouri, New York, and North Dakota); (4)
184 managed care organization contracts (administrative funding and capitated rates), including North Carolina; and
185 (5) preventive services.[13] All of these examples can guide California's effort to integrate CHW/Ps in care
186 management interventions under CalAIM. Oregon's efforts through its coordinated care organizations can help
187 inform activities in California. Oregon similarly emphasized using a community-connected health workforce,
188 including community health workers; developing strong population health goals; focusing on equity and racial
189 disparities; using capitated payment rates between the state and coordinated care organizations; and pursuing
190 broader alternative payment efforts. The below figure outlines payment mechanisms within the Health Care
191 Payment Learning and Action Network (LAN)'s Updated Alternative Payment Model (APM) Framework, a model
192 designed to track progress towards payment reform. These payment models can be considered within the
193 context of funding of CHW/Ps in population health improvement efforts.

Figure 1: The Updated APM Framework



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Equity Considerations in Financing CHW/Ps

CHW/Ps are uniquely situated to address broader racial disparities in health outcomes. This workforce more closely mirrors the patient population by race, ethnicity, and shared experiences, and has strong relationships and connections within a community. These shared experiences, alongside skills and competencies in engagement, relationship building, patient advocacy, and ability to navigate both medical and nonmedical resources, aid in building trust and authentic relationships between CHW/Ps and patients with complex needs. This workforce is also uniquely qualified to work with priority populations under ECM and to achieve the equity goals as stated in CalAIM, including addressing health disparities based on race.[14]

CHW/Ps have an identity and history dating back to the 1950s.[15] The origin of this role has deep roots in building trusting relationships and strengthening individual and community capacity. The success of CHW/Ps relies on their community expertise and soft skills, including nonjudgmental attitudes, ability to solve problems, and engagement skills that are often gained through personal experiences and shared challenges in accessing health care or social services.

As MCPs explore the integration of CHW/Ps into care delivery programs, CHW programs and CBO providers must consider equitable roles at each stage in partnership development. A mutual commitment to equity is essential for supporting this critical workforce. Examples of equity considerations related to partnership development include (1) determining an appropriate partner to serve priority populations; (2) involving CHW/P staff and leadership in designing the program; (3) supporting flexibilities in contracting and considerations for CHW/P program infrastructure to attract effective CBO partners; and (4) working with CHW/P programs, CBOs, and other partners to ensure appropriate funding for training, infrastructure, fair compensation, and career pathways. These considerations will be discussed in this resource package.

Key Implementation Approaches

MCPs face several key considerations in developing strategies to integrate CHW/Ps into program approaches and determining the scope of these programs. Below is a list of primary considerations that factor in ECM and ILOS benefits.

Statewide Considerations for Estimating Financial Requirements of Program

MCPs can consider the priority population, needed services, strategic priorities, and measures of success to determine financial requirements of incorporating CHW/Ps into their ECM and ILOS services. Determining these factors alongside a longer-term focus on ROI is critical for MCPs. Following are high-level steps for initiating such an exploration:

Step 1: Evaluate data to determine priority populations

MCPs will need to stratify existing member and cross-system data to identify priority populations eligible for ECM who would benefit from CHW/P services. CHW/Ps are essential to population health programs, which require customized interventions to meet a broad range of medical and social needs. Each identified priority population will require specific expertise.

Per California Department of Health Care Services (DHCS) guidelines, ECM priority populations may include:

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- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g., California Children's Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis)
- Individuals experiencing homelessness or chronic homelessness or who are at risk of becoming homeless
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits
- Individuals at risk for institutionalization who are eligible for long-term care services or nursing facility residents who wish to transition to community
- Individuals at risk of hospitalization with serious mental illness (SMI), substance use disorder (SUD) with co-occurring chronic health conditions, or children with serious emotional disturbance (SED)
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community[16]

Step 2: Consider needed services and program models

As MCPs examine data to better understand their priority populations, they should consider existing provider networks and CBO partnerships for needed interventions and services, and the extent to which gaps exist in needed services. ILOS services are supplemental services that can be used together with ECM services to best meet the needs of eligible populations. These services offset less clinically appropriate and more expensive services, including hospitalization or skilled nursing facilities.[17] Some examples of these optional services include recuperative care (medical respite), housing deposits, and meals/medically tailored means (full list of services are below).[18] The community-connected workforce, including CHW/Ps, are uniquely qualified in outreaching to these patients who qualify for ECM, building meaningful relationships, and connecting to these potential ILOS resources.

