Community Health Workers and *Promotores* in Enhanced Care Management and In Lieu of Services: A Model of Care Resource

A Project of the California Health Care Foundation

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

Purpose

This document was developed as a resource for managed care plans completing the CalAIM Model of Care Template. The chart that follows indicates the potential role that CHW/Ps contracted via established local organizations can play in the enhanced care management (ECM) core services and in lieu of services (ILOS).

This document provides insight into:

- How CHW/Ps can support outcomes, produce data, and build relationships necessary for program delivery and reporting
- How CHW/P services align with billable encounters

Audiences

Appropriate audiences for this resource include:

- Managed care plans (MCPs)
- Community-based organizations (CBOs) and primary care and behavioral health providers incorporating a CHW/P into their ECM care team or ILOS services
- CHW/P training entities

Development

This resource was produced by Heidi Arthur, Laura Collins, Lauren Ohata, and Nayely Chavez (Health Management Associates) and informed by Shannon Mong (In-Sight Associates) for the California Health Care Foundation (CHCF) *Community Health Workers &* Promotores *in the Future of Medi-Cal* project This material was based on the Draft CalAIM Model of Care Template, which was released for public comment in June 2021. It has been reviewed by members of the project's Stakeholder Group who provided input on the needs of the CHW workforce in California and MCP needs related to CHW/P integration.

Chart Structure

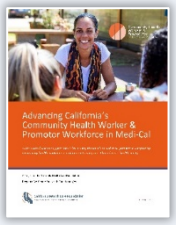
For each core ECM service component, the chart identifies the key function(s) involved, the function a CHW/P could perform, the specific potential CHW/P role and responsibilities, and whether such capacity must be present when the CHW/P is hired or can be developed via training and supervision. ECM/ILOS functions will not be the sole function of a CHW/P, but will instead be conducted by a team, with a lead CM who can be supported by a CHW. In some cases, the lead CM could be a CHW/P.

As part of their role in ECM Core Services, CHW/Ps can facilitate identifying member eligibility for and connection to ILOS, for those MCPs planning to implement ILOS. The chart details how that role can be integrated into the CHW/P's role for ECM, just as CHW/Ps can support identifying member eligibility for and connection to other local community-based services.

Identified functions are not intended to be prescriptive or comprehensive, as the CHW/P role, tasks, activities, and scope will necessarily vary by member, contracting entity (i.e., primary care providers, behavioral health providers, community-based organizations, or counties), and team composition — as well as CHW/P skill, experience, and certifications (e.g., more experienced CHW/Ps know how to address more of these functions).

Learn More

This resource is part of the *Advancing California's Community Health Worker &* Promotor *Workforce in Medi-Cal* Resource Center. The Resource Center and accompanying Resource Guide are a compilation of resources and information gathered by the California Health Care Foundation as part of a project to better integrate community health workers and *promotores* (CHW/Ps) into California's health system. To learn more, visit **www.chcf.org/chwps-medi-cal**.



ECM Core Service: Outreach

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Requirements for conducting outreach primarily through in-person contact.*	Community-based outreach	• Prioritize in-person contact where the member lives, seeks care, or is accessible. • Conduct home visits to support engagement in care management.	• Comfort and skill conducting home visits.	✓	✓
Use of other modalities for outreach, including how and under what circumstances teleconferencing and telehealth may be used to supplement in-person contact; number of required attempts.*	Engagement	• Explore the member's preferences for communication and leverage multiple options, as necessary, to retain contact and liaise on behalf of the care manager and care team. • Use the following modalities, as appropriate, if in-person modalities are unsuccessful or to reflect a member's stated contact preferences: (a) mail; (b) email; (c) text; (d) telephone; (e) video conferencing; or (f) other protected communication tools, such as member portal.	• Ability to ensure that a minimum number of required outreach attempts is made to engage and then maintain member engagement. • Able to manage multiple member relationships via multiple simultaneous communication channels to orient and enroll members in ECM.	✓	✓
Prioritization of those with the most immediate needs.*	Risk screening	• Build rapport with the member and gather information, as necessary for risk screening and stratification. Conduct risk screening and interpret the results.	• Able to utilize and to interpret standardized screening tools. • Able to review the member's chart. • Ability to identify needed documents, data, and assessments. • Able to check in with the supervisor and team regarding clinical gaps and priorities.		✓
Approach to outreach to members who are experiencing homelessness or with whom it may otherwise be challenging to make contact.*	Outreach to those who are homeless or hard to find	• Utilize personal knowledge of the specified member population and knowledge of local community and geographic area to actively seek, find, and engage members who might otherwise be hard to find.	• Proactive and self-directed. • Creative and flexible. • Familiarity with the population of focus and local community, including the people, places, and programs where the identified population is likely to be found and where engagement opportunities are supported.	✓	✓

