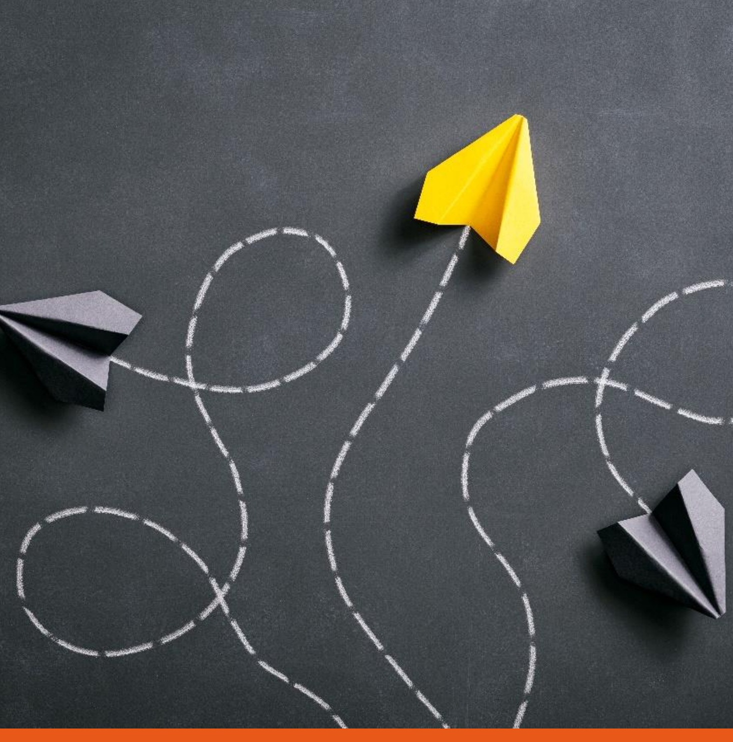

Community Health Workers & *Promotores*
in the Future of Medi-Cal

Resource Package #4: Developing and Financing Sustainable Programs with CHW/Ps

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 benefits provided by managed care plans (MCPs) and contracted providers. According to the American Public Health Association, a community health worker (CHW) 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. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[1] *Promotores de salud*, or *promotoras*, share many similarities with CHWs. They are characterized as lay health workers with the ability to provide culturally appropriate services informed by their lived experiences, and they often serve Spanish-speaking communities.[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 integrating CHW/Ps into their 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, consumer engagement, health coaching, health care, housing navigation, employment services, and community outreach. In different settings, however, these professionals do 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 programs with CHW/P to advance health equity and improve outcomes. 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 programs with CHW/Ps 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[7]
- Developing and financing sustainable CHW/P roles in Medi-Cal services

In September 2021, these four resource packages will be adapted into a comprehensive toolkit, with updates related to the CalAIM initiative as available. A comprehensive stakeholder engagement process, including a health plan council, advisory council, and stakeholder group, helped 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 programs with CHW/Ps: (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 programs with CHW/Ps as key components in their strategies.

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. The information herein can also inform MCP partner organizations that develop programs with CHW/Ps to serve Medi-Cal members. The implementation approaches and considerations detailed in this resource package focus on how MCPs can most effectively create or expand organizational and financial commitment to integrate CHW/Ps and the community-connected health workforce into the MCP benefit. This resource provides a framework for MCPs, partners, and CHW/Ps to share perspectives and solutions. It highlights

- Program design and development considerations
- Partnership development between MCPs and organizations that employ CHW/Ps, such as providers and CBOs
- ECM and ILOS roles in coverage and financing for CHW/Ps
- Estimating financial requirements of a program, based on required program design components, outcome measures, and priority populations
- Assessing community capacity to support CHWs, including local health and social needs, strategic goals of MCPs based on statewide goals, and core competencies of contracted partners
- Infrastructure needs related to training, data collection and reporting, capacity to meet metrics, and supporting invoicing and payment requirements

Background and Key Concepts

CHW/Ps provide a critical opportunity to advance the goals of CalAIM and provide vital connections to the community. CHW/Ps support the health care system by developing strong and trusting relationships with patients and community members. As health care services expand to include the CHW/P workforce, it is critical that the role does not become overly medicalized. Developing thoughtful partnerships across stakeholders who have a role in the CHW/P workforce — including CHW/Ps themselves, CBOs, MCPs, government partners, community colleges, providers, training programs, patients, and others — is important to expansion and long-term sustainability.