CalAIM optional In Lieu of Services (ILOS)

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as residential care facilities for elderly and adult residential facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptions (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

When determining the needs of priority populations, the care management team, including CHW/Ps, can use ILOS paired with ECM services to meet pressing needs that impact health and avoid potential hospitalizations. For example, people who are formerly incarcerated (a priority population for ECM) are 10 times more likely to be homeless than the general population.[19] Providing housing connected with services for formerly incarcerated people with complex care needs can ensure a secure environment and facilitate critical connections to needed primary and behavioral health care services. ILOS services, including housing transition navigation services, housing deposits, and housing tenancy and sustaining services (among others), can be critically important for this population.

Step 3: Consider strategic priorities, return on investment, and impact

When considering potential care management partners and CHW/P programs, MCPs should consider their own priorities, including quality improvement, member engagement in services, broader population health goals, and cost

containment.[20] In interviews with MCPs, CHW/Ps can be effective in engaging patients that would otherwise not be engaged in care, and demonstrating impact for patients and a return on investment for plans.

A former MCP CEO in Oregon found that specific ethnic groups were attending adolescent well visits and development screenings at much lower rates, compared to other ethnic and racial groups. A CBO partner, IRCO, developed a successful outreach program to the local Russian community by partnering with CHWs to engage those adolescent and young adults to get their well visits. A similar initiative was deployed to improve developmental screening rates for African communities in the same area. As a result, the MCP achieved specific incentive metrics and realized a major return on this investment. In planning their CalAIM services, MCPs should identify areas of likely ROI for each priority population, both direct and indirect.

MCPs can look at how CHW/Ps can help address key goals related to engagement, population health, quality improvement, racial equity, or cost containment. For example, if children in foster care or those with complex needs (an ECM priority population) are not attending well visits, CHW/Ps can engage children and families and address barriers to care.

In California, several care plans that have longstanding CHW/P partnerships have found that CHW/P were critical in engaging members that would not engage in programs or services.

> "I think the better measures are looking at engagement or how many members do we have engaged and are we making inroads there? Because again, if you don't have people engaged, they're not going to enroll. They're not going to get the services. You're never going to get the ROI." Cynthia Carmona, LA Care, in reference to their Health Homes Program

Step 4: Evaluate and assess potential partners

As MCPs analyze data related to ECM eligible populations, MCPs should consider the types of organizations that are best suited as partners, including CBOs. Examples of partnership considerations include (1) history of involvement in the community, (2) examples of similar projects and outcomes, (3) capacity of program to serve members or ability to hire new staff, (4) capacity to gather and collect data to drive treatment planning and measure individual and population-level outcomes, and (5) financial and organizational stability and standing.

As MCPs consider appropriate partners for eligible ECM populations, including the ECM priority population — "high utilizers with frequent hospital admissions" and significant health-related social needs — MCPs should look to CBOs connected with CHW/P programs. These programs have a unique capacity to build trusting relationships and provide access to services that respond to the most pressing needs of members. A community-connected health workforce is not only able to skillfully engage these priority populations but is also familiar with and physically present in the specific neighborhoods of these members, enabling them to connect to the right resources and types of care.

Step 5: Structure core contract components

MCPs can support programs with CHW/Ps in developing the core contract components that fund CHW/Ps. Several costs need to be included within an MCP partnership and contracting arrangement. First, funding for yearly salary, benefits, and supervision costs is essential to bringing CHW/Ps onboard and can be considered within capitated costs. MCPs can contract for MCP/P roles or opt to build their own programs under Health Homes and Whole Person Care pilots. Inland Empire Health Plan funded annual salaries of CHW/Ps within their own CHW/P program.

