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CHW Quality Improvement Efforts
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CONNECTING COMMUNITY HEALTH WORKERS TO BROADER QUALITY IMPROVEMENTS EFFORTS: OPPORTUNITIES FOR ALIGNMENT WITH MANAGED CARE PLANS

Background

Over the last few years, the California Department of Health Care Services (DHCS) has increased quality and performance requirements for Medi-Cal managed care plans (MCPs) to align with the state's quality strategy and equity goals. Each year, plans must demonstrate achievement in 30-40 quality measures known as the Medi-Cal Accountability Set (MCAS) with financial penalties issued to plans that do not meet minimum standards. Several measures within MCAS focus on Medi-Cal populations that are eligible for the Community Health Worker (CHW) benefit, including children who have experienced Adverse Childhood Experiences (ACEs) and have unmet health or health-related social needs. As MCPs invest in efforts to meet and exceed minimum performance levels, CHW providers can play an essential role in supporting MCP efforts to improve quality and outcomes for higher-risk populations.

This paper is designed to highlight the opportunities and benefits of MCPs and CHWs working together to improve quality and equity. In particular, we lift up how these collaborations can be impactful when working with young people and their families who have experienced ACEs. Because ACEs significantly contribute to the risk of chronic conditions and health related social needs – and because the toxic stress that ACE exposure causes is amenable to treatment, healing and prevention - this patient population can benefit from MCP and CHW collaborations to improve coordination, support and access to medical, behavioral health and social services.

Community Health Worker Benefit

The CHW benefit is available to Medi-Cal beneficiaries with one or more chronic health conditions (including behavioral health), who are at risk for a chronic condition, have exposure to violence and trauma or who face barriers in meeting their health or health-related social needs.
Below are examples of children and youth populations that are eligible for the CHW benefit[1]:

- Presence of medical indicators or risk of chronic disease (e.g., elevated blood glucose levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
- Any stressful life event presented via ACE screening.
- Results of a Social Determinants of Health (SDOH) screening indicating unmet health-related social needs, such as housing or food insecurity.
- One or more visits to a hospital emergency department within the previous six months.
- Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
- Two or more missed medical appointments within the previous six months.
- Need for recommended preventive services, including updated immunizations, annual dental visit, and well child visits for children.

CHWs provide a critical linkage in assisting individuals access health care and social services and supporting the coordination of those services to ensure improved overall health.

Opportunities to Align Quality and Equity Efforts

Medi-Cal MCPs are prioritizing many of the CHW-eligible populations in their quality improvement efforts, including children that screen positive for ACEs, such as ensuring adults and children receive evidence-based immunizations and screenings, and improving coordination of care after a hospital/emergency room visit.
Below are a few examples of MCAS measures that could align with CHW children and youth populations[2]:

[1]DHCS CHW APL24-006
[2]Medi-Cal Managed Care Accountability Sets

- Well-child visits for babies (first 30 months of life), children and adolescents
- Developmental screenings in the first three years of life
- Immunizations for children and adolescents
- Lead screening in children
- Depression screening and remission or response for adolescents
- Topical fluoride for children
- Prenatal and postpartum care
- Follow-up after emergency department visit for mental illness
- Follow-up after emergency department visit for substance use

Assets CHW providers can offer to MCPs and communities:

- CHWs are embedded in the community and are trusted community partners
- Lived experience, understanding and knowledge of the patients they work with
- Can help families navigate services (enroll in Medi-Cal and identify other eligible services, get to appointments, assist with coordination of health and social supports)

Funding opportunities to support CHW and quality improvement

Several funding streams may be available to support and sustain efforts for CHW providers and MCPs interested in working together to meet certain quality and equity goals. Below are opportunities CHW providers and MCPs could explore together in their communities:

1. Managed care plan pay-for-performance programs: Several MCPs set aside a portion of funding to providers for performance-based improvement. These pay-for-performance programs often prioritize specific quality goals (e.g., addressing gaps in care, increasing utilization for certain services or populations) to improve performance on MCAS measures where the MCP may not meet minimum performance or requires additional focus.
    - Some MCP pay-for-performance programs are only available to contracted primary care providers. If that is the case, CHW providers could partner with a local primary care provider/ FQHC to meet performance goals. Alternatively, MCPs could pilot a new pay-for-performance program focused on CHWs and other community providers.
2. Managed care plan grant funding: MCPs also set aside funding each year to support local providers or activities that are important to their members and overall service delivery.

- IPP and HHIP: Beginning in 2022, MCPs began receiving state funding for two grant programs: Incentive Payment Program (IPP) and the Housing and Homeless Incentive Program (HHIP), which seek to connect individuals at risk for adverse health outcomes with needed services and social supports. HHIP is available to organizations supporting individuals experiencing homelessness, while IPP supports expanding capacity and participation in Enhanced Care Management (ECM), Community Supports (CS) and the CHW benefit. IPP and HHIP funds are time limited; however, MCPs may have funding available in 2025 to support quality improvement, and CHW implementation, capacity building and outreach efforts.
- In addition to IPP and HHIP, MCPs may have other funding available to support broader population health management efforts, pilot innovative programs and support broader community priorities.

3. Community grants and local government agency funding: Grants may be available from foundations, government agencies and other local partners that are working to improve quality and equity for certain populations. These grants can help cover additional costs that may not otherwise be reimbursed through the CHW benefit (e.g., building technology infrastructure, training staff, etc.).