The implementation of CalAIM, specifically through the ECM and ILOS benefits, provides a unique opportunity to finance and amplify health systems engagement with the community-connected health workforce, including CHW/Ps, in health care interventions statewide.[8] Simultaneously, it is important that MCPs, providers, and programs with CHW/Ps align financing strategies to best achieve program goals while supporting and strengthening the CHW/P workforce.

As MCPs consider partnerships with providers and CBOs to integrate CHW/Ps, it's important to understand that each partner has different constraints and considerations related to funding models, cultures, and processes. Successful partnerships that integrate CHW/Ps recognize the unique strengths and values of MCP, community-based organization (CBO) partners, and providers. CalAIM presents an opportunity to incorporate CHW/Ps within community and health care settings and engage CHW/Ps to support Medi-Cal members with enhanced coordination of social and medical needs and culturally competent and appropriate care.

Examples of State Efforts to Design and Finance CHW/P Workforces

As MCPs consider developing partnerships with programs employing CHW/Ps to better serve patients eligible for ECM and ILOS benefits, they can look to successful examples where CHW/Ps were integrated within the Whole Person Care pilots and Health Homes Programs. For example, across California's Whole Person Care pilot program, nearly all pilot sites used CHWs and/or peers in their program. Most significantly, these pilots reported that CHWs and/or peers played a critical role in the success of their intervention.[9] Funding for programs with a community-connected health workforce varies nationally and throughout California. Although federal grants and foundation grants have been used to fund a community-connected health workforce, including CHW/Ps, these sources do not provide a sustainable method of financing this workforce. Medicaid reimbursement provides an opportunity to grow and sustain CHW/Ps.

Nationally, many states are determining how to best use Medicaid funding to support the CHW/P workforce. Different examples include (1) fee-for-service (as implemented by Minnesota, Indiana, and California under behavioral health contracts); (2) 1115 waiver authority (Oregon and New Mexico); (3) state plan amendments (Maine, Michigan, Missouri, New York, and North Dakota); (4) managed care organization contracts (administrative funding and capitated rates), including North Carolina; and (5) preventive services.[10] These examples can guide California's effort to integrate CHW/Ps into care management interventions under CalAIM.

Payment models that can be considered within the context of Medi-Cal MCP funding of CHW/Ps in population health improvement efforts will vary depending upon the structure of the partnership and state and federal financing rules. ECM and ILOS provide additional options and flexibility for payments to CHW/Ps, but there are several considerations that will impact how these partnerships can be effectively designed. Although Medi-Cal MCPs have been able to pay for CHW/Ps through pilot program funding as described earlier, the capitation payments currently paid to the Medi-Cal MCPs do not include CHW/Ps as recognized providers. This omission

significantly impacts the ability to directly contract and pay CHW/Ps. In California's approved budget (FY 2021–2022), CHWs have been added to the class of skilled and trained individuals who can provide clinically appropriate Medi-Cal covered benefits and services effective January 1, 2022.[11] This may increase the options for building CHW/Ps directly into MCP networks and increase the ability to pay partners for services provided by CHW/Ps. Further, plans have received draft rates for ECM service provision, which are adjusted upward for MCPs that provide ILOS.

Additionally, through additional guidance from Department of Health Care Services about CalAIM and through services under ECM and ILOS, MCPs are encouraged to partner with community-based organizations and providers in their network. Thus, it's critical for MCPs to assess, engage, and contract with effective partners for these services.

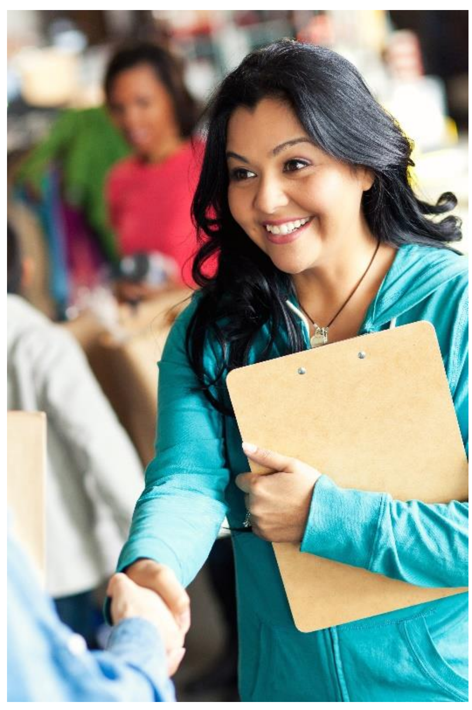
Addressing Equity

As part of the communities they serve, 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 their communities. These shared experiences enable skills and competencies in engagement, familiarity with community needs and strengths, patient advocacy, knowledge of resources, ability to navigate both medical and nonmedical resources, and ability to build trusting authentic relationships with patients with complex needs. This workforce is uniquely qualified to work with priority populations under ECM (see below) and achieve the equity goals as stated in CalAIM, including addressing racial disparities in health outcomes.[12] Moreover, CHW/Ps, and their role in integrated care teams, can play a critical role in addressing the range of factors that most influence health, including social determinants of health, environment, and behavior.