312 Second, there are other additional direct and indirect upfront costs to consider in calculating funding
313 requirements, including training and data infrastructure costs. Successful health homes similarly invested in
314 upfront costs before program launch, recognizing that CBOs and programs with CHW/Ps may need to hire and
315 increase their capacity before implementation. Coordinated Care Organizations in Oregon contribute funding to
316 support backbone organizations that facilitate coordinated care organizations (a type of accountable care
317 organization) and CHW/P partnerships and address the costs of operating a CHW/P program. Leaders from both
318 MCPs and providers need to invest the time necessary to understand the value CHW/Ps bring to
319 multidisciplinary teams and interventions.

320 As MCPs are developing contract components to engage CHW/Ps, they can consider the types of training needs,
321 data infrastructure, and appropriate caseloads given ECM priority populations and ILOS service options.

322 ## Step 6: Develop incentives and a sustainability plan

323 One way that MCPs can reward quality among partners and address the direct and indirect cost of CHW/P
324 programs is to adopt payment reform models. For example, capitated rates with quality incentives can
325 encourage the coordination between physical, behavioral health, and social needs for patients. CHW/Ps are
326 uniquely able to coordinate these disparate services within their own communities and connect individuals to
327 appropriate formal and informal services that address social needs.

328

> The Pathways HUB model is a nationally replicated model that develops a network of CBOs, providers, and other agencies. Community health workers enroll patients into the HUB. MCPs base incentive payments to community health workers on the achievement of specific quality measures. An Ohio-based Pathways model focused on improving care for newborns produced an average 236% return on investment.

333 Under CalAIM, DHCS is proposing a variety of funding changes and alternative payment models that can
334 promote the use and expansion of CHW/Ps.

335 - **MCP incentives linked to quality and performance improvements**. These payments could
336 potentially support pilot use of CHW/Ps for specific priority areas, populations, or quality
337 improvement goals that involve ECM and ILOS services.[21] Incentives can be passed down to CHW/P
338 programs and staff who are meeting these quality targets. This funding be used to make critical
339 investments in the workforce, including ensuring fair pay, sufficient supports and training, and
340 career pathways. Incentive payments were also a critical tool for Coordinated Care Organizations in
341 Oregon, in addition to capitated global budgets.[22] For example, Eastern Oregon CCO that has used
342 their quality incentive funds to support the training and certification of CHWs for the past several
343 years. CHW/Ps are able to achieve a return on investment and the MCP is able to reinvest some of
344 this funding into training programs.[23]
345
346 - **Shared savings (LAN Category 3) and incentive methodologies that will involve MCP and other
347 stakeholder engagement**. Shared savings models can be used as a mechanism to reward partner
348 organizations in achieving benchmarks and quality goals. One way agencies can use shared savings
349 models is to pay for potential career pathways and opportunities for CHW/P advancement. One
350 former MCP CEO noted that a key barrier in integrating the CHW/P workforce is turnover and the
351 subsequent retention of high-quality CHW/P workers.[24] Competitive salaries and clear pathways for
352 development is one way to mitigate this challenge.[25] Career development and interest in higher
353 salaries was a high priority need listed by CHW/Ps in California.[26]

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Collaboration with Partner Organizations

Successful partnerships between MCP and CHW/P programs should be mutually beneficial and based on a shared understanding of program goals, priority populations, and appreciation of the value of CHW/Ps and their role within the broader care management intervention. These principles should be reflected at each stage of the partnership engagement and contracting process. National models, Whole Person Care pilots, and Health Homes Program examples can provide insight into best practices at each stage of the partnership development and contracting process.

Key Considerations in Assessing Potential CHW/P Partners

MCPs should consider eligible populations, existing partnerships, strategic goals, and community needs to guide the assessment of local CHW/P partners. Below are considerations in how MCPs should research, assess, and engage potential CHW/P program partners.

