An Exploration of Sustainable Funding for Community Health Workers in Travis County, Texas

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PREPARED FOR

Austin Asian Community Health Initiative (AACHI)

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EXECUTIVE SUMMARY

On behalf of the Austin Asian Community Health Initiative (AACHI), consultants Wanda Thompson, PhD, and Jacquie Shillis, MEd, completed a project to identify potentially sustainable funding strategies for community health workers (CHWs) in Austin/Travis County, Texas, and to begin to implement the most feasible strategies. As originally conceived, the project had three phases:

- Research to identify the most feasible funding strategies
- Workgroup formation and facilitation to develop action plans for up to four strategies
- Coalition building to kickstart implementation

PHASE 1

The consultants began the project by conducting background research to identify potential funding strategies for CHWs. As this work proceeded, the client reached out to contacts and formed a core planning group, which included representatives from city and county governmental entities, higher education, a foundation, and a local nonprofit organization.

The consultants initially identified 15 potential funding strategies related to:

- Medicaid
- Private health insurance
- Healthcare providers, including private, federally funded, and locally funded systems
- Nonprofit organizations
- New business models

Fourteen stakeholders participated in interviews by phone or video conference. They shared their connection to and experience with CHWs and rated the feasibility of the funding strategies on a scale of 1 to 5, where 1 represented "very feasible" and 5 "not at all feasible." The consultants looked for clusters of rating numbers, considered participants' thoughts about what it would take to implement a strategy, including any potential barriers, and categorized the strategies as follows:

NOT FEASIBLE

- Submitting a Medicaid state plan amendment to add Medicaid coverage of preventive services provided by CHWs
- Increasing access to CHWs under private health insurance coverage
- Using pooled funds from third-party payers to cover the costs of CHWs

SOMEWHAT FEASIBLE

- Increasing the use of CHWs in Medicaid 1115 waiver projects
- Categorizing CHW expenses as quality improvement (QI) costs in Medicaid managed care contracts
- Requiring or incentivizing Medicaid managed care providers to offer services from CHWs
- Working with accountable care organizations (ACOs) to add access to CHWs
- Increasing private donations to nonprofits

MOST FEASIBLE

- Increasing investment in CHWs at city/county safety net healthcare providers
- Working with private healthcare providers to increase access to CHWs
- Working with federally qualified health centers (FQHCs) to increase access to CHWs
- Increasing grants to nonprofit organizations
- Increasing contracts with nonprofit organizations

PHASE 2

After considering the findings from the interviews and input from the core planning group, the clients and consultants decided to move forward with three strategies:

- Increasing investment in CHWs at city/county governmental entities
- Working with FQHCs
- Working with private healthcare providers

For each strategy, the consultants reached out to one or more critical stakeholders to explore options for taking the next step. In all three cases, it became clear that the originally proposed approach (i.e., forming a workgroup to develop an action plan) would not be feasible or helpful. Each strategy would demand more time and longer-term effort than allowed in the project scope. Nevertheless, the Phase 2 conversations shed light on the potential paths forward.

INCREASING INVESTMENTS THROUGH THE CITY/COUNTY

Austin Public Health (APH), the city's public health department, and Central Health, Travis County's hospital district and healthcare safety net, are both working to increase the number and impact of CHWs within their organizations. Central Health is newly licensed to provide medical services so staff are reviewing job descriptions and exploring how CHWs can continue to provide services within their scope in a variety of settings, including clinical teams. APH is actively working to build internal infrastructure — to create job titles, a progressive career ladder, and a hub — and is committed to establishing a center for continuing education credits for CHWs across the state. While APH currently employs CHWs rather than contracting with other entities for those services, contracting could be possible in the future.

Increasing investments in community-based CHWs through the city and county could still be on the table, but only as a long-term strategy that would require coalition building and advocacy to make community-based CHWs a priority for additional funding. Since city and county funding is necessarily short-term, reflecting budget cycles, these advocacy efforts would need to be sustained over time.

WORKING WITH FQHCS

The consultants followed up with the two representatives from FQHCs who participated in the interviews to explore next steps. One had since moved to another job. The other reported that her management team believes they have already maximized funding for CHWs. Next, the consultants met with representatives from the Texas Association of Community Health Centers (the statewide organization that supports and advocates for FQHCs) and learned that neither of the two proposed FQHC funding mechanisms would result in more funding for CHWs. However, a potential opportunity remains. Of the three FQHCs in Austin, two have funded numerous CHWs with grants and subsequently transitioned their positions to sustainable general operations. With the right leader and motivated team, this successful funding model could be replicated in other FQHCs as well as private primary care clinics.

WORKING WITH PRIVATE HEALTHCARE PROVIDERS

During the interviews, several participants mentioned that the Baylor Scott & White (BSW) healthcare system employs a large number of CHWs and suggested that the consultants contact them to learn more about their model and assess whether it could be replicated with other healthcare systems in the Austin area.

After talking with a BSW representative and learning about the system's fast-growing commitment to CHWs, the consultants met with representatives from another Austin-area private healthcare system to share the research findings, give a general overview of how BSW employs CHWs, and determine if they would be amenable to expanding the use of CHWs in their system. The representatives showed a general appreciation for the value of CHWs, noting that their system employs a number of navigators who function similarly to CHWs. They did not show any interest in replicating the work BSW has done. Much like the conclusion drawn for the FQHC strategy, the opportunity to replicate BSW's success exists but would require the right champion stepping up to organize the effort.

FINAL CONSIDERATIONS

Beyond the next steps above for the three strategies carried forward, the interactions with the interview participants, core planning group, and representatives of the organizations involved in Phase 2 disclosed a number of general activities that could strengthen the foundation for CHWs in Travis County:

- Build a coalition to raise general awareness about the value of CHWs to potential funding sources and entities that could benefit from using CHWs.
- Explore options for developing a common language and terminology around CHWs.
- Start a concerted effort to compile and analyze local data related to CHWs.
- Organize and advocate for some of the Medicaid strategies:
    - Explore ways to maximize the use of CHWs in local 1115 waiver projects.
    - Form a broad coalition to push for a Medicaid state plan amendment.
- Acknowledge that the CHWs who are most likely to be sustainably funded are those working within organizations in the healthcare, health insurance, and governmental spaces where general operating funds, grants, or both can cover costs. Nonprofit organizations that employ CHWs to provide general, less clinical services (e.g., outreach; education; assistance with transportation, housing, and other social determinants of health; translation; and healthcare navigation) and especially organizations that serve smaller segments of the population based on culture and language, have very limited funding options.
- Share the findings of this study widely so that healthcare providers, insurance companies, and governmental entities understand that to reap the full benefits of CHWs, they will need to provide ongoing resources to support CHWs within their systems as well as to help fill funding gaps in the community.

INTRODUCTION

On behalf of the Austin Asian Community Health Initiative (AACHI), consultants Wanda Thompson, PhD, and Jacquie Shillis, MEd, completed a project to identify potentially sustainable funding strategies for community health workers (CHWs) in Austin/Travis County, Texas, and to begin to implement the most feasible strategies. As originally conceived, the project had three phases:

- Research to identify the most feasible funding strategies
- Workgroup formation and facilitation to develop action plans for up to four strategies
- Coalition building to kickstart implementation

The full project proposal is included in Appendix A. Once the research was completed, the consultants and clients encountered numerous challenges and concluded that the work demanded a longer-term commitment and more complicated process than allowed within the scope of the project. The original proposal did not include the development of a formal report, but the consultants and clients agreed to add this deliverable when it became clear that implementing the second and third phases of the project would not be possible. This report details the completed work and challenges faced by the team, as well as potential next steps. It is our hope that the record of the project can serve as a foundation for future efforts to achieve more sustainable funding for CHWs in Travis County and beyond.