The origin of this role has deep roots in building trusting relationships and strengthening individual and community capacity. There is a significant history of CHWs, peers, and persons with lived experience in behavioral health interventions, addressing HIV/AIDS, working with people experiencing homelessness and those involved with the justice system. CHW/Ps who have worked with these specific populations can be effective at reducing stigma and helping to address additional barriers to care.

As MCPs explore the integration of CHW/Ps into care delivery programs, MCPs, providers, and CBOs must consider equitable roles for each partner 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 organizations that employ CHW/Ps, CBOs, and other partners to ensure appropriate funding for training, infrastructure, fair compensation, and career pathways. These considerations will be mentioned in this resource package.

Key Implementation Approaches



As MCPs look to integrate CHW/Ps into program approaches, they will need to use data to understand their priority populations, identify program goals, and determine needed services. Next, MCPs can assess potential partners that employ CHW/Ps, develop strong partnerships and integration models, and implement financing approaches that grow and sustain this workforce.

Program Design and Development

Assess Community and Organizational Needs and Determine Priority Populations

The health needs of a community or priority population should drive the development and scope of programs with CHW/Ps. Conducting a community health needs assessment or community focus groups can help identify these needs. For example, MCPs considering creation or expansion of programs that employ CHW/Ps may be interested in more effectively addressing member needs such as chronic conditions, health-related social needs, and preventable acute care utilization, as well as focusing on the needs of high-risk patients and/or historically under-resourced communities. As organizations develop goals for programs with CHW/Ps, they should carefully balance input from health care leaders and community members to establish a shared set of principles and program goals.

Before launching a CHW/P program, MCPs also need to assess their organizational readiness for these programs, including buy-in from senior leadership. MCPs that answer yes to the questions in **Exhibit 1** may especially benefit from programs that employ CHW/Ps.

Exhibit 1. Organizational Assessment

- Does your organization experience lack of trust and barriers to patient engagement, especially among members who have more complex health care needs?
- Do your organization's clinical indicators and feedback from frontline staff demonstrate that you may need to improve your approach in meeting the needs of historically underserved populations?
- Would your members — or a subset of your members — benefit from supports such as
    a. Accompaniment to medical appointments
    b. Assistance using telehealth technology to access care
    c. Access to the appropriate resources to address their social needs
    d. Relationships that uncover barriers that may prevent members from realizing health goals
    e. Choice of cultural and linguistic preferences when accessing health care
- Does your organization have difficulties linking to community-based organizations to address the social needs of your members?
- Have you assessed member health disparities to identify populations who might benefit from a CHW/P program?
- Does your organization struggle to engage members who have behavioral health needs, are experiencing homelessness, or are "hard to find"?
- Does your organization underserve particular demographics or geographic areas due to cultural and linguistic barriers?
- Do you have the budget or approval for appropriate expenditures to recruit CHW/Ps appropriately and at the highest level of competence?

Next, MCPs can evaluate data indicators across different systems that point to broader social needs, frequent hospital admissions, and behavioral health data. This data will help to identify what populations may most benefit from CHW/P services and broader approaches to ECM and ILOS. More information about ECM and ILOS is detailed in **Exhibits 2** and **3**. CHW/Ps provide critical benefits to population health programs, which require customized interventions to meet a broad range of medical and social needs. Each ECM priority population will require specific expertise.

Exhibit 2. ECM Priority Populations[13]
▶ 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) or 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

Exhibit 3. CalAIM Optional In Lieu of Services (ILOS)[14]
▶ 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

Consider Needed Services

As MCPs examine data to better understand priority populations, they should consider existing provider networks and partnerships with CBOs to fill extended service gaps. ILOS can be used together with ECM benefits to best meet the needs of eligible populations. These services are optional for both the Medi-Cal MCP and the member and must offset less clinically appropriate and more expensive services, including hospitalization or skilled nursing facilities.[15] Some examples of these optional services include recuperative care (medical respite), housing deposits, and meals/medically tailored means.[16] The community-connected health workforce, including CHW/Ps, are uniquely qualified in reaching patients who qualify for ECM, building meaningful relationships, and connecting individuals to potential ILOS resources.