- Conduct a crosswalk or assessment of the potential priority populations, needed services, and existing partnerships. Assessment activities should particularly focus on CalAIM requirements and MCP strategic priorities. This assessment can allow a plan to determine what providers and partners are already engaged and what additional partners and services are needed.
- Research and engage partners based on MCP needs, eligible populations, and required expertise. Trusted community partners, members, and providers can provide a good start in helping MCPs to identify potential partners. While potential CHW/P program options may depend on MCP coverage area and location, it can be helpful to engage several partner options to consider unique expertise. CBOs that have expertise in specific priority populations (e.g., individuals with behavioral health needs) may be interested in expanding their workforce models to include community health workers. Other MCPs, health systems, training organizations, and affinity groups can provide information on potential CHW/P programs in your region.
- Assess the expertise and outcomes of available CHW/P programs. In assessing potential program partners, MCPs should seek to understand the staffing, program model, population expertise, and specific value CHW/Ps bring to a potential partnership. MCPs should examine program outcomes and the CBO's success in providing connections to resources for specific priority populations. Considerations related to initial hiring and ongoing training, staffing, supervision, and broader structure should all be factors in assessing a potential partnership. Specific guidance in this area is explained in greater detail in *The Role of CHW/Ps in Health Care Delivery for Medi-Cal Members* and *Training Approaches for Community Health Workers and* Promotores *to Support Medi-Cal Members*.
- Determine financial controls, billing, and contract capacity. MCPs should evaluate the financial controls, organizational structure, and compliance records before engaging with a contracted partner. These considerations may lead MCPs to connect with larger CBOs that have a more robust financial foundation or a designated attorney on staff. Some smaller CBOs may be the right service partner for MCP priority populations but may lack the ability to contract directly with an MCP or bill and receive payments.[27] One way to mitigate this challenge is to develop subcontracting arrangements with this potential partner and have other CBOs act as fiscal agents. MCPs may need to adjust their current contracting approaches to address this need.
- Determine the size and scale of the contracting arrangement. As MCPs pursue a potential contractual arrangement with a CHW/P program, it is helpful to consider the scale of the partnership in

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relationship to overall program goals. MCPs that are new to integrating CHW/Ps in contracted services may benefit from starting small with a targeted goal of expansion over time. This approach can help MCPs adjust, learn, and scale depending on eligible populations and care management team interventions. Upfront conversations related to capacity, referrals, standards, and caseload expectations can help clarify a shared understanding among MCP and CHW/P program partners.

Key Considerations in Entering Contracting Agreements

MCP and CHW/P programs have both constraints and differences related to legal support, data infrastructure, and financial stability, impacting the way that MCP and CHW/P programs can effectively partner. While these are challenges in developing partnership arrangements, understanding potential limitations and providing flexibility where possible can aid in developing successful partnerships. A list of potential contract terms for consideration by MCPs and their partners is included in Appendix A. Following are recommendations for facilitating effective contracting arrangements between MCP and CHW/P partners.

Develop a clear and shared understanding of the roles, responsibilities, and expectations of CHW/Ps.

Successful programs with CHW/Ps require a common understanding across all stakeholders — including leadership and clinical partners — on each partner's role on the care team.[28] This will also ensure that services are not duplicated and will ensure clarity for members. Roles, expectations, and outcome metrics that CHW/Ps are responsible for should be developed collaboratively with MCP and CHW/P partners. MCPs and CHW/P partners should expect that refinements to the model will be made over time based on strategic goals and outcomes.

In integrating CHW/Ps into its Medicaid program, Oregon found that it is critical to establish realistic expectations for program outcomes for short- and mid-term time frames.[29] In developing these partnerships it is unrealistic to expect an immediate ROI. Many CHW/P programs that have shown an impact in quality and cost containment require a year of engagement. One Oregon stakeholder reflecting on lessons from CHW integration remarked: "I think we need to make smart investments and strengthen communities without having the granular clinical pressure to somehow prove that the dose of a community health worker is what delivers the A1c [diabetes monitoring test] going from 9 to 7.5."