PHASE I ACTIVITIES

The research phase entailed initial online background research, followed by qualitative research conducted through interviews with key stakeholders.

BACKGROUND RESEARCH

The research phase began with a review of the literature to identify strategies that had already been proposed as potential funding sources for CHWs. Since documentation of the process was not part of the scope of work at the beginning of the project, the consultants did not create a full catalog of the resources that were reviewed. However, Appendix B lists some of the primary resources that were considered. The following funding strategies were identified as possibilities to discuss in interviews with stakeholders.

STRATEGIES RELATED TO MEDICAID

- Submitting a Medicaid state plan amendment (SPA) to add coverage of preventive services provided by CHWs
- Increasing the use of CHWs in Medicaid 1115 waiver projects
- Legislation to categorize CHW services as quality improvement (QI) costs instead of administrative costs in Texas Medicaid managed care contracts
- Policy/practice changes to require or incentivize Medicaid managed care providers (MCOs) to offer services from CHWs

STRATEGIES RELATED TO OTHER HEALTHCARE COVERAGE

- Policy/practice changes in private-pay or employer-provided health insurance to include services from CHWs
- Using pooled funds from third-party payers to cover the costs of CHWs
- Working with accountable care organizations (ACOs) to identify ways to increase access to CHWs for people covered by Medicare
- Working with the city and county to increase access to CHWs for people in the Medical Access Program (MAP)

STRATEGIES RELATED TO HEALTHCARE PROVIDERS

- Changes to prospective payment system (federally qualified health centers, or FQHCs) to increase funding for CHWs
- Policy changes to internal financing mechanisms of private healthcare providers (e.g., hospitals, primary and specialty care) to increase access to CHWs
- Increasing investment in CHWs at city/county safety net healthcare providers

STRATEGIES RELATED TO NONPROFIT ORGANIZATIONS

- Increasing grants from foundations and governmental entities to cover the cost of CHWs
- Increasing private donations
- Increasing contracts

NEW BUSINESS MODELS

- Partnerships and agreements through public-private partnerships (for example, pooled funds/coordination of local foundations, nonprofits, FQHCs, and local governmental entities) to fund CHWs

CORE PLANNING GROUP

As the background research proceeded, the client reached out to contacts and formed a core planning group for the project. This group provided critical input and feedback as the project moved from Phase 1 to Phase 2. The group included:

Veronica Buitron-Camacho	**Boramic C. Lee**	**Amy Einhorn**
Ricardo Garay	**Anthony Schmucker**	**Adrienne Sturrup**

Collectively, these individuals brought experience and knowledge from the local government, higher education, advocacy, philanthropic, and nonprofit sectors.

IN-DEPTH INTERVIEWS

The clients, consultants, and core planning group identified key stakeholders involved with and knowledgeable about CHWs. The consultants then contacted them to determine if they would be willing to share their insights about the potential funding strategies. The list included representatives of city, county, and state health-related governmental entities; higher education; health insurance; healthcare; community-based nonprofit organizations, and one foundation.

The consultants drafted an interview guide and finalized it with feedback from the clients and core planning group (Appendix C). The guide included questions about:

- Connection with and knowledge of CHWs
- Role of CHWS employed or contracted by participant's organization
- Perception of feasibility for each strategy, on a scale of 1 to 5, where 1 is "very feasible" and 5 is "not at all feasible"
- Final thoughts regarding any strategies not covered in the interview and any other key stakeholders the consultants should interview

The consultants used the guide to interview 14 stakeholders by phone or video conference. Participants received a handout before the interview that included a definition of a CHW, a table showing the number of certified CHWs employed in Travis County sorted by employer type, and a list of the strategies to be discussed (Appendix D). Participants were asked to have the handout available during the interview. The consultants offered to provide a short verbal description of each strategy as it was introduced and gave participants the option of skipping a strategy if they were unfamiliar with it.

The interviews took place between January 11 and February 24, 2022, and lasted between 30 and 90 minutes, depending on the depth of participants' knowledge of the strategies. At the beginning of the interview, the consultants assured each participant that the information from the interview would be confidential and that comments would not be linked to names when the findings were reported to the core planning group. A final, more public report was not anticipated at the time of the interview, so participants were not asked for permission to share their names and that of their organizations. Consequently, this report does not identify the participants or the organizations they represent.

DATA ANALYSIS METHODOLOGY/PROCESS

All interviews were recorded and transcribed. The consultants reviewed the interview transcripts and transferred key data points to a spreadsheet, including:

- Perceived feasibility ranking on a scale of 1 to 5 (with the option to pass)
- What participants thought it would take to implement the strategy
- Data needed
- Barriers to implementation
- Who to involve
- Notable quotes

Because participants could opt out of assigning a number to a strategy if they were unfamiliar with it, the raw numbers from the rankings were meaningless. Instead, the consultants considered patterns in the numbers for each strategy as well as participants' comments about the strategies, since the comments often explained why they assigned a given number. The numbers clusters were interpreted as follows:

- 1–3 range: Most feasible
- 2–4 range: Might be feasible
- 4–5 range: Least feasible

The consultants compiled the key findings and presented the following information to the core planning group during a Zoom meeting:

- Research methodology
- CHW roles and funding in the organizations
- Overarching findings
- For each strategy, grouped by level of feasibility:
  - A definition/description
  - What participants said it would take to implement
  - Who would need to be involved
  - Perceived barriers

The goal of this meeting was to review the research and decide together which strategies were the most promising to carry forward into Phase 2. However, the planning group delayed the decision to give members time to process the information that was presented. A few weeks later, the consultants facilitated another meeting to get further input. For the six strategies that stakeholders had identified as the most feasible, planning group members considered the following questions:

- Critical success factors
  - Is there a clear champion? If so, who/what organization?
  - Are there people with the knowledge/willingness to do the work? If so, who/what organizations?
  - Can the data needed to implement the strategy be generated/collected with reasonable effort? If so, who/what organization would be the lead?
- Additional considerations
  - How high are the initial costs associated with pursuing the strategy (i.e., personnel, technology, legal costs, etc)?
  - Are the organizations that would need to be involved aligned with the concept and goals of CHWs?
  - How complex is the strategy? Does it involve primarily changing internal processes, or would external partners need to be involved?
  - Who *has* to be involved, internally or externally, to make the strategy work?
  - Are there other key considerations?

After the guided discussion, core planning group members each gave input on whether to move the strategy forward, based on the following scale.

1 = Strongly agree (with moving forward)
2 = Agree
3 = Somewhat
4 = Disagree
5 = Strongly disagree

In the weeks following this discussion, the consultants and clients considered the data from the core planning group and narrowed the number of strategies to three, which were carried over to the project's next phase.