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 to 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.[17] Providing housing connected with services for formerly incarcerated people with complex care needs can ensure a safe 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.

Identify Program Goals and Design Program Scope

As organizations begin to develop programs that employ CHW/Ps or integrate CHW/Ps into existing programs, they will need to identify the concrete goals they wish to achieve. All CHW/P roles and responsibilities will flow from these program goals. Programs that employ CHW/Ps are designed to achieve different goals and outcomes with distinct populations. For example, programs may aim to address health-related social needs, decrease missed appointments, increase use of preventive care, increase connections to behavioral health services, provide nutrition and physical activity coaching, strengthen community engagement, or improve patient activation among prioritized populations. By identifying program goals and measurable outcomes upfront and then matching program roles and responsibilities to the outcomes, MCPs and their partners can develop a specific description of CHW/P roles and expectations that increases the likelihood of success. MCPs should set CHW/P program goals with an eye toward outcomes, using the following guiding questions:

- How will your organization measure patient activation or trust?
- How does your organization document and measure health-related social needs?
- What clinical and nonclinical measures would you use to identify the needs of populations served, and who would administer these?
- What are the intended outcomes?
- How would your organization measure success?
- How would return on investment (ROI) be demonstrated?
- How will CHW/Ps be involved in identifying needed program or system improvements?

It is also critical to develop a communication plan or strategy during initial program planning to keep internal and external stakeholders informed regarding program goals, gain and maintain organizational buy-in, and communicate the value and lessons from the CHW/P program.

Once an MCP clarifies program goals, they can tailor a program to meet these needs by considering who is best positioned to serve the population and in what setting (e.g., community or clinic). Then MCPs can establish the responsibilities of the interdisciplinary team and clearly identify specific items to be addressed by the CHW/P position. When determining the size and scope of a CHW/P program, it is helpful to consider

- Program goals
- Size of the priority population and the appropriate CHW/P caseload
- Health disparities and social care needs of the population
- Cultural and linguistic needs of the population

- Capacity of the population to engage with technology and telehealth
- Geographic service area, including considerations for travel time and available transportation
- Data infrastructure, including electronic documentation tools and data exchange capabilities[18]

When considering potential care management partners and programs with CHW/Ps, MCPs should evaluate their own priorities, including quality improvement, member engagement in services, broader population health goals, and cost containment.[19] CHW/Ps can be effective in engaging members who would otherwise not be engaged in care, demonstrating impact for members and an ROI for MCPs.

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. Because CHW/Ps often live in the same neighborhood and share similar experiences with members, they are skilled in connecting with parents and families and supporting them in navigating health and social service resources.

One example shared by a former CEO of an Oregon managed care organization illustrates a CHW/P success story. This managed care organization found disparities based on ethnicity in rates of adolescent well visits and development screenings. They identified the need to engage specific immigrant communities and engaged CBO partners with CHW/Ps with deep ties, knowledge, and trust with those communities to develop successful outreach programs that engaged adolescents and young adults to participate in well visits and developmental screening. As a result, the MCP improved well visit and screening rates with this high-priority population and realized a significant return on this investment.[20]

In California, several care plans that have longstanding CHW/P partnerships established through Health Homes and Whole Person Care pilots found that CHW/Ps were critical in engaging members who would not otherwise engage in programs or services to improve care coordination and health outcomes.

> *"I think the better measures look at engagement or how many members do we have engaged and are we making inroads there? Because 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, L.A. Care, about their Health Homes Program*

Set the Stage for Effective Integration of CHW/Ps

MCPs will need to closely engage staff at all levels to integrate CHW/Ps into their workforce structure, requiring a focus on capacity building and careful planning. Conducting training and engagement at the beginning of program development can support long-term buy-in. The typical structures of health care systems, however, can hinder efforts to easily integrate CHW/Ps. Other barriers can include different funding streams for physical and behavioral health and a lack of data sharing across physical health, behavioral health, community-based organizations, and social systems (such as criminal justice). For example, a health system, Riverside University Health System (RUHS), integrated CHWs within several clinics.[21] Doing so successfully has required being mindful of potential challenges like space for additional staff, issues related to information technology, and purchasing delays. An important strategy for successful integration at RUHS has been continual communication with clinic managers and all levels of staff about the program and real benefits of CHWs in their practices.

It will be important to have regular and open lines of communication, anticipate these potential challenges, identify creative solutions, and develop workflows and systems that address them and smooth the path to implementation.