There are specific considerations for CHW/Ps that are overseen by providers. MCPs should consider the various degrees of readiness of clinics and hospitals in integrating CHW/Ps into their multidisciplinary teams. Inland Empire Health Plan found that some smaller practices took a longer period to recognize the full value and services that CHW/Ps can provide patients. One strategy that was important for IEHP to maximize success was bringing providers and clinic staff into the training process alongside CHW/Ps.

Develop strong communication processes between partners. Building intentional communication channels between appropriate stakeholders is critical to ensure there is understanding of roles and appropriate point people in place for when challenges arise. An example of important protocols between partners includes the sharing of information between MCP electronic health records and CBO care management systems. CHW/Ps generally sit outside the traditional health care delivery system and will need support integrating into a multidisciplinary team. It is important to have both leadership and administrative involvement and clinical/provider support at the MCP, CBO, and provider level for integration of CHW/Ps into health care delivery systems. MCPs and CBOs in successful Health Homes co-designed program goals and met regularly to troubleshoot challenges and address barriers.[30]

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> "Healthcare is usually this vertical hierarchy, you know, you've got the doctors, nurses and all the additional staff. We throw it on its side and make it horizontal. The nurse is equal to the care coordinator is equal to the community health worker…they all have have a voice (and) are expected to speak and advocate and share their opinions..."- Catherine Knox, Inland Empire Health Plan

Barriers and Solutions

Developing and sustaining partnerships between MCP and organizations with a CHW/P workforce requires an understanding of the different expertise, culture, goals, and challenges of each partner. While these differences can result in common barriers, with deliberate flexibility and planning, partners can implement solutions to overcome these challenges.

Funding Differences

Programs that employ CHW/Ps often rely on grant funding or other time-limited funding streams, and often need to operate successfully by braiding public and private funding steams. While these programs operate with less continuous funding, and CHW/P are paid less than much of the health care workforce, they are key to addressing the complex challenges in health care, including population health and the reduction of racial disparities in care. While MCPs and CHW/P programs can develop successful partnerships and overcome funding challenges, differences in requirements, funding, and capacity should be acknowledged and accounted for in the contracting and implementation process.

Infrastructure Needs

CHW/P programs likely need resource and financial support for data infrastructure, technology, and legal infrastructure to meet the requirements of plans around data collection, reporting, and even contract negotiation and implementation.

Data Infrastructure and Technology

Many CBOs and CHW/P programs have different types of care management systems to manage projects as well as client data and lack needed data infrastructure and technology.[31] It is important for MCPs and CHW/P programs pursuing a potential partnership discuss needs related to data capabilities, data protection, and specific data elements. One potential pathway for CBOs and CHW/P partners to view population data is through read-only access of patient information, which provides data that is useful but has some built-in sharing restrictions that can aid in care management efforts. The third resource package on data and outcomes includes some additional consideration more specifically on this topic.

One former MCO CEO in Oregon reflected that the plan needed to demonstrate flexibility and recalibrate expectations around data capacity.[32] Considerations should also be given to technology investments that can promote care coordination and data exchange, including iPads, tablets, and computers. One best practice among Health Home was ensuring effective ramp-up costs for CBOs to make necessary investments in technology and data before program launch.[33] MCPs should work with CBO partners to better understand what investments are needed to effectively integrate CHW/Ps and support needed investments where possible. The

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469 flow of data and security protocols should be outlined in contracting, training, and in shared workflows and
470 policies.

471 *Legal Infrastructure*

472 MCPs and CBOs differ on the ability to review, draft, and execute a contract. CBOs and CHW/P programs may
473 not have an attorney on staff or may have an attorney only on a limited basis. This can pose a challenge as
474 having adequate legal support on both sides can help ensure clarity in roles, expectations, and that the terms of
475 agreements are mutually beneficial, which can support longer-term partnerships. In New York City, the Lawyers
476 Alliance provides pro bono legal support to CBOs for Medicaid contract review, addressing a key hurdle for many
477 CBOs to effectively partner with MCPs.