4. Linkage to Enhanced Care Management and Community Supports: MCPs are also expanding provider capacity and working to improve quality and outcomes for individuals eligible for ECM and CS. CHW providers and MCPs could work together to align these services and funding available in a manner that allows for a smooth transition from ECM to CHW (e.g., step up or step down care), improves care coordination and sustains improved health for eligible members.

Hypothetical example

Below is an example of how an MCP and CHW provider could partner to develop a pay-for-performance program and achieve specific quality goals.

Priority quality measures: For the last two years, an MCP has not achieved minimum performance on two MCAS measures:

- Childhood immunization status (CIS-10): Percentage of children under the age of two that have received the following vaccinations: DTAP, IPV, MMR, HIB, Hepatitis B, VZV, PCV, Hep A, RV, and Influenza.

- Well-child visits in the first 30 months of life (0-15 months and 15-30 months): Assess whether children 0-15 months of age had at least six well-child visits with a primary care physician, and children at 30 months of life had at least two primary care visits in the prior 15 months.

Target population: 5,000 MCP member children will need immunizations and well-child visits in calendar year 2025. The MCP is particularly focused on 2,000 children who have a higher incidence of screening positive for ACEs and live in neighborhoods with disproportionately low immunization rates and insufficient well-child visits. To achieve minimum performance, the MCP will need to ensure at least 3,500 children receive both the recommended immunizations and well-child visits within the appropriate timeframe.

Establishing a new partnership between the MCP and a local CHW provider: The MCP is already contracted with a CHW provider serving this community. Together they develop a pay-for-performance pilot focused on child immunizations and well-child visits in the community. The goal for the first year is to reach 500 children and 1,000 children in the second year. The pilot includes the following financing and data elements:

- Financing structure:
  - MCP will provide $250k in one-time funding to the CHW provider for start-up infrastructure and capacity building to hire staff and improve data and billing capabilities.
  - CHW provider will continue to bill for CHW services for eligible children and families that obtain services.
  - Bonus quality payments: CHW provider will receive a $25 bonus payment for every child that has a well-child visit and another $25 bonus payment for every child receiving all scheduled immunizations. If the child receives their scheduled immunizations during a well-child visit, the CHW provider will receive $50. This will be a fee-for-service payment based on utilization.

- Data:
  - The MCP and CHW provider will work together to identify children and families they currently serve and those that are eligible for scheduled services.
    - MCP will provide a list of eligible children (and name of the parent/guardian or authorized representative) in the region that have not yet met their required immunizations or number of well-child visits.

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        - CHW providers will send the MCP a list of all children (or adults with young children) that have received services in the last year and enrolled with the MCP. MCP will review the list and identify who is eligible for CHW services and in need of scheduled immunizations or well-child visits. (If the CHW provider is not able to verify Medi-Cal coverage or cannot provide a list, they will work together based on the MCP file.)
    - CHW providers will submit claims for all individuals who receive CHW services.
        - CHW providers will also develop a care plan for clients who receive services beyond 6 hours.
    - CHW provider and MCP will coordinate on processes and any required documentation for the continuum of CHW services.
    - CHW provider will submit data quarterly to the MCP on the members that have received an immunization or well-child visit. MCP will confirm the data and provide the quarterly bonus payment.

Coordination with primary care providers: As the MCP and CHW provider are developing the pilot, they will also engage two primary care clinics that serve many of the patients in the community. Clinics are engaged 3-6 months before the start of the measurement year. Together, the CHW provider and primary care clinics establish a process to refer patients for CHW services and a process for CHW providers to help get patients in for needed well-child visits and immunizations. In addition, the MCP and primary care provider will explore opportunities to expand ACEs screening which can help CHW eligible families and connect individuals with services and supports.

Connection to additional support and community services: CHW providers are often trusted members of the community. By working with children and families, they can play a critical role in helping identify additional needs, connect them with essential services and reduce barriers to care, The MCP and CHW provider will also explore strategies to seamlessly connect children and families with other available services, including leveraging closed loop referrals to streamline referrals for ECM or Community Supports, or improve linkages to other Medi-Cal benefits (e.g. behavioral health, doula) and screenings (e.g. developmental, ACEs, etc.). Addressing other basic needs will assist in the achievement of multiple quality and equity priorities for the MCP and CHW.

Potential next steps:

If your organization is interested in exploring how CHW services could contribute to broader quality improvement efforts, below are some suggested next steps:

1. Learn more about the health plan's quality priorities and which CHW providers in your community could be helpful partners in this effort. Encourage the conversation early, maybe six months prior to MCAS measurement year.
    a. For primary care clinics, hospitals and CHW providers: What populations or quality/equity measures are MCPs most focused on? What steps have they taken to improve quality and what existing hurdles remain? Where do they need help?
    b. For MCPs: Which CHW providers are in the communities or serve the populations that could best support MCP quality/equity improvement efforts? How are they identifying community residents? What strategies have they employed to build trust and local engagement?
2. Assess how the MCP's quality priorities align with the CHW organization's expertise and capacity. How could your work potentially overlap? What would a potential partnership look like? What opportunities exist to expand ACEs screenings to more effectively identify eligible individuals and connect them with appropriate services?
3. Learn more about potential funding opportunities to support this work. In addition to the CHW reimbursement from the Medi-Cal fee schedule, what other areas of funding may be available from the MCP or other local partners that incentive utilization of services or quality and equity improvement? For programs that have already implemented robust responses to ACEs, CHWs can serve as a core component of prevention and resilience, building responses to improve health outcomes for families.