Explore Partnerships between MCPs and Organizations that Employ CHW/Ps

Designing and implementing a program that employs CHW/Ps often requires MCPs to collaborate with multiple partners. In seeking ways to support CHW/Ps, MCPs can identify opportunities to leverage the skills and assets of external organizations such as providers, health systems, CBOs, training organizations, and state and county authorities. These organizations can lend specific expertise and enhance MCPs' efforts to support members via the CHW/P workforce.

Successful partnerships between an MCP and programs with CHW/Ps 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.

For MCPs to meet the goals of CalAIM implementation, they will likely need to expand their contracting to include organizations with track records employing CHWs who extend medical, mental health, and substance use services into the community. There will be a tremendous need to partner with new stakeholders to effectively support integrated care. These partnerships will require MCPs to develop trusting relationships with all health and social service entities that interface with members.

Assess Partnership Opportunities

One key program design decision is whether MCPs will hire CHW/Ps directly or contract with another organization and locate the position therein. **Exhibit 4** outlines pros and cons for MCPs as they consider options around hiring CHW/Ps directly at the plan level versus contracting with another organization to hire, support, and supervise the workforce.

Exhibit 4. Pros and Cons for MCPs Hiring CHW/Ps Directly vs Contracting with Another Organization to Hire	
MCP Hires Directly	**MCP Contracts Out**
PROS ▶ MCPs can develop a more direct understanding and appreciation for the value of the CHW/P workforce. ▶ MCPs can build internal care management services that include the role of CHW/Ps. ▶ MCPs can better control staffing ratios by engaging with CHW/Ps across all their members eligible for these services. ▶ MCPs can achieve better integration of CHW/Ps within their interdisciplinary teams. ▶ MCPs can incorporate CHW/Ps into overall operational costs, which may be a more sustainable payment model than that for a contracted CBO. ▶ CHW/Ps will experience limited barriers to data sharing.	**PROS** ▶ MCPs can place the CHW/P resources closer to the communities they are serving. This supports the CalAIM ECM requirement that members receive services where they want, including home or the community. ▶ MCPs can rely on the strong, existing expertise of partner organizations to hire, support, and supervise CHW/Ps. ▶ MCPs can leverage the strengths of CBOs with a history of integrating CHW/Ps into their workforce, who may have a better sense of appropriate roles and responsibilities. ▶ CBOs are often trusted members of a community and have strong connections to the community. MCP members can benefit from these existing connections, which can be hard for MCPs to build from scratch. ▶ CBOs can support MCPs in finding culturally specific programs, organizations, and services. ▶ CBOs often have more direct access to other social supports that they can connect members to.
CONS ▶ MCPs may not already have the supervisory structure or organizational culture necessary to support a CHW/P in being successful. ▶ MCPs may be limited in reaching populations with distrust of health care systems. ▶ MCPs may risk overmedicalizing the CHW/P's role, and potentially disconnecting the CHW/P role from the community they seek to serve.	**CONS** ▶ Low-volume providers may not have adequate panel size to support the organizational capacity building and training that is needed to support a CHW/P program. ▶ Lack of infrastructure at some CBOs impedes contracting, reporting, and payment. ▶ Data-sharing barriers may be more prevalent.

If MCPs decide to partner with an external organization that administers programs with CHW/Ps, they should consider the types of organizations that are best suited as partners. This assessment will be based on the program goals and populations of focus. For example, MCPs looking to develop a comprehensive approach to engage the ECM priority population of "high utilizers with frequent hospital admissions" and significant health-related social needs should look to CBOs and providers that employ CHW/Ps and bring extensive experience engaging this population. 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. Similarly, for the ECM priority population, “individuals at risk for institutionalization who are eligible for long-term care services or nursing facility residents who wish to transition to community,” CHW/Ps can play a key role in navigating resources, liaising with family members, and addressing cultural preference to keep people aging in place at home.

Below are suggested steps for MCPs to research, assess, and engage potential CHW/P program partners.

- **Conduct a crosswalk or assessment of the potential priority populations, needed services, existing partnerships, and allowable financing arrangements.** Assessment activities should focus on CalAIM requirements and MCP strategic priorities. This assessment can allow a plan to determine what providers and partners are already engaged, what additional partners and services are needed, and how to best structure reimbursement and financing for these services.
- **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. Although 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 CHW/Ps. Other CBOs and providers might be using CHW/Ps or peers in services already. In examining integration with health systems and FQHCs, they can look at their own network, including current services and performance. Other MCPs, health systems, training organizations, and affinity groups can provide information on potential programs with CHW/Ps in their region(s). MCPs can also look to partner organizations and consumer advisory boards to guide partnership ideas and better understand community-specific health needs.
- **Assess the expertise and outcomes of available programs that employ CHW/Ps.** In assessing potential program partners, MCPs should seek to understand the staffing, program model, population expertise, and specific value that organizations bring to a potential partnership. MCPs should examine program outcomes and provider and CBO 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.
- **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.[22] 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. MCPs can play an important role in supporting partners who are new to integrating CHW/Ps and contracting for services more generally. MCPs can help partners in identifying opportunities for ROI, investing in provider capacity, and supporting needed infrastructure to be successful.
- **Determine the size and scale of the contracting arrangement.** As MCPs pursue a potential contractual arrangement with partners to integrate CHW/Ps, it is helpful to consider the scale of the partnership in 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 and set expectations for the volume of work that an organization may get from the MCP under the arrangement.