478 Sustainability Considerations

479 The ability to recruit and retain a high-quality CHW/P workforce relies on investments that extend beyond
480 individual contracts and programs. In California, there are several key challenges to ensuring an adequate
481 pipeline of CHW/Ps to meet long-term needs. These include adequate wages, pathways for growth, and a
482 commitment to ensuring community-connected services through integration efforts.

483 *Ensuring Support for CHW/P Workforce*

484 CHW/Ps engage in complicated and emotionally challenging work, often having to juggle multiple priorities,
485 system partners, and patients. One critical approach to sustaining and growing this workforce is to ensure an
486 adequate support structure, which can include opportunities for peer learning/sharing; ensuring adequate,
487 ongoing, and real-time supervision structure; and building in reflection and self-care opportunities at work.

488 *Adequate Wages and Pathways to Growth*

489 The low rate of pay and short-term funding streams is a significant challenge for the CHW/P workforce overall.
490 In a stakeholder forum with CHW/Ps in California, improving salaries and compensation, ensuring sufficient
491 support through strong supervision, and clear pathways for growth were mentioned as key needs.[34] MCPs can
492 work with CBOs and CHW/Ps to ensure that salaries and benefits are aligned with living wages and comparable
493 to local standards (e.g., consider salaries within public health departments and clinics that are doing comparable
494 work). Developing continuous funding streams can help ensure continuity to the care management intervention
495 and broader CHW/P program overall.

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Inland Empire Health Plan (IEHP) has been successful in strong staff retention of community health workers that work in clinic and community setting. A key strategy in ensuring retention of this workforce has been ensuring competitive and continuous funding. IEHP specifically pays CHW/Ps on the higher end of care coordination positions.

497 *Ensuring Core Components of Effective CHW/P Interventions*

498 CHW/Ps provide a critical opportunity to advance population health goals under CalAIM. To support these goals,
499 it is critical that CHW/Ps are community based. CHW/Ps support the health care system by developing strong
500 and trusting relationships with patients and community members. As CHW/Ps expand within health care
501 delivery interventions, it is critical that the role does not become overtly medicalized. Developing thoughtful
502 partnerships across stakeholders who have a role in the CHW/P workforce, including CHW/P themselves, CBOs,
503 MCPs, government partners, community colleges, providers, training programs, patients, and others, is critical
504 to expansion and long-term sustainability.

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Resources and Tools

RESOURCE TITLE	BRIEF DESCRIPTION
Community Health Worker Payment Model Guide	This report developed by the Oregon Community Health Workers Association is a guide of payment models for integrating and utilizing community health worker services.
Sustainable Financing Models for Community Health Worker Services in Connecticut: Translating Science into Practice	This report created by the Connecticut Health Foundation demonstrates how payer or provider organizations can apply findings from published peer-reviewed studies to develop evidence-based, cost-effective CHW interventions in their own organizations.
Community Health Workers in Payment and Delivery Transformation: How New Delivery and Payment Models Can Incentivize and Support the Use of CHWs	This case study by Families USA highlights how health system transformation initiatives implemented in Vermont and Oregon align with the value that CHWs provide and can incentivize CHW integration.
Community Health Worker Financing Webinar	This recorded webinar from CDC covers topics such as community clinical linkages, CHWs' financing approaches, Medicaid, and CHW financing opportunities and the New Mexico story for financing CHWs.

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Examples from Other States

RESOURCE TITLE	BRIEF DESCRIPTION
CHW: Billing and Reimbursement	This resource, from the Minnesota Department of Health, outlines how CHWs are reimbursed through the state's Medicaid program.
Community Health Worker Documentation and Billing Work Flow in an Electronic Health Record: Lessons Learned	This resource, from Hennepin Healthcare in Minnesota, outlines CHW workflows and how they bill for their time.
How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities	This brief, produced by Families USA, discusses key questions regarding sustainable funding of CHW programs through Medicaid reimbursement for states that want to start or expand such programs.

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Sustainability of the Workforce

RESOURCE TITLE	BRIEF DESCRIPTION
Developing Sustainable Community Health Worker Career Paths	This issue brief from the Penn Center for Community Health Workers shares key findings from a participatory action research framework about community health workers' perspectives on job satisfaction and career advancement and informs the design of a career development program.