RESEARCH FINDINGS

To compile a more complete version of the findings for this report, the consultants returned to the original interview transcripts and color coded themes. Input from core planning team members is also included for those strategies discussed by the team. Indented, italicized text in the body of the report represents a direct quote from a participant. The full findings include:

- Common themes that emerged across strategies
- Participants' roles in relation to CHWs
- Number of CHWs employed by participants' organizations, their roles, how they are evaluated, and how they are funded
- Participants' perceptions of the feasibility of the funding strategies, and depending on the assessment of feasibility:
  - Actions it would take to implement the strategy, including the data needed, and who should be involved
  - Any barriers to implementation

CONNECTIONS TO CHWS AND CHW ROLES AND FUNDING SOURCES

To gain context, the consultants began each interview by asking participants about their knowledge of and experience with CHWs, and whether their organization employed CHWs. Participants whose organizations employ CHWs were asked to describe:

- The roles these CHWs play
- How they are funded
- The metrics used to demonstrate the value of CHWs

Participants exhibited broad and varied knowledge and experience working with and, in some cases, as a CHW. Nine of the organizations represented in the research employ CHWs, ranging in number from as few as two to more than 20. These CHWs function in a variety of roles, depending on the work setting and the populations they support. As one participant said, "One community health worker is one community health worker. They all have a slightly different skill set." Participants' responses to these initial questions are summarized below, organized by sector.

GOVERNMENT

The participants representing governmental entities are connected to CHWs through various programs and initiatives where CHWs play a role. One oversees a program that uses CHWs; another became involved with CHWs through the training and certification process; and the third first experienced CHWs through a project related to maternal and child health.

Roles filled by CHWs are:

- Outreach and navigation, connecting clients to healthcare
- Facilitating transition of care after hospitalization
- COVID-19 education and outreach
- Addressing health disparities affecting communities of color
- Maternal/infant outreach (psycho-social support) in pregnant or parenting African American women
- Chronic disease and injury programs in businesses and schools

Participants described a variety of metrics used to evaluate the effectiveness of CHWs, including:

- Number of people connected to care
- Number of patients keeping appointments
- Number of people with specific chronic diseases identified at community events
- Metrics required by the grant funding the CHW

Most of the CHWs at these governmental entities are funded through local, state, and federal grants. A few are funded through general or operating funds. Two of the participants are hoping to increase the number of CHWs in the near future. One has requested funding through operating funds and the other through both grants and general funds.

HIGHER EDUCATION

Participants in higher education reported being connected to CHWs through conducting research on CHWs' impact on chronic disease self-management, providing training and support to CHWs, and working with CHWs in various demonstration projects aimed at improving healthcare involving Texas Medicaid providers.

Roles filled by CHWs include:

- Population health initiatives
- Community needs assessments/surveys

CHWs working in these institutions are funded through the operations budget and/or grants.

HEALTHCARE

Participants from the healthcare field manage teams that include CHWs. CHWs in this sector work in prevention and outreach but are also embedded within primary care teams.

Roles filled by CHWs include:

- Outreach and marketing, including assistance enrolling through the clinic's patient portal
- Health education (e.g., chronic disease, healthy eating, fitness, sexual health)
- Hospital transition of care for special populations
- Health navigation and assistance with social determinants of health as an embedded member of a clinical team

The healthcare facilities represented in the study track the number of screenings and referrals done by CHWs, and consider provider and patient feedback. One participant said her clinic is exploring longer-term metrics, such as changes in no-show rates and patients' ability to advocate for themselves after interactions with CHWs.

Both participating healthcare organizations fund their CHWs with a combination of grants and general operating funds. Participants said they have shown enough value through grant-funded CHWs to convince leadership to sustain the funding internally. One facility plans to add a CHW to the clinical teams that do not already have one. Administrators have committed to adding those positions as part of the operating budget.

HEALTH INSURANCE

Participants representing health insurance companies said they are connected to CHWs through oversight of teams that include CHWs and initiatives that include interventions by CHWs.

Roles filled by CHWs are:

- Case management for high-need patients
- Connecting monthly or quarterly with specific members and helping them navigate insurance benefits, schedule and keep doctor appointments, and take care of health issues before they become emergencies
- Conducting home visits
- Accompanying members to appointments and advocating on their behalf with healthcare providers

At both companies, CHWs are evaluated through outputs such as the number of patient encounters. One participant acknowledged the challenge of tying outcome measures to CHW interventions:

> *What is the impact of these folks [CHWs]? It's a pretty convoluted system when you start looking at all of the different factors and supports that are going in on a given member to figure out, "Which one do we think is driving this?" So it is difficult to tease those out.*

One company funds CHWs through the operating budget; the other through a Medicaid contract with the state.

COMMUNITY BASED ORGANIZATIONS

One participant from a nonprofit organization previously managed the CHW program. In her current role overseeing a broader health initiative, she supervises a health educator and a CHW. The other participant is a certified CHW and a CHW instructor.

Roles filled by CHWs at the two participating nonprofit organizations include:

- Health education (e.g., chronic disease, nutrition, physical fitness)
- COVID-19 outreach and education
- Greeting patients and assisting them with the intake process
- Patient follow-up related to appointments

For most of the CHWs employed at these nonprofit organizations, evaluation measures are driven by grant-reporting requirements. One entity is considering collecting data that could show cost savings from employing CHWs over another type of health professional.

Most of the CHWs at the nonprofit organizations are funded by local, state, and foundation grants. One organization funds two part-time CHWs through general operating funds.

CROSSCUTTING FINDINGS

Two common themes emerged across all the strategies: the critical need for people and data. Time and again, participants cited the need to involve the right people: strong, visible champions as well as others willing and able to plan for and implement a strategy.

> *If you have a champion for it, it can do amazing things. But if you don't have that champion … they [initiatives] tend to fall flat.*

> *I just think having the right key stakeholders involved and really having those champions to promote this and push forward.*

Participants also consistently said data proving the concept of CHWs would be critical to implementing each of the strategies. They suggested that the type of data required could vary depending on the strategy and setting in which it would be implemented. For example, insurance companies might pay the most attention to data showing that the use of CHWs results in cost savings. Healthcare facilities might be persuaded to use more CHW services if they were presented with data related to health as well as cost savings (e,g., increased compliance keeping appointments, reductions in ER visits and readmissions to the hospital, better management of chronic conditions, and better health outcomes). Some participants said data reflecting community needs related to social determinants of health might show the need for CHWs and set the stage. Others said qualitative data, such as stories from people who have had positive interactions with CHWs — and from clinical teams that have seen benefits from integrating CHWs — would be helpful in making a case. Many suggested that it would take local data to truly prove the concept of CHWs to providers and other organizations in Travis County.

PERCEIVED FEASIBILITY OF STRATEGIES

Participants' perceptions of the feasibility of the funding strategies are summarized in three categories:

- Not feasible
- Somewhat feasible
- Most feasible

STRATEGIES PERCEIVED AS NOT FEASIBLE

Participants ranked three strategies as not feasible:

- Submitting a Medicaid state plan amendment to add Medicaid coverage of preventive services provided by CHWs
- Increasing access to CHWs under private health insurance coverage
- Using pooled funds from third-party payers to cover the costs of CHWs

SUBMITTING A MEDICAID STATE PLAN AMENDMENT TO ADD MEDICAID COVERAGE OF PREVENTIVE SERVICES PROVIDED BY CHWS

A state plan is an agreement with the Centers for Medicare and Medicaid Services (CMS) that sets out the groups and services covered, and the methodologies for reimbursement to healthcare providers. A 2013 CMS rule change allowed for non-licensed practitioners, such as CHWs, to provide and be reimbursed for preventive services, as long as those services are recommended by a physician or other licensed practitioner. To receive reimbursement for qualifying CHW services, states must submit an amendment that outlines the education, training, or credentialing required for CHWs and defines the preventive services they will provide and how these services will be reimbursed.