** Activity related to ILOS.*

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Requirements for culturally and linguistically appropriate communication.*	Culturally competent communication	• Communicate with the identified populations for which each ECM provider is responsible, in their preferred language, utilizing strategies that reflect the member's values, attitudes, and beliefs. • Engage with the member and their family in the language and style that the member prefers, serving as a cultural broker for the care manager and care team, on the member's behalf, when necessary.	• Person is culturally and geographically connected to a traditionally underserved population with complex needs. • Person is able to linguistically respond to the member and the member's caregiver/family.	✓	✓
Real-time or frequent information sharing between the MCP and ECM Providers, to ensure that the MCP can assess members for other programs if they cannot be reached or decline ECM.*	Documentation of outreach attempts	• Track and document outreach efforts to ensure that contractual time frames are honored. • Provide timely reporting when members cannot be found, engaged, or choose not to enroll in ECM. • Facilitate engagement in alternate services, as indicated, when members choose not to enroll in ECM.	• Self-directed and able to organize and plan activities as necessary to effectively manage time, meet targets, and ensure thorough documentation and follow-up. • Able to seek guidance from supervisor and care team, as needed.	✓	✓
How the MCP will facilitate information sharing between ECM providers and the MCP in a way that meets local, state, and federal privacy and security rules and regulations.*	Confidentiality protection	• Able to understand and comply with state and federal member protections related to confidentiality and information sharing. • Able to communicate with the member about state and federal confidentiality protections.	• Knowledge of HIPAA rules and regulations, including member rights and responsibility and procedures for reporting HIPAA violations.		✓

** Activity related to ILOS.*

ECM Core Service: Comprehensive Assessment and Care Management Plan

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Identify necessary clinical and nonclinical resources that may be needed to appropriately assess member health status and gaps in care.	Risks, needs and strengths assessment	• The following activities are provided either directly or in support of the ECM: • Utilize standardized tools and instruments to assess holistic risks and needs. • Make initial referrals as necessary to completely assess member needs.	• Ability to engage members in the manner that works for each person to complete risk assessment. • Knowledge of local system of care and resources available to conduct rapid assessments.	✓	✓
Developing a comprehensive, individualized, and person-centered care plan by working with the member to assess risks, needs, goals, and preferences and collaborating with the member as part of the ECM process that leverages input from multidisciplinary care team members, support networks, and caregivers, as appropriate.	Goal setting and prioritizing	• Support member in identifying strengths and needs and in setting priorities for achievable short- and long-term goals. • Identify and obtain contact information for the family members, peers, friends, caregivers, and providers who the member wishes to include in care planning. • Obtain contact information and support outreach to schedule care team meeting with member.	• Ability to establish and build Member trust and willingness to participate in goal setting and care planning.	✓	✓
Incorporating into the member's care management plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorder (SUD), long term services & supports (LTSS), oral health, palliative care, necessary community-based and social services, and housing.	Care team identification, convening, and facilitation	• Utilize motivational interviewing and other evidence-based approaches to support members in achieving their goals.	• Person-centered care planning skills, motivational Interviewing skills, and other evidence-based approaches, such as problem-solving treatment and behavioral activation. • Skills based on harm reduction principles.		✓
Ensuring the member is reassessed at a frequency appropriate for the member's individual progress or changes in needs and/or as identified in the care management plan.	Individualized care plan development	• Support member to participate in the care team as needed, including providing transportation, translation assistance, and encouraging member partnership regarding needs and preferences.	• Flexible and creative problem-solving to support member engagement in their care plan (e.g., obtaining a cell phone or data card from the MCP; assisting in setting up teleconferencing, downloading required application, assisting with first-time use).	✓	✓
Ensuring the care management plan is reviewed, maintained, and updated under appropriate clinical oversight.	Re-assessment and care plan updates	• Sustained engagement with members to rapidly intervene when status changes or updates are otherwise necessary. • Documentation and care plan development.	• Documentation skills and capacity to provide routine check-in contacts in person or via member preferred method.		✓