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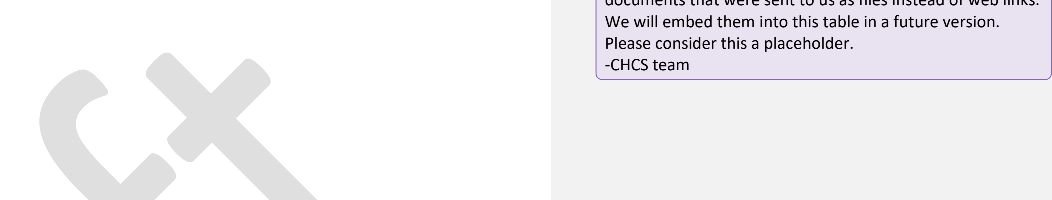
Examples of CHW Salaries

RESOURCE TITLE	BRIEF DESCRIPTION
Contra Costa County: Community Health Worker I	This is a job posting with a salary range for an entry-level Community Health Worker.
Contra Costa County: Community Health Worker II	This is a job posting with a salary range for a mid-level Community Health Worker.



Commented [AN1]: Note to reviewer: these are resource documents that were sent to us as files instead of web links. We will embed them into this table in a future version. Please consider this a placeholder.
-CHCS team

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Appendix A

Model Contract Terms

The following includes a list of potential contract terms for MCPs to use with partners (CBOs, counties, and other organizations that employ CHW/Ps). Plans and partners can use this list as a starting point in conversations to discuss pros and cons, track decisions, and further flesh out specifics for the agreement.

Contract Section	Contract Elements
1. Scope of Services	**Defining Services** • Outreach, including number of attempts and whether outreach was successful in reaching member, and type of attempt that will count, for example, mail, phone, in-person, connection through another provider • SDOH screening and any other assessments, including whether assessments will include pre- and post-service assessment to obtain baseline data, and identifying barriers to accessing health care services • Linkages to physical health care, behavioral health care, and social services, including follow-up to determine if referral/linkage was successful in terms of being screened and/or whether it resulted in provision of additional services or interventions addressing SDOH • Maintenance of up-to-date CBO referral sources by checking against success of existing referrals and linkages and/or use of a community utility that is a resource to all community resources (e.g., UniteUs) • Care coordination/care management • Health care promotion and disease prevention activities • Linguistic and culturally appropriate services for LEP populations • Building capacity and/or advocating for individuals and communities • Arranging transportation for members to service providers or other referrals • Participation on interdisciplinary teams for assessment and person-centered planning **Defining Populations** • Options developed under "enhanced care management" as defined by DHCS' California Advancing and Innovating Medi-Cal (CalAIM) proposal: ○ Children or youth with complex physical, behavioral, developmental, and oral health needs ○ Individuals experiencing homelessness or chronic homelessness or who are at risk of homelessness ○ High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits ○ Nursing facility residents who want to transition to the community ○ Individuals at risk of institutionalization with SMI, children with SED, or SUD, with co-occurring health conditions ○ Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community • Options developed under "in lieu of services" as defined by CalAIM proposal, which may or may not be focused on specific populations: ○ Housing transition navigation services ○ Filling other gaps to address social determinants of health, such as linkages to community transitions, personal care and homemaker services, home modifications, meals, sobering centers, and asthma remediation

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	• Geography • Age range, if applicable • Limits on caseloads and cumulative numbers of patients if applicable, and whether there will be waiting lists • Prioritization of populations or needs, if applicable based on MCP priorities **Providing Training and Supervision** • Certification • Approval of job descriptions • Training expectations • Supervision expectations • Evaluation and feedback

2. Measuring and Improving Outcomes	**Selecting Measures**
	• Inputs
	  ○ Successful engagement
	  ○ Intake data
	  ○ Completion of assessments
	  ○ Referrals
	  ○ Participating in interdisciplinary care meetings and adding interventions to person-centered plan
	
