Cal SIM Community Health Workers
Workgroup Meeting
August 15, 2014

Attendees: Carol West; Gloria Robertson; Barbara Masters; José Ruiz-Salas; Wendy Soe; Tim Berthold; Marci Aguirre; Alma Avila; Maria Lemus; Diane Factor, Scribe: Jennifer Bernstein

1. Debrief on Community Forums with CHWs

Two Community forums were held: one on July 18th in LA, and one on August 8th in Oakland. Workgroup members were thanked for their efforts to identify participants, secure space, help facilitate the forums and attend. A total of 50 Community Health Workers attended the forums. The forums had significant racial, ethnic, and gender diversity, as well as diversity with respect to the types of organizations and geographic representation.

Some of the questions asked at the forum:

- What is fulfilling/rewarding about your job?
- What aspects of your job do you think are the most important?
- What is your contribution in terms of improving the health of the people you work with, with regard to data/collection and linking to the health care system?
- What roles/skills/qualities/characteristics do they feel are most important in terms of roles CHWs play
- What type of training and supervision do you find most helpful?

Workgroup members offered the following observations from the meetings. Forum participants:

- Expressed that the most fulfilling/rewarding aspects of their jobs were about making a difference, the relationships they build, outreach, and serving as a linkage between the broader health system.
- Play various roles with respect to data. They recognize that there is an important need to collect data, but there were questions about how to collect quality over quantity and how to connect with consumers while at the same taking down notes.
- Engaged in significant discussions about additional roles that could be played in order to further improve the health of their communities.
- Discussed the importance of working better with other health practitioners both in the clinic or in the community; many also commented that it is critical that providers know what everyone's role and scope of work is.
- Expressed a difference of opinion regarding what kinds of roles they can and should play with respect to basic medical interventions, for example medical tests.
- Discussed the importance of heart, having cultural competency and an understanding of community.
- Discussed the importance of investing in training and integration of community health workers into larger care teams.

- Areas of tension emerged, as well, including:
    - Role of community health workers who work from the "heart" vs working as professional member of the health workforce
    - Data collection vs maintaining trust and communication
    - Viewing the people they work with as clients vs. consumers
    - Their role in collecting clinical vs qualitative data
    - CHW's role as client advocate vs. working part of health care team; for example, CHWs are often in positions where they have important information to share based on the time they spend with clients, but they often experience a lack of reception or response from health care providers. Part of the issue is that there are certain kinds of qualitative data that go beyond clinical work into social determinants work - information about the lives people are leading and their environment and experiences that have a profound effect on their life and health. Often, there is no way to transfer that into a medical record.

CHWs expressed appreciation for being able to come and voice their experience. Going forward, the voices of grassroots must continue to be included in the discussion.

2. Reimbursement and Financing

The next part of the meeting was spent discussing how a sustainable financing system might be created. A summary of how some Workgroup members fund CHWs is provided in the table below. Generally, most CHW programs are reliant on grant funding, which is limited as a long-term solution. Other methods include:

- Self-financing
- Membership
- Capitation
- Managed care reimbursement
- Assessments

Programs that utilize CHWs often serve patients with complex medical needs. Utilization of community health workers is dependent on the value added—it is a cost benefit analysis about whether patients with complex needs can be identified, and if unnecessary hospital admissions and procedures can be reduced through the use of a team based approach that utilizes a culturally competent person from the community who is trained and integrated into the team.

There is not a lot of cost benefit data yet, although there are some studies that are demonstrating results. If there is a positive cost benefit, then the business model for employing community health workers is there. If providers are operating under capitated rates, and this proves to be effective in lowering their cost, there will be an incentive to change to this population based community based, model of health care delivery.

Several Workgroup members mentioned that Americorps provides a pipeline for CHWs because they are paid, although the host site still needs to provide supervision. In

addition WIA could be explored as a means to support CHWs. However, not all CHWs/Ps would quality for Americorps.

Maria Lemus discussed the contracting process with Covered California for patient navigators. There is significant paperwork and screening requirements, as well as training for CHWs/P to undergo in order to meet the standards. She indicated that they also work with the CBOs to enable them to successfully incorporate CHWs into their organizations.

The Workgroup discussed the need to also address employer organizations and their readiness to hire CHWs, recognizing culture and supervision issues. With specific regard to CBOs, Workgroup members observed that the readiness varies; however, with some training, many could hire Promotores (e.g. they would need to be able to take TIN number instead of a SSN) and then act as "brokers" for the health system. Generally, however, CBOs are required to fundraise in order to support CHWs/Ps in the absence of sustainable financings. Under the "broker" model, it was suggested that provider coalitions could come together to pay for training at CBOs as well as develop contractual relationships to hire CHWs/Ps. Such a broker model could also be a good approach in rural areas.

Workgroup members emphasized the importance of close collaboration between potential employers and training so that the training relates to the specific needs of the employer, building on general core competency training. Therefore, education programs like SFCC would train on the core competencies but then employers would need to offer customized training to address their particular needs. Workgroup members discussed how an Apprenticeship model could be a good fit, but clarified that such a model would address the specialized training aspect not the long term hiring of CHWs/Ps.

Finally, with regard to financing, it was noted that LA County receives a global capitated rate under Medi-Cal managed care to provide the full spectrum of health care and has decided to hire CHWs to work in their Person Centered Medical Homes.

Name	Type of organization	How do you finance CHWs?	How do you or your contractors pay CHWs
	e.g. Clinic, hospital, health plan, intermediary/ *CHW organization*	*e.g., Grants, general operations, funding included in capitation rate, FQHC rate* *(For example, if you are an insurer, do you rely on grants or is any funding included in your capitation rate? Similarly, if you are a provider, does the capitation/FQHC/FFS rate provide funding/reimburse for CHWs? Or do you rely on outside sources?)*	*Salary, hourly, with or without benefits* *Please indicate if directly hire or by contractor*
Visión y Compromiso	Network of Promotoras and Community Health Workers	Employ nearly 70 promotores in numerous federal/foundation/county/state and collaborative agreements with universities. They are employed full and parttime. The funding of the positions is negotiated with the contractor and including edd costs, and benefits as appropriate. Other programs require volunteers to implement the outreach. We have been successful with this model also. Their inclusion is and continued relationship with us is founded on their commitment to their community and VyC.	95% of the promotores are on payroll. Few are paid manually, if they receive stipends for instance. This may occur on small and special project. Suggested starting pay level of $15 an hour. Many organizations seem to follow suit. We encourage agencies, contractors to work with local cbo to hire and work with promotores. We offer benefits to fulltime permanent staff (health, dental,vision)

LA DHS	County health department	25 CHWs will work in person centered medical homes Medi-Cal managed care capitation rate includes funding for CHWs. It allows employer to include unlicensed professionals.	
California Hospital Medical Center	Non Profit Hospital	General operating funds and grants	Directly hire Salary with benefits
Stanford Chronic disease program (from Carol West)	Hospital?		Stipend of $25 per session
CHW Initiative of Sonoma County	Advocacy organization	Individual member support	No paid staff
Goodwill Industries	Peer support specialists	Proposition 63 funding	