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

Advancing California's Community Health Worker & *Promotor* Workforce in Medi-Cal

Model Contract Terms

The following includes a list of potential contract terms for managed care plans (MCPs) to use with partners — community-based organizations (CBOs), counties, and other organizations that employ community health workers and *promotores* (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 • People 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

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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 **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 - Improved behavioral health outcomes, including self-reported health, adherence to behavioral health appointments

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2. MEASURING AND IMPROVING OUTCOMES *(continued)*	• 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 **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

CONTRACT SECTION	CONTRACT ELEMENTS
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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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.