	• Outputs and Outcomes
	  ○ Health education services
	  ○ Improvements demonstrated from self-reporting
	  ○ Health-related services about appointments made
	  ○ Closed-loop referrals to CBOs that result in services
	  ○ Interventions that successfully address SDOH, such as housing, food support, other remediations
	  ○ Transportation assistance to visit health care or other social service providers
	
	Choosing How to Measure
	• Quantitative
	  ○ Individual level
	    ▪ Addressing individual SDOH gaps
	    ▪ Overcoming barriers to accessing health care services, including linkage to a patient-centered primary care home
	    ▪ Housing retention
	    ▪ Improving health outcomes, such as avoidable ER visits, hospitalizations, and rehospitalizations, or other clinical indicators such as medication adherence, improvements in A1C, etc.
	    ▪ Improved behavioral health outcomes, including self-reported health, adherence to behavioral health appointments
	
	  ○ Population-level that addresses health disparities and closes gaps (e.g., if disparities exist between racial groups on preventive health screens, did CHW interventions close gaps?)
	• Qualitative
	  ○ Member satisfaction surveys, interviews, and focus groups
	  ○ Surveys and interviews of health care providers and care coordinators
	
	Setting Goals
	• At individual level

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	• By percentages on inputs • By percentages on outcomes • As improvement targets for making progress toward closing an identified gap • Will plans work on quantifying data into dollars saved or cost-avoidance (e.g., reducing unnecessary care through improvement in care for ambulatory care–sensitive conditions or other AHRQ quality indicators, or dollars leveraged in services that are provided or linked) **Defining Data to Track Measures** • Data that will live with CHWs and be shared with plans • Data that will live with CHWs and be shared with providers • Data that will live with plans and be shared with CHW providers

3. Payment Requirements	**Determining Payment Amounts and Methodology**
	• Flat rates per referral, per member per month or for longer time periods
	• Flat rates adjusted by population cohort (which will require definition)
	• Value-based performance
	    o Identification of value metrics
	    o Identification of financial risks, rewards, or shared savings
	    o Determine if cost information will be exchanged
	    o Incentive structure, if applicable
	    o Funding for start-up/infrastructure development
	
	Establishing Frequency of Invoicing and Payments
	• Responsibility for generating claims or invoices
	• Type and frequency of documentation required
	• Whether CBOs must use customer relationship management tool
	• Other underlying requirements for data collection and reporting to support payments, such as number of interactions or referrals for services
	• Decide if payment will be dependent on reaching "milestones"— for example, upfront funding with payments made on cadence related to contract performance
	• Decide if payment will be based on achieving outcomes

4. Communications between Plan and CBO	**Making Referrals**
	• Determine how referrals will be taken: for example, by phone, email, and/or portals, warm or cold transfers
	• Determine frequency of referrals (e.g., daily, monthly list, etc.)
	• Determine how receipt of referrals will be confirmed
	• Availability of staff to take referrals and setting expectations around warm/cold transfers, and timing of follow-up and contacts
	• Linguistic and cultural capacity
	
	Implementing Regular and Ongoing MCP and CHW/P Communications
	• Regular check-ins and data review
	• Interdisciplinary team communications and meetings
	• Care manager interface including generating care plan, sharing care plans, prior authorizations if relevant (such as for transportation), coordination of services
	• Process for troubleshooting with named persons as contacts on both sides
	    o Emergent issues
	    o Problems in process related to referrals and/or data
	    o Financial risk issues
	
	Sharing Data

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	• Determine how CBO will share data with plan • Determine if CBO and/or plan will use visual tracking tools, such as dashboards and other graphic organizers • Determine how data will be shared with health care providers and/or care managers and by whom • Determine if/how plan will share data with CBO • Determine if/how providers and/or care managers will share data with CBO **Securing Consent and Ensuring Privacy** • Documentation of member consent for participation and for data sharing • HIPAA compliance

521 Created by: Michele Melden, Health Management Associates for purposes of the CHCF *CHW/Ps in the Future of Medi-Cal Project*

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