Perceived Feasibility

Most participants ranked this strategy in the 3 to 4 range. As participants discussed barriers and considered what it would take to implement the strategy, most concluded that amending the Medicaid State Plan would not be feasible at this time. The most commonly cited barrier was the current political climate in Texas.

> *I believe we have all the information we need to be able to support such an initiative. So, in terms of feasibility, is it doable, yeah it's doable. I don't know if there's the political will to do it.*
>
> *This is a very contentious political setting right now, making bipartisan work difficult … Also, priority/focal point of the state legislature during session could push this issue further down the agenda.*

Barriers

Several participants cited as a barrier the lack of a strong political champion to push the SPA forward.

> *Having a key representative that's your sponsor that's really going to help push something like this forward within the state government makes a big difference.*

Other participants mentioned as a barrier the fact that the state has one general CHW certification, but individual CHWs have very different skill sets and roles. Along those same lines, another said Texas lacks a clear definition of services provided by CHWs, which would make it difficult to implement the SPA.

The cost to change the state's Medicaid technology system to reflect an SPA was also seen as a potential barrier. Some estimates have calculated the one-time cost being between $700,000 and $1 million.

INCREASING ACCESS TO CHWS UNDER PRIVATE HEALTH INSURANCE COVERAGE

This strategy would entail working with health insurance companies on policy/practice changes to add coverage for CHW services. The strategy is based on the idea that health insurers are increasingly interested in investing in ways to keep their members healthier, and may be willing to pay for CHWs as part of a bundled payment to providers in their network or allow services from CHWs as part of a capitated rate. Companies might be convinced to start with a demonstration project to determine the return on investment (ROI).

Perceived Feasibility

Most participants were not optimistic about private health insurance plans adding coverage for CHWs, generally ranking the strategy in the 3 to 4 range. They most commonly cited a lack of knowledge about the value of CHWs and the nature of the health insurance business model.

> *A lot of companies are focused on profits, understandably. We're a capitalist society. And so if they don't think there's a return on investment or they don't feel like they have to do it to be competitive, then I don't expect them to do it.*

Barriers

Two participants said this strategy could bump up against the assumption (accurate or not) that people with private health insurance coverage "have the ability to do a lot more things on their own" and would not benefit from interventions by CHWs as much as patients covered by Medicaid or Medicare. Others noted that it is hard to change any system, especially when that change involves a shift in finance.

> *When you start talking about some of the financing pieces, I think that's where people kind of clam up and kind of dig in, and they're just very defensive about the idea of, "Well, what does that mean? Is that going to mess up our total approach to things? And how much is it going to cost us to change this process?" So I think getting over that hurdle and helping them see the benefit that it's going to provide and what that impact is going to be, to show that it will, in more cases than not, offset whatever the challenge is.*

A few participants pointed out that since there is no mechanism to require private health insurance companies to offer and cover CHW services, the only leverage is expectation. It will take at least one insurance company's changes leading to a visible competitive advantage, and consumers' expectations that CHW services be provided, for other companies to follow that example.

USING POOLED FUNDS FROM THIRD-PARTY PAYERS TO COVER THE COSTS OF CHWS

This strategy is based on the idea of an entity or consortium setting up a mechanism to collect and pool funds that could be drawn from to cover the cost of CHW services. For example, Vermont assesses health insurers a fee of $17,500 per every 1,000 patients to support Community Health Teams (CHTs) across the state. The CHTs include CHWs and other health professionals who are responsible for outreach, care coordination, and connecting residents to needed services. Vermont's CHTs have been successful in reducing hospital and emergency department utilization, while improving health and healthcare. In this example, Vermont coordinates the effort at the state level, but the strategy could also be adopted voluntarily by a group of insurers, providers, governmental entities at any level, or a combination.

Perceived Feasibility

While a few participants perceived this strategy as possible, more ranked it lower, with several giving it a 5 for not at all feasible.

Barriers

The most common barrier cited was the difficulty of coming together to share money.

> *I've seen very little group cooperation on these things, even when it would totally make sense for groups to come together and do this. And it just seems like their internal business-company red tape seems to get in the way. A lot of times they just don't seem to have a clear mechanism to partner. … We're talking about capitalism, right? There just seems to be a hesitation to want to really partner with your competitors. It seems like people tend to say, "Well, we'll just take this back and we'll just do our own thing for our own members."*

One participant described a collaborative effort made possible by the declaration of the COVID-19 public health emergency. Federal funds became available for the state to contract with multiple entities to do contact tracing. Without a similar infusion of funds, and a mechanism for coordination, he wondered how viable the idea of pooled funds would be.

STRATEGIES PERCEIVED AS SOMEWHAT FEASIBLE

Participants ranked the following five strategies as somewhat feasible:

- Increasing the use of CHWs in Medicaid 1115 waiver projects
- Categorizing CHW expenses as quality improvement costs
- Requiring or incentivizing Medicaid managed care providers to offer services from CHWs
- Working with accountable care organizations to add access to CHWs
- Increasing private donations to nonprofit organizations

For each of these five strategies, as well as the ones participants thought were the most feasible, the sections below include a summary of their thoughts about what it would take to implement the strategy, who/what organizations should be involved, and potential barriers. These details should not be considered as complete, but rather as starting points for any future efforts to implement the strategies.

INCREASING THE USE OF CHWS IN MEDICAID 1115 WAIVER PROJECTS

The Medicaid 1115 waiver is used by states to test different benefit designs or new models for delivering care. Some states have used these waivers to pay for employing CHWs. In the past, Delivery System Reform Incentive Payments (DSRIPs) have been part of the Texas 1115 waiver program and have provided grant funding for innovative health system reforms, including the use of CHWs.

Texas received approval for a 10-year extension of its 1115 waiver in January 2021, including for some new programs. CMS rescinded approval in April 2021. In August, a federal district judge temporarily reinstated the extension. In April 2022, after the interviews were completed, CMS withdrew the rescission of the extension, allowing Texas's 1115 waiver, originally approved in January 2021, to continue for the next 10 years.

This strategy would involve exploring options for increasing the use of CHWs within the projects funded under the waiver.

Perceived Feasibility

A few participants ranked this strategy a 4, but most ranked it in the 2 to 3 range, making it somewhat feasible.

Implementation

When asked what it would take to implement this strategy, most participants indicated that the first step would be to research what is included in the current 1115 waiver extension and to identify areas where CHWs could be incorporated or how their use could be expanded. A couple participants suggested reviewing what other states have done and exploring how those states have demonstrated the feasibility and positive impact of CHWs.

Suggestions for who should be involved in planning and implementing the strategy included:

- A broad coalition of stakeholders to provide a unified front
- Texas Health and Human Services Commission (HHSC)
- Texas Association of Promotoras and Community Health Workers
- Key state legislators

Barriers

Interviews were conducted in January and February 2022. At that time, the 10-year waiver extension request was tied up in the courts, and DSRIP grants were scheduled to sunset September 2022. Several participants thought that given these realities, state leadership would be focused on keeping money flowing to the Texas provider system and would not be open to supporting new projects that might require additional state funds.