- **Determine capacity to integrate CHW/Ps successfully into MCP and partner workflows.** While MCPs are determining appropriate partners, it is important to lay the groundwork for approaches to program design and implementation. Common challenges that can be discussed and assessed within the contracting stage include workflow changes, workflow arrangements between partners, and key point people at the MCP and partner organizations who can address workflow challenges.

Develop Strong Contractual Partnerships

When MCPs decide to partner with external organizations that employ CHW/Ps, they will need to develop contract agreements that support sustainable and effective programs. Additionally, they will need to establish strong communication around aligned goals and protocols.

Core Contract Components between MCPs and Partner Organizations

MCPs can support programs with CHW/Ps by developing the core contract components with CBOs and providers. 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. Many MCPs have experience contracting or building their own programs under Health Homes and Whole Person Care pilots. Inland Empire Health Plan, for example, funded annual salaries of CHW/Ps within their own CHW/P program for the Health Homes Program.

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

As MCPs develop contracts to engage CHW/Ps, they can consider the types of training needs, data infrastructure, and appropriate caseloads given ECM priority populations and ILOS options and how these benefit and financing models can help support the integration of CHW/Ps into the care delivery system. Training and data infrastructure costs are critical investments that need to be considered when developing a contractual agreement and designing the program. Appropriate caseloads of patients to CHW/Ps varies in the context of the team composition, experience of staff, and needs of patient population. For example, LA County Department of Health Services has a caseload size of 10–35 patients per CHW[23] and Riverside University Health System has a ratio of 25 patients per CHW for those that are based in the community.[24] For more information, see Resource Package #1: "The Role of CHW/Ps in Health Care Delivery for Medi-Cal Members."

It is important for MCPs to work in partnership with provider and CBO partners to ensure that contracting and programmatic agreements eliminate potential barriers for CHW/Ps in doing their work. **Appendix A** includes sample 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 outline specifics for the agreement.

Facilitate Effective Contracting Arrangements

MCP and programs with CHW/Ps have constraints and differences related to legal support, data infrastructure, and financial stability, impacting how these programs can effectively partner. Although these differences pose challenges in developing partnership arrangements, understanding potential limitations and providing flexibility can help support successful partnerships. A list of potential contract terms for consideration by MCPs and their partners is included in **Appendix A**.

In pursuing contracting arrangements, it is important to 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 — of each partner's role on the care team.[25] This will ensure that services are not duplicated and will provide 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 it critical to establish realistic expectations for program outcomes for short- and mid-term time frames.[26] In developing these partnerships, it is unrealistic to expect an immediate ROI. Many programs with CHW/Ps 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 CHW is what delivers the hemoglobin A1C [diabetes monitoring test] going from 9 to 7.5."

There are specific considerations for CHW/Ps who 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.

Sustain Strong Programs that Employ CHW/Ps

Successful integration of CHW/Ps requires the leadership and buy-in of executives and clinical staff. A strategy that one MCP in California used was identifying how outcomes meet specific priorities for leadership. For example, staff were able to make the case that CHW/Ps were much more successful in engaging and enrolling patients at the bedside into programming and services. Staff were then able to make the business case argument that CHW/Ps were essential to increasing the revenue that relied on per-member per-month funding.

Next, it is important to ensure capacity to measure success and make changes as needed, by continuously tracking, measuring, and pivoting approaches based on operational effectiveness and outcomes. For one hospital-based

CHW/P program in New York City, an early commitment to program design and the ability to track effectiveness was identified as important in sustaining funding and buy-in.[27]

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 (EHR) 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 pilots co-designed program goals and met regularly to troubleshoot challenges and address barriers.[28]

> *"Health care is usually this vertical hierarchy — 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 a voice (and) are expected to speak and advocate and share their opinions..."*
>
> *— Catherine Knox, Inland Empire Health Plan*

Develop Incentives and a Financial Sustainability Plan

One way MCPs can reward quality among partners and address the direct and indirect cost of programs that employ CHW/Ps is to adopt alternative payment models that support enhanced care delivery and improved outcomes. For example, capitated rates with quality incentives can encourage the coordination between physical health, behavioral health, and social needs for patients. CHW/Ps are uniquely able to coordinate these disparate services within their own communities and connect individuals to appropriate formal and informal services that address social needs.