** Activity related to ILOS.*

ECM Core Service: Enhanced Coordination of Care

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Organizing patient care activities, as laid out in the care management plan, sharing information with those involved as part of the member's multidisciplinary care team, and implementing activities identified in the member's care management plan.	Guide care plan implementation	• Based on CHW experience, the CHW may act as the lead care manager or as a care management extender. • CHW coordinates with the member, caregivers, and providers/programs as necessary to ensure the care plan is implemented based on member priorities and goals.	• Ability to build rapport with members to ensure that members' voices are both heard and documented with regard to their priorities and needs toward achievement of the members' goals.		✓
Maintaining regular contact with all providers who are identified as being a part of the member's multidisciplinary care team, whose input is necessary for successful implementation of member goals and needs.*	Coordinate care team communication	• Outreach, when necessary, to the member and to providers to confirm access, resolve barriers, and facilitate seamless attention to integrated and trauma-informed care. • Expedited, seamless closed-loop referrals to treatment and services. • Routine documentation in a shared care plan used by all members of the ECM team.	• Capacity to communicate effectively with a range of professional providers.	✓	✓
Ensuring care is continuous and integrated among all service providers and referring to and following up with primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, ILOS, and housing, as needed.*	Coordinate access to care	• Support lead care manager by facilitating the member's access to the clinical and community services necessary to implement the member's care plan. Communicate with the member and the member's providers to ensure that comprehensive whole person needs are identified and addressed.	• Meet with members in their home or other preferred location to identify and discuss medical and nonmedical needs, progress with recommended behavior changes, access to care, and referral follow-up.		✓

** Activity related to ILOS.*

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Providing support to engage members in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to member engagement in treatment.*	Support for treatment adherence, including compliance with medication and attendance at appointments	• Know and represent the member's perspective and priorities to ensure that care planning is realistic and responsive to each member's individual circumstances. • Leverage home-based access to the member to monitor and improve treatment compliance and medication adherence. • Identify member's prescriptions and over-the-counter medications. Review the member's understanding of use and administration of medication or medical devices. • Conduct medication reviews to inform reconciliations. • Arrange transportation to fill prescriptions. • Conduct visits to check in with the member and report back to the care team about progress in the ECM program. • Work with members to identify and document their personal network of supports and program participation, should members need to be located in the future.	• Capacity to conduct and/or participate in root cause analysis to identify "barriers below the surface." • Capacity to provide interventions that reflect the principles of harm reduction.		✓
Communicating the member's needs and preferences timely to the member's multidisciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.*	Member advocacy	• Review appointments and support scheduling and rescheduling. • Identify barriers to treatment adherence and/or high-risk behaviors for the member and the care team to consider care plan adjustments, when necessary.	• Capacity to communicate with members and maintain trust and rapport.	✓	✓
		• When needed, accompany members to clinic visits. May also support visits virtually, as appropriate.	• Capacity to support members to attend appointments.	✓	✓

** Activity related to ILOS.*

SERVICE COMPONENTS	KEY FUNCTIONS	CHW FUNCTION	CHW ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PRE-REQUISITE	VIA TRAINING/ SUPERVISION
Ensuring regular contact with the Member and their family member(s), guardian, caregiver, and/or authorized support person(s), when appropriate, consistent with the care plan.	Ongoing engagement	• Engage with the Member using the Motivational Interviewing approach. • Provide trauma-informed, harm-reduction, and other evidence-based interventions when necessary to promote Member wellness. • Collaborate with Members in making necessary adjustments to their Care Plan. • Engage Members with regard to medical and behavioral health crisis prevention plans (e.g., the Wellness and Recovery Action Plan, or WRAP) to obtain Members' treatment preferences and preferred contacts that can be utilized as a crisis prevention or stabilization tool.	• Knowledge and skilled in the Motivational Interviewing, Harm Reduction, and Trauma-Informed Care approaches.		✓
			• Sustain ongoing engagement with the Member, the Care Team, and the Care Manager, as indicated to support Member goal achievement.	✓	✓