The need to obtain state approval to expand the use of CHWs was listed as a major barrier, along with state/federal relationships.

> *So, just the state/federal relationship seems to come into play when we're looking at some of those waivers, especially if they're meant to have any form of matching or supported federal funding.*

Another barrier cited was the bandwidth of HHSC, the state agency that administers the Medicaid program. Participants felt that state employees are already working at capacity to address laws, regulations, and programs they are required to implement, so it would be difficult to find the time and resources to pursue anything that is not mandated. Participants also saw the federal requirement for CHWs to be certified as a barrier, since not all individuals working in the role of a CHW in Texas are certified. One participant thought that the fact that the CHW certification process is so general could pose a challenge determining whether a CHW is qualified to do a specific type of work.

CATEGORIZING CHW EXPENSES AS QUALITY IMPROVEMENT COSTS

In the first few interviews, this strategy was described as passing legislation to allow Medicaid managed care organizations (MCOs) to categorize certain CHW activities as QI costs instead of administrative costs. The assumption was that this coding distinction could benefit MCOs financially, making it more likely they would use CHWs. A 2019 Texas House bill that would have codified the option in state law passed the House but did not get a hearing in the Senate. One of the participants clarified that during the legislative process, HHSC bill analysts said the legislation was not needed and that MCOs could already use this strategy. She pointed the consultants to a QI cost clarification HHSC issued in June 2021. In subsequent interviews, the consultants reframed the strategy as working with MCOs to educate them about how to use the QI cost designation to increase the use of CHWs.

Perceived Feasibility

Most participants ranked this strategy in the 2 and 3 range, making it somewhat feasible.

Implementation

Since categorizing the cost of CHW services as QI costs is currently allowable, to implement the strategy, participants said HHSC would need to:

- Educate MCOs on the guidelines.
- Clarify what services would qualify as QI costs.
- Send a clear message to MCOs that the agency wants them to increase the use of CHWs.

A few thought additional funding for CHWs would move the needle.

> *Unless HHSC sets this [using CHWs] as a priority, I just think health plans will probably dip their toe in it, but they're going to be much less likely to make a sustained commitment to this. They're looking for the state to say, "This is important to us, and here's how we're paying for it."*

Suggestions for who should be involved include:

- HHSC
- Universities for research
- FQHCs
- Episcopal Health Foundation
- Texas Association of Promotoras and Community Health Workers
- Supportive legislators

Barriers

Participants cited as barriers the confusion around allowability and the complicated financial calculations involved in state funding for MCOs. This strategy's potential benefit would come from taking costs associated with CHWs out of the administrative cost bucket (which has a cap) and putting them into the QI cost bucket (unlimited medical costs). One participant noted that while that might sound like an incentive, there would likely be little benefit to the MCOs. She explained that most QI costs are not considered when the state sets capitation rates — the fixed amount of money for services per patient paid in advance — which is calculated from a two-year look back and adjusted for current factors, such as COVID-19, new technology, or caseload increases. To get around these barriers, the participant suggested an alternative strategy: exploring how to categorize CHWs as "in lieu of" services instead of QI costs because these services are factored in when the state sets the capitation rate.

Citing another barrier, she described how the state's zero-sum funding system builds in a disincentive to lowering costs. For example, if an MCO, through the activities of CHWs, is able to reduce hospital costs, the next time HHSC sets capitation rates, the algorithm reduces the capitation rate for hospital costs rather than allowing the MCO to keep the savings.

REQUIRING OR INCENTIVIZING MEDICAID MANAGED CARE PROVIDERS TO OFFER SERVICES FROM CHWS

Medicaid MCOs already have the flexibility to incorporate different models of care within their capitation rate. This strategy would involve working with HHSC to include contract language encouraging or requiring Medicaid MCOs to use CHWs. Advocacy for contract changes would need to happen prior to the state's procurement process.

Perceived Feasibility

Most participants ranked this strategy in the 2 to 3 range, perceiving it as somewhat feasible. At the time of interviews, the public comment period was open for re-procurement of some Medicaid contracts. Some participants saw this timing as an opportunity, raising their hopes that the strategy could be implemented.

Implementation

Participants said implementation would require convincing MCOs of the value and benefits of CHWs. Supporters also would need to work with HHSC to encourage MCOs to utilize CHWs. It would take partnerships with advocates and community organizations that have experience working toward policy change to successfully implement this strategy.

Suggestions for who should be involved include:

- HHSC and other state agencies
- MCO representatives
- Central Health/Austin Public Health (APH)
- Dell Medical School
- Texas Association of Promotoras and Community Health Workers
- Texas Association of Community Health Plans

Barriers

At the time of the interviews, the re-procurement process for some Medicaid MCO contracts was underway. However, the public comment period – when language requiring use of CHWs could have been recommended – had passed. At that time, Texas had 17 Medicaid MCOs statewide, five of them in Travis County. One participant suggested that standardizing practices across all these MCOs would be a challenge, especially since some are national plans with policies and practices driven by their corporate office. Some participants thought MCOs would resist change. A few said it all comes down to money: Plans want to know if they will get paid.

> *I think they [MCOs] would only do it if they felt like it both helped them meet their metrics and also was cost effective.*

A few participants pointed out that compared to other states, Texas is less prescriptive with plan requirements. One cited the historical hands-off approach of HHSC.

> *The line of thought I heard was, "We don't want to direct. We allow the MCOs to do whatever they feel like is beneficial to them."*

WORKING WITH ACCOUNTABLE CARE ORGANIZATIONS TO ADD ACCESS TO CHWS

The Affordable Care Act established accountable care organizations as voluntary groups of physicians, hospitals, and other healthcare professionals who accept responsibility for the overall quality, cost, and care of a defined group of Medicare beneficiaries. When Medicare saves money on services because a patient population is healthy, it splits the savings with participating ACOs. This strategy would involve working with the three ACOs in Travis County to convince them to cover CHW services within their capitation rate.

Perceived Feasibility

Several participants said they were not knowledgeable enough about ACOs to rank the feasibility of the strategy. Others confused ACOs with Medicare Advantage Plans, which they thought would probably be amenable to adding CHW services into the mix if they understood the value of the services. The participant who knew the most about ACOs described how difficult it has been for ACOs to integrate financial systems and share cost savings for the services they are already providing. He thought adding CHWs to the mix would only make it more difficult.

Barriers

The most knowledgeable participant was direct about the barriers to implementing this strategy.

> *If you can't prove the cost effectiveness of adding community health workers, it's probably not going to get very far.*

INCREASING PRIVATE DONATIONS TO NONPROFITS

This strategy would entail increasing contributions to nonprofits from the private sector: individuals and businesses.

Perceived Feasibility

Most participants ranked this strategy in the 2 to 3 range, believing it somewhat feasible.

Barriers

One barrier cited by participants was that soliciting donations to fund CHWs has less emotional appeal compared to other causes like pediatric disease. Persuading donors to contribute funds for CHWs would require educating them about the roles and value of CHWs. At the time of interviews, in-person meetings were limited because of COVID-19. Some participants saw the inability to meet potential donors in person to make a case for the value of CHWs, as they had successfully argued in the past, as a significant barrier.