Spotlight on CHW/P Model

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 CHWs on the achievement of specific quality measures. An Ohio-based Pathways HUB model focused on improving care for newborns produced an average 236 percent ROI.

Under CalAIM, DHCS is proposing a variety of funding changes and alternative payment models to promote the integration and expansion of CHW/Ps.

- **MCP incentives linked to quality and performance improvements**. These payments could potentially support pilot integration of CHW/Ps for specific priority areas, populations, or quality improvement goals that involve ECM and ILOS.[29] Incentives can be passed down to organizations that employ CHW/Ps and which are meeting these quality targets. This funding can be used to make critical investments in the workforce, including ensuring fair pay, sufficient supports and training, and career pathways. Incentive payments were also a critical tool for Coordinated Care Organizations in Oregon, in addition to capitated global budgets.[30] For example, an Eastern Oregon CCO has used their quality incentive funds to support the training and certification of CHW/Ps for the past several years. CHW/Ps can achieve an ROI using global payment models and the MCP is then able to reinvest some of this funding into training programs.[31] This is a model that California could consider in its incentive program structure.
- **Shared savings and incentive methodologies will involve MCP and other stakeholders**. Shared savings models can be used as a mechanism to reward partner organizations in achieving benchmarks and quality goals. One way agencies can use shared savings models is to pay for potential career pathways and opportunities for CHW/P advancement. One former MCP CEO noted that a key barrier in integrating the CHW/P workforce is turnover and the retention of high-quality CHW/P workers.[32] Competitive salaries and clear pathways for development is one way to mitigate this challenge.[33] Career development and interest in higher salaries was a high-priority need listed by CHW/Ps in California.[34] Creating the ability for Medi-Cal MCPs to use these financing methods to increase retention and build provider capacity should be explored and can be made explicit in guidance from DHCS to create a sustainable CHW/P workforce.

Support the CHW/P Workforce

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

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

Effective programs that retain high-quality CHW/Ps as members of interdisciplinary teams have several common features in their program design. First, many of these programs create pathways for CHW/P advancement, such as through a senior CHW/P position, as well as opportunities for increased compensation with more experience. They also develop a salary scale that considers market rates, , lived experience, and skills, and have opportunities for full-time positions with salary increases over time. Employees in other positions, such as care coordinators, may be strong candidates for the CHW/P position, and salary flexibility may be a cost-effective strategy to recruit employees with the right skills and experience. These programs may consider training opportunities for otherwise qualified individuals who may not have requisite skills and experiences, such as computer literacy or written English proficiency. Other incentives to support CHW/P sustainability include providing self-care resources and facilitating opportunities for CHW/Ps to provide input on program design, workflow, and improvements.

The low rate of pay and short-term funding streams is a significant challenge for the CHW/P workforce overall. In a stakeholder forum with CHW/Ps in California, improving salaries and compensation, ensuring sufficient support through strong supervision, and clear pathways for growth were mentioned as key needs.[35] MCPs can work with providers, CBOs, and CHW/Ps to ensure that salaries and benefits are aligned with living wages and comparable to local standards (e.g., consider salaries within public health departments and clinics that are doing comparable work).

Developing continuous funding streams can help ensure continuity to the care management intervention and broader CHW/P program overall. Competitive salaries, supports, and benefits can play a key role in retaining a high quality workforce, which can positively impact the MCP's ROI.

Spotlight on MCP Approach

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

Infrastructure Barriers and Solutions

Developing sustainable programs and partnerships that integrate CHW/Ps requires an understanding of the different expertise, culture, goals, and challenges of each partner. Although these differences can result in common barriers, with deliberate flexibility and planning, partners can implement solutions to overcome these challenges.

Funding Differences

Many programs, specifically CBOs and behavioral health 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. Although these programs operate with less continuous funding, CHW/Ps play a critical role in addressing the complex challenges in health care, including population health and the reduction of racial disparities in care. For MCPs and organizations that employ CHW/Ps to 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. Although grant funding can be helpful in filling gaps, it will not sustain ongoing program operations.