** Activity related to ILOS.*

ECM Core Service: Health Promotion

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Working with members to identify and build on successes and potential family and/or support networks.	Identify opportunities for health within member's current or potential network	• Health promotion and self-management training for member, integrating support from family and community resources as indicated. • Assist with linkage to social supports.	• Knowledge of and ability to liaise with local health and wellness resources to make referrals and engage in follow-up related to member health conditions, including physical and mental health promotion.		✓
Providing services to encourage and support members to make lifestyle choices based on healthy behavior, with the goal of supporting members' ability to successfully monitor and manage their health.	Health education and coaching	• Distribute health promotion materials. • Provide one-on-one education. • Conduct group classes.	• Reinforce and encourage healthy behaviors. • Provide motivational interviewing skills and health coaching skills.		✓
Supporting members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.	Support for self-management to achieve wellness goals	• Provide consistent follow-up regarding member-identified goals. • Offer coaching and social support to enhance motivation. • Model, role play, and practice member-directed engagement in care, including activities such as scheduling appointments and assessing member status to inform health behavior change efforts, care plan updates, and treatment decisions.	• Motivational interviewing skills; health coaching skills; care coordination skills; specific health promotion interventions in areas such as, but not limited to, healthful eating, physical activity, alcohol and drug abuse prevention, breastfeeding, asthma management, and prevention and management of cardiovascular disease, type 2 diabetes, and overweight/obesity.		✓

** Activity related to ILOS.*

ECM Core Service: Comprehensive Transitional Care

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PRE-REQUISITE	VIA TRAINING/ SUPERVISION
Strategies to reduce avoidable member admissions and re-admissions across all members receiving ECM.	Inpatient admission/ re-admission prevention	• Support members and their care teams to identify risks to their stability in the community.	• Lived experience or prior experience supporting transitions to the community.	✓	
		• Ensure that each member's care plan includes member-developed strategies and strategies, identified by the member, to prevent avoidable admissions and build member capacity to become self-sufficient: • organizational skills (medication lists, appointment planning, PCP and specialists contact information). • Assess and support member understanding of discharge orders and follow-up plans.	• Ability to engage members within hospitals, facilities, and institutions; support care planning for community (re)integration.		✓
For members who are experiencing or are likely to experience a care transition: (a) Developing and regularly updating a transition plan for the member; (b) Evaluating a member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges; (c) Tracking each member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members; (d) Coordinating medication review/ reconciliation; and (e) Providing adherence support and referral to appropriate services.	Transition planning	• Work with members who are transitioning from inpatient or institutional settings to community-based care to develop transition plans that include support to access social services and attend health care appointments. • Support members to participate with inpatient treatment staff on the transition plan. • Provide advocacy on behalf of the member with health care professionals.	• Capacity to engage member in discussion of (1) treatment plan, including medications, (2) medication adherence, and (3) health literacy.		✓
	Support for treatment adherence, including medication review and reconciliation	• Monitor treatment adherence (including medication) and identify necessary adjustments to the transition plan based on the member's adherence with treatment, including medication reconciliation. • Arrange transportation as needed and communicate with member and care team to facilitate care coordinated visits.	• Ability to coordinate access to transportation.		✓

** Activity related to ILOS.*

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PRE-REQUISITE	VIA TRAINING/ SUPERVISION
Technologies, tools, and services that can be deployed and used to provide real-time alerts that notify ECM and care team members about care transitions (acute and subacute care facilities, ED, residential treatment facilities, incarceration, etc.) and other critical health and social determinant status changes (e.g., housing and employment).	Use technology, tools, and targeted interventions to support successful community integration and avoid re-admission	• Leverage technology to monitor risks to member's stability in the community and promote effective care delivery.	• Ability to use technology or learn interventions necessary to support member wellness.		✓