> *I have been exposed to some private donors and after they see what promotores do, the CHWs do, they actually are willing to go the extra mile and not just donate their money, but also ask other friends or family members to do the same.*

STRATEGIES PERCEIVED AS MOST FEASIBLE

Participants identified five funding strategies as the most feasible:

- Increasing investment in community health workers at city/county safety net healthcare providers
- Working with private healthcare providers to increase access to CHWs
- Working with FQHCs to increase access to CHWs
- Increasing grants to nonprofits
- Increasing contracts with nonprofits

The consultants and clients met with the core planning group to review each of these strategies to seek input on narrowing the number to three or four, which would advance to the project's next phase. Key points raised by planning group members are integrated below with the findings for each strategy.

INCREASING INVESTMENT IN CHWS AT CITY/COUNTY SAFETY NET HEALTHCARE PROVIDERS

Initially, the researchers asked participants about the feasibility of two separate strategies related to local governmental entities:

- Increasing access to CHWs in the Medical Access Program, health insurance coverage available through Central Health, the county's hospital district
- Increasing access to CHWs who are employed or contracted by APH and Central Health

After a few interviews, it became apparent that participants did not distinguish between access to CHWs through county-provided health insurance and direct access to CHWs through city/county entities. So, the question was modified to a more general strategy: increasing investment in CHWs at city/county safety net healthcare providers

Perceived Feasibility

Whether commenting on the more general strategy or the original two more specific strategies related to city/county governmental entities, participants consistently perceived the strategies as feasible, ranking them as 1, 2, or 3. Representatives from city and county health-related entities who participated in the interviews said they are already working to maintain and grow their CHW workforce and to increase access to CHWs in collaboration with others.

> *We work collaboratively with our partners. And I think if we can get aligned and continue the strong relationships that we have, I think that will increase access to CHWs for people who have MAP. That's one way. Another way is we bring on more community health workers in the different environments that we work in and where we know our patients are.*

Implementation

Participants stressed the need for a strong leader — someone or some organization to carry the banner to make things happen, and someone to "take the first step to demonstrate a commitment and resources."

> *I think you need kind of a cheerleader to get it started, somebody who's really invested in community health workers and has the data to back it up and would like to see all of our community partners come together.*

As with many other strategies, participants cited the need for data related to CHWs' impacts on patient outcomes and cost effectiveness.

> *You're going to have to have data. … I have a friend that says the numbers don't lie. So it's really hard to dispute that, right? The unique patient stories will only get you so far. You need to be able to show why you want to use them [CHWs], data to support why you want to use them, and then data to show how the work that they're doing is impactful and beneficial.*

Suggestions for who should be involved in planning and implementing the strategy included:

- Central Health
- Austin Public Health (APH)
- Texas Department of State Health Services (DSHS)
- Sendero Health Plans (offers health insurance for low-income residents)
- Local FQHCs
- Dell Medical School
- Integral Care (Travis County's mental health safety net)
- Community colleges (from a workforce perspective)
- Local nonprofit organizations that employ CHWs

Barriers

While some participants believe Central Health and APH are well aware of the value of CHWs, several people said data would be needed to expand their use. Some acknowledged the difficulty of getting compelling data. As one person put it, "Just capturing that data in the clean format is something that we struggle with."

Some participants highlighted the difficulty of coordinating multiple partners, especially when funding is involved.

> *It's been very hard for people to get on the same page and say, "Well, you should be funding this. No, you should be funding that." Just people not being able to figure out who's going to fund it. It's always like this: Whose responsibility is it?*

Participants see one of the key barriers to increasing access to CHWs for governmental entities as limited funding.

> *Is there a place within the health department? Is there a place where it now becomes just part of the budget and expectation of the local community? Whether it's the county or the cities within the county that, "Hey, this is something we want to do. We think it's important."*

Key Insights from the Core Planning Group

Members of the planning group raised several points about data for this strategy, noting that data proving the concept of using CHWs would be key. Central Health has leverage with FQHCs and other providers that see MAP patients, and planning group members thought strong data could influence them to increase CHW usage. That said, they also acknowledged that getting the right data could be challenging. Central Health has complicated processes to access data, including data release committees.

The planning group also discussed who should be the lead for data collection, once the type of data needed to help define the problem or inform the strategy is identified. The logical lead would depend on the type of data. APH could take the lead in identifying disparities and the evidence base for the work, but rounding out that data set with real time examples of CHW successes in the community would require a point person from other organizations like healthcare providers, universities, insurance companies, and advocates.

Driving any type of change in governmental entities relies heavily on public and often complex processes. For example, any increase in the APH budget for CHWs would need to be driven by the community. Typically when a group brings a health-related budget proposal to the Austin City Council, the council consults with APH. If APH agrees that the proposed increase is a good idea, it is considered during the budget process. Each governmental entity has its own budget calendar, which affects the timing of the advocacy work. For changes to the APH budget, the community would need to advocate for change in February and March.

WORKING WITH PRIVATE HEALTHCARE PROVIDERS TO INCREASE ACCESS TO CHWS

This strategy involves policy/practice changes to offer patients access to CHWs at private healthcare providers such as hospitals and primary or specialty care clinics.

Perceived Feasibility

Participants perceived this approach as feasible, with most ranking it in the 2 to 3 range. They cited several ways they believe hospitals and healthcare systems could benefit from using CHWs:

- Reducing ER visits for issues that could be addressed by a primary care provider
- Improving the transition from a hospital stay to clinic care/reducing readmissions (e.g., by finding transportation and prompting patients about follow-up care)
- Relieving hospital social workers of tasks like referrals that can be done more cost effectively by a CHW
- Assisting people with scheduling and prompting them to show up for preventive and primary care appointments
- Helping patients navigate specialty care

A few pointed to Baylor, Scott & White (BSW) as an example of a system that has successfully integrated CHWs into their business model.

> *Look at Baylor, Scott & White … They have a multi-tier community health worker infrastructure where community health workers can be on a career path. … They provide a lot of training support, they're engaging community health workers in a lot of different ways, and they're having really good health outcomes.*

Implementation

Asked what it would take to implement the strategy, participants most often cited the need for:

- Educating healthcare providers about the value of CHWs
- Sharing concrete ROI data showing improved health outcomes and cost savings
- Strong advocacy for employing CHWs

Implementation would require the involvement of:

- Healthcare system leaders
- University researchers
- Insurance company leaders
- CHWs
- Organizations advocating for CHWs

Barriers

Participants acknowledged the difficulty of proving the value and ROI of employing CHWs. Without a successful local demonstration project, and in the absence of any mechanism to require healthcare providers to use CHWs, they believe this sort of system change will be challenging.

Key Insights from the Core Planning Group

Discussion in the core planning group centered around what it would take to implement the strategy, highlighting two critical factors:

- Getting executive leadership on board and designating others in the organization to do the work required to implement the strategy
- Clearly demonstrating the benefits of CHWs

Echoing participants, the planning group acknowledged that Baylor Scott & White employs many CHWs. However, they doubt BSW would champion the strategy for their competitors. A community-based nonprofit organization that employs CHWs or a local governmental entity would be a more likely convener. Either would need to be armed with a thorough cost-benefit analysis and prepared to make a strong sales pitch and advocate for change.