Infrastructure Needs

Programs with CHW/Ps likely need resources and financial support for data, technology, and legal infrastructure to meet the requirements of plans around data collection, reporting, and even contract negotiation and implementation. Under the CalAIM incentive funding, DHCS has indicated that it will use $1.2 billion incentive funding available over three years for eligible MCP partner organizations to promote participation and capacity building for the implementation of ECM and ILOS, which specifically includes investments in delivery system infrastructure development and workforce capacity. MCPs will submit Gap-Filling Plans, and DHCS will determine how to appropriately allocate the funding across the state within three priority areas:

1. **Infrastructure development**: Core MCP, ECM, and ILOS provider Health Information Technology (HIT) and data exchange infrastructure for the delivery of ECM and ILOS.
2. **ECM capacity**: ECM workforce training, technical assistance, workflow development, operational requirements, and oversight capacity.
3. **ILOS uptake and capacity**: ILOS training, technical assistance, workflow development, operational requirements, take-up, and oversight.

Because WPC and HHP counties may have some capacity because of existing pilot funding, counties with less infrastructure will potentially receive a higher proportion of the incentive payment dollars. Additionally, the amount of potential incentive payment funding within a county will also be increased based on the proportion of enrollees who are members of the ECM focus populations to ensure capacity to provide sufficient access to ECM in those counties.[36]

Data Infrastructure and Technology

Many CBOs and programs with CHW/Ps have different types of care management systems to manage projects as well as client data and lack needed data infrastructure and technology.[37] It is important for MCPs and organizations that employ CHW/Ps from pursuing a potential partnership to 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 Resource Package #3: Data and Evaluation Considerations for CHW/Ps Supporting Health and Social Care Integration for Medi-Cal Members includes additional considerations specifically on this topic. MCPs should work with partners to determine data capabilities and compatibility with EHR systems. Incentive dollars could be used to create an interface to EHR systems or upgrade an EHR system to create compatibility, all of which is critical to tracking outcomes, quality reporting, and billing.

One former MCO CEO in Oregon reflected that the plan needed to demonstrate flexibility and recalibrate expectations around data capacity.[38] 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 the Health Home pilots was ensuring effective ramp-up costs for CBOs to make necessary investments in technology and data before program launch.[39] MCPs should work with CBO partners to better understand what investments are needed to effectively integrate CHW/Ps and support investments where possible. The flow of data and security protocols should be outlined in contracting, training, and in shared workflows and policies.

Legal Infrastructure

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

Resources and Tools

Sustainable Funding Models

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 CHW 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 the CDC covers topics such as community clinical linkages, CHWs' financing approaches, Medicaid, and CHW financing opportunities and the New Mexico story for financing CHWs.

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 documentation and billing workflows.
South Dakota Medicaid Billing and Policy Manual: Community Health Worker	This resource from South Dakota Medicaid outlines the CHW covered and non-covered services as well as well as billing codes.
Sustainable Financing Models for Community Health Worker Services in Maine	UMass Medical School health policy experts have developed sustainable financing models for the state of Maine to support four community health worker (CHW) interventions that focus on patients with the greatest, and most costly, health care needs.
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 for the integration of CHW/Ps through Medicaid reimbursement for states that want to start or expand such programs.

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 CHWs' perspectives on job satisfaction and career advancement and informs the design of a career development program.

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.
Community Health Worker Payment Model Guide	This is a resource that provides additional considerations for salaries and sustainable funding mechanisms for CHW/Ps.

Designing Program Scope

RESOURCE TITLE	BRIEF DESCRIPTION
Readiness Assessment Tool to Secure Financing for Community Health Workers	This Readiness Assessment Tool, developed by the CDC, will allow chronic disease programs and their partners to assess current initiatives for securing financing for CHWs in their state and identify sustainability strengths and challenges
Benchmarks for Reducing Emergency Department Visits and Hospitalizations Through Community Health Workers Integrated Into Primary Care	This journal article demonstrates the cost-saving benefits of CHWs helping with chronic disease management. It also provides examples of CHW caseload sizes.

Appendix

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 hospitalization with serious mental illness (SMI) or 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

Contract Section	Contract Elements
1. SCOPE OF SERVICES *(continued)*	▶ 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 ▶ 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

Contract Section	Contract Elements
2. MEASURING AND IMPROVING OUTCOMES *(continued)*	**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 ▶ 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 • Identification of value metrics • Identification of financial risks, rewards, or shared savings • Determine if cost information will be exchanged • Incentive structure, if applicable • Funding for start-up/infrastructure development

Contract Section	Contract Elements
3. PAYMENT REQUIREMENTS *(continued)*	**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 • Emergent issues • Problems in process related to referrals and/or data • Financial risk issues **Sharing Data** ▶ 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

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