** Activity related to ILOS.*

ECM Core Service: Member and Family Supports

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Documenting a member's chosen caregiver(s) or family/support person.	Identifying family support	• Engage the member in identifying family supports, including caregivers, "chosen kin," and peer supports.	• Capacity to engage members in identifying available support.	✓	✓
Including activities that ensure the member and chosen family/support persons, including guardians and caregivers, are knowledgeable about the member's condition(s) with the overall goal of improving the member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.	Family engagement	• Engage member and family in discussion of member health needs and goals. • Utilize health materials to inform family members about the member's health conditions and the role they can play to support the member. • Engage member in developing strategies that leverage caregiver and family support to assist them in achieving care plan goals.	• Capacity to engage family supports in member care, identifying strategies that promote adherence, health promotion, and wellness.	✓	✓
Ensuring the member's ECM lead care manager serves as the primary point of contact for the member and chosen family/support persons.	ECM single point of contact	• Communicate with family and member regarding ECM primary care manager and care team roles. Facilitate communication as indicated based on role.	• Streamlined communication via lead care manager, in person, via email, text, and phone and other virtual communication as indicated.		✓
Identifying supports needed for members and chosen family/support persons to manage members' conditions and assist them in accessing needed support services.	Connection to wellness supports	• Engage member and family to identify assistance necessary to support member goals.	• Knowledge of available health supports and resources, including ILOS.		✓
Providing for appropriate education of the member, family members, guardians, and caregivers on care instructions for the member.	Health education	• Utilize health materials to inform members and their families about members' health conditions.	• Knowledge of resources, including care team members, and ability to coordinate and communicate effectively with informants and members.		✓
Ensuring that the member has a copy of care plan and information about how to request updates.	Sharing the care plan and updates with member	• Provide care plan to member, including updates.	• Ability to appropriately transmit electronically or in hard copy the member's care plan.		✓

** Activity related to ILOS.*

ECM Core Service: Coordination of and Referral to Community and Support Services

SERVICE COMPONENTS	KEY FUNCTIONS	CHW/P FUNCTION	CHW/P ROLE AND RESPONSIBILITIES FOR FUNCTION	CAPACITY	
				PREREQUISITE	VIA TRAINING/ SUPERVISION
Determining appropriate services to meet the needs of members, including services that address social determinants of health needs, including housing, and services that are offered by the MCP as ILOS.*	SDOH service planning; ILOS screening and eligibility assessment	• Support members to identify their full array of needs. • Ability to identify and support members who have low literacy and numeracy skills. • Make closed-loop referrals to local human service system to support members in addressing their SDOH needs including but not limited to housing, food, personal safety, transportation, childcare, energy assistance, education, income assistance, education, etc. • Ensure that each member who is authorized to receive a particular ILOS is appropriately outreached and oriented about the service. • Coordinate with members and their families to facilitate the members' agreement to the receipt of that ILOS and authorization for the data sharing and reporting necessary to support members' successful engagement and appropriate utilization of the ILOS service.	• Understanding of SDOH needs, knowledge of local resources, and ILOS services. • Capacity to initiate conversations about the member's needs, including issues related to food and housing security and personal safety that may require initial trust building. • Capacity to provide warm handoffs to local service providers, including ILOS provider(s). • Capacity to track and manage closed-loop referrals. • Skills related to supporting the member, member's family, and the member's care team to access needed services and ILOS.	✓	✓
Coordinating and referring members to available community resources and following up with members to ensure services were rendered (i.e., "closed-loop referrals").*	Closed-loop referrals	• Provide warm handoffs for members to identified individuals locally able to address the SDOH needs. • Open, track, and manage referrals for community and support services. • Follow-up as necessary to ensure that the need has been met. • Ensure that members know how to use the available resources to benefit from those services.	• Knowledge of and personal connections to local resources. • Capacity to support efficient planning to target priority needs. • Able to utilize tools and processes to close referral loops and track services.	✓	✓

** Activity related to ILOS.*