WORKING WITH FQHCS TO INCREASE ACCESS TO CHWS

As presented to interview participants, this strategy included two different potential mechanisms. The first involves changes to the prospective payment system to include services from a CHW in an encounter. Encounter fees generally cover all services provided during a visit, rather than these services being billed individually. For example, an exam by a physician and lab tests that occurred in one visit would be included in a single encounter fee. FQHCs are already allowed to incorporate the cost of employing CHWs into the total cost proposal on which they negotiate per patient visit rates with Medicaid. It is unknown how many do so.

Under the second mechanism, CHW expenses may also be treated as part of FQHC "enabling services" under the U.S. Health Resources and Services Administration (HRSA) Section 330 grant funding, along with transportation and language services.

Perceived Feasibility

Only four participants felt they knew enough about these strategies to give them a feasibility ranking. Among those who did comment, most ranked the strategy in the 1 to 2 range, meaning they thought it was feasible.

Implementation

The two participants representing FQHCs were particularly interested in exploring whether their organizations knew about the option for the prospective payment system and whether their leadership team had considered implementing the strategy. Both saw the first steps as an internal exploration.

> *If it's an opportunity that's available to us, it really just takes convincing the right people in our compliance team who would have to write up and look over contracts to okay that.*
>
> *We've never done it. However, I feel like we have a lot of good data and information to make the case for it, especially since we've had CHWs for a while and how we've used them.*

However, both also saw potential value in pulling together a team of people from several FQHCs.

> *I think that if we're able to work with other FQHCs who are coding and billing similarly to understand the barriers, I think that makes it more of a 1 than a 2. If we're doing this work collaboratively, because that's less work for our team to have to figure out. We could split it up and figure out little pieces here and there and bring that back together.*

Barriers

Most participants could not identify any specific barriers. Instead, they had questions:

- If these strategies are allowable now, why aren't the FQHCs implementing them?
- How complicated is the process to renegotiate encounter fees? Is it just too much work?
- Where are the local FQHCs in terms of readiness? Do their cultures embrace change?

One knowledgeable participant clarified that renegotiating encounter fees relates to Medicaid. This fact lowered the feasibility of the strategy in the eyes of the consultants and clients, since most other Medicaid strategies were perceived as not very feasible.

Key Insights from the Core Planning Group

The planning group echoed the questions posed by interview participants.

> *We don't know why the FQHCs have not implemented this strategy already. Is this mainly an issue of leadership and the overall culture that they haven't moved forward with it, even if they potentially know about it? Is it because they don't really feel like it's like a priority? Or is it a complex process and they need extra legal counsel or specialists?*

They raised new questions about the importance of defining the role of CHWs compared to the role of other professionals. For example, what does a social worker do compared to what a CHW does? The absence of a clear line can make it hard to prove the value of CHWs and difficult for leadership to decide to go one way or the other in a hiring decision. When a CHW is also a certified nurse aide and can do more clinically, it further complicates the issue.

INCREASING GRANTS TO NONPROFITS

Grant awards are currently one of the most common arrangements for funding the CHW workforce. This strategy would entail increasing federal grants to local governmental entities and universities as well as increasing grant funding to nonprofits and healthcare providers from governmental entities, universities, and foundations.

Perceived Feasibility

Participants expressed a high level of interest and enthusiasm for this strategy. Most perceived increasing grants as feasible, ranking it in the 1 to 2 range. Some participants acknowledged that grant funding is temporary, but thought grants could be a way to demonstrate the value of CHWs and provide a pathway to more sustainable funding.

> *It is a great way to jumpstart work around this… if those [grant] investments can be strategic so that we're evaluating and making a case for the cost effectiveness, for the value that community health workers bring.*

Implementation

Participants suggested that to make the biggest impact, stakeholders should strategize together on an approach to grant opportunities. Proposals should focus on the potential impact on the health of community members and on systems changes and sustainability. Participants said foundations, governmental agencies, and other entities would have to be convinced that funding CHWs is a good investment. It would be crucial to educate these organizations on the benefits of CHWs through widespread educational and promotional campaigns.

> *You're going to have to show foundations and people who have money that's a good place to put their money… You have to pull on those heartstrings and you have to make an impact.*

A number of participants recommended that stakeholders act soon to take advantage of what they perceive as a heightened awareness of CHWs and a high level of interest in health disparities and social determinants of health. They also feel that foundations are interested in innovative approaches and that philanthropy is trending toward more general, flexible funding approaches, both of which would lend themselves to CHW funding.

> *Like agencies are opening up to fund CHWs and that is becoming more visible nowadays. If we go back five years, it was hardly ever that there was much money available for CHWs…. I think nowadays there are a lot more benefits that are directly related to CHWs that aren't as specific.*

Participants said it would be important to use grant-funded projects to collect data proving the case for CHWs, such as ROI, impact on patients' health, and other data points like reduction in ER visits and hospitalization.

Suggestions for who should be involved in implementation of this strategy include:

- The project's core planning team
- Policy makers: city council members and county commissioners
- APH
- Central Health
- CommUnity Care
- Travis County Health and Human Services
- Healthcare providers
- Foundations: St. David's Foundation, Michael and Susan Dell Foundation, Episcopal Health Foundation
- Dell Medical School
- Nonprofits that employ CHWs
- Representatives from the DSHS CHW program

Barriers

Across the board, participants recognized as the biggest barrier to increasing grants the will or ability of governmental entities to earmark funding and offer grant opportunities. They also identified a number of other barriers to implementing this strategy:

- Grant funders may not understand or appreciate the value of CHWs and, therefore, not want to fund them.
- The field is crowded: Numerous organizations and causes are continuously seeking grants, resulting in competition for limited funding.
- Grants are short-term and often have restrictions on how the money can be spent, such as caps on salaries and administrative costs.
- Funders may have priorities other than CHWs.
- Funders may prefer to support broader sustainable systems change initiatives that include CHWs instead of ongoing operational costs for CHWs.
- Grant writing is time consuming and may disrupt the focus on normal operations.

Key Insights from the Core Planning Group

The planning group was optimistic about this strategy because they see it is already happening. They pointed to the Texas Accountable Communities for Health Initiative (a partnership between St. David's Foundation and Episcopal Health Foundation) as an example, and noted that there are many opportunities to build on work that already incorporates CHWs.

They saw a possible parallel to the approach that the City of Austin has taken to address homelessness by engaging the "big guns in philanthropy in Austin and Central Texas," as well as private businesses that have a stake in that game. That said, they recognized that a coordinated community effort to seek grant funding feels challenging because it would involve multiple entities.

> *You can't pull a lever to make this happen. It's more like everyone proving the benefit of CHWs through other activities and through other grants, and then collectively that raises the profile of that particular role. But the idea of convening these people to change things seems very challenging.*

One member said there may be an advantage to grants from local governmental entities, compared to contracts, since grants have fewer administrative burdens, offer greater programmatic flexibility, and typically provide the full funding upfront. In contrast, nonprofits with contracts are reimbursed after the fact for expenses, which can be challenging for smaller organizations. Finally, the group pointed out the importance of being aware of foundation funding cycles.

INCREASING CONTRACTS WITH NONPROFITS

This strategy would involve increasing contracting arrangements between nonprofits that employ CHWs and governmental entities, universities, or healthcare providers.

Perceived Feasibility

Most participants ranked this strategy in the 1 to 2 range, perceiving it as feasible.

> *Like how we [a local FQHC] have our medical-legal partnership. They're here at the clinic, but they're employed by Texas RioGrande Legal Aid. I feel like that would be a really good approach, with hospital systems to partner with nonprofit organizations …where they [CHWs] are in the ER, following up with patients upon discharge.*

Implementation

Participants said key stakeholders would need to come together to strategize how to educate potential contracting entities on the importance and value of CHWs, and make the financial case for why they should invest in contracted CHWs.

Successful implementation would require data that identifies community needs (e.g., transportation, access to healthcare, nutrition) and shows how the services CHWs offer can help address those needs. One participant suggested a promotional campaign with print and digital media highlighting CHWs and creating a "sales force" of CHWs equipped with metrics showing their successes and impact.

Suggestions for who should be involved in implementation include:

- The core planning group
- Dell Medical School
- Other entities interested in CHW services
- Nonprofits that employ CHWs
- CHW associations

Barriers

A few participants believe some organizations will not want to contract with CHWs, preferring employees rather than contractors so that they have more control and flexibility.

> *When it comes to contracting arrangements for community health workers, I think entities want to invest more in their own employees and build them to what they want them to be.…You want to be able to direct and guide your CHWs. Sometimes contracts don't allow that to happen efficiently.*

Participants recognized as a barrier the limited number of nonprofits in Travis County that employ CHWs. Other barriers cited included:

- Disjointed arrangements because contracted CHWs would not be fully part of the team
- Potential difficulty or inability for contracted CHWs to access providers' electronic health records systems
- Governmental entities and healthcare providers not understanding the value of CHWs and not wanting to contract for their services

Key Insights from the Core Planning Group

Core planning group members cautioned that it may be difficult to identify a clear champion for this strategy because every nonprofit serves a different priority population. They identified AACHI, El Buen Samaritano, Latino HealthCare Forum, Foundation Communities, and GAVA (Go Austin/Vamos Austin) as nonprofits that employ or have employed CHWs. They also pointed to One Voice Central Texas, an umbrella organization for about 30 nonprofits that has been successful in advocating for people experiencing homelessness, as a model or roadmap for how to organize.

On a more encouraging note, one member said the seeds for this approach have already been planted, giving as an example APH's program for new moms with St. David's and Ascension Seton hospitals.

> *CHWs visit new moms in the hospital and do an assessment of how prepared they are to be with a baby at home. They pass that information on to the nurse. The hospitals like it because they're not paying a staff position to do that entry level assessment. Through this partnership … there is a recognition by some of our larger healthcare or hospital partners of the value of CHWs.*

ENGAGING THROUGH NEW BUSINESS MODELS

This strategy entails partnerships and agreements among foundations, nonprofits, FQHCs, MCOs, insurance companies, and local governmental entities where these stakeholders work together to establish a mechanism for collaboration. Stakeholders would define roles and shared goals, and contribute resources in a coordinated way.

Perceived Feasibility

There was no clear pattern of perceived feasibility. Some participants ranked this strategy as a 1, thinking it very feasible.

> *This is the ideal scenario. This is to me what should happen… I think if it's presented right and you have the right people in the room.*

Others ranked this strategy in the 3 to 4.5 range, or not very feasible. They felt collaboration among stakeholders would be difficult.

> *If we have a relationship with one other party, we're able to work through a variety of things pretty well. But it seems like even if you add a third party, now there's three of us and it's just every party after that you add, it really seems to bog everything down… To have these many stakeholders come together, it's really difficult.*

Implementation

Participants said implementing this strategy would require a strong champion or lead organization that could bring the stakeholders together and look for synergies and places where missions, goals, and objectives overlap. A few suggested it would be useful to search for examples of success or models that might work for this scenario, such as the social impact funding model or hub model.

Ideas for who should be involved include:

- City/county leaders
- FQHCs
- Dell Medical School
- ECHO (Ending Homelessness in Austin and Travis County), as a model
- St. David's Foundation
- Nonprofits
- Health insurance companies

Barriers

The greatest barrier cited by participants was bringing the various stakeholders together to focus on tasks and agree on critical items such as:

- What process and model to implement?
- What organization will take the lead?
- Who will be in charge of the funds?

Participants thought politics would likely play a role in complicating the answers to these questions, and competing priorities could hamper progress. To be successful, partners would need to fully participate and contribute; the strategy would not work if partners only had a general interest.

Upon reflection, the consultants and clients concluded that participants' ambivalence about the feasibility of this strategy may have been because this approach focuses on process rather than content, and could apply no matter which strategies the group chose to advance. Considering forming partnerships for the more feasible concrete funding strategies would naturally be perceived as easier than forming partnerships for the less feasible strategies.

PHASE 2 ACTIVITIES

After considering the findings from the interviews and input from the core planning group, the clients and consultants decided to explore next steps for three strategies:

- Increasing investment in CHWs at city/county safety net healthcare providers
- Working with FQHCs to increase access to CHWs
- Working with private healthcare providers to increase access to CHWs

For each strategy, the consultants reached out to one or more critical stakeholders to explore options for taking the next step. In all three cases, it became clear that the originally proposed approach (forming a workgroup to develop an action plan) would not be feasible or helpful. Each strategy would demand more time and longer-term effort than allowed in the project scope. Nevertheless, the Phase 2 conversations shed light on the potential paths forward.

In an effort to increase general interest in and call attention to potential funding strategies for CHWs, the consultants formally presented the research findings to the Texas Department of State Health Service Training & Certification CHW Advisory Committee and to the Austin/Travis County Community Health Improvement Plan (CHIP) Access to and Affordability of Health Care Workgroup. No new leads or potential next steps resulted from these presentations.

INCREASING INVESTMENT IN CHWS AT CITY/COUNTY SAFETY NET HEALTHCARE PROVIDERS

The main players for this strategy are APH (the local public health department) and Central Health (the Travis County Hospital District). The core planning group thought this strategy was a good candidate for further exploration because the stakeholders most critical to implementation are all within these systems. Additionally, for both entities, implementing the strategy would not be a new pursuit but would build on what they have already started.

AUSTIN PUBLIC HEALTH

APH offers a wide range of public health services, including screenings for a variety of health conditions; nutritional support through the Women, Infants, and Children Program (WIC); birth and death certificates; inspection and permitting of restaurants and food establishments; outreach and education, and emergency preparedness programs.

After a member of the core planning group shared that APH employs CHWs in various capacities, the consultants and clients held a video call with someone more closely associated with the program to get more details. The city is actively working to build infrastructure within the department — to create job titles, a progressive career ladder, and a hub. APH is also committed to establishing a center for continuing education credits for CHWs across the state. While APH currently employs CHWs rather than contracting with other entities for those services, contracting could be possible in the future.

CENTRAL HEALTH

Central Health is responsible for providing healthcare to indigent persons residing in Travis County. The hospital district covers primary care, as well as indigent care at the county's safety net hospital and other providers. Central Health also administers MAP, which provides health insurance coverage for Travis County residents with low income who are not eligible for or enrolled in Medicaid or Medicare, and do not have private insurance. MAP participants can access healthcare at any MAP-approved provider.

There are two potential paths to implementing this strategy at Central Health:

- Increase the number of CHWs employed by healthcare providers who serve MAP participants.
- Increase the number of CHWs employed or contracted by Central Health.

The consultants met with a representative of Central Health to explore next steps. She shared that the district was in the process of developing the internal infrastructure and expanding the number and roles of health management liaisons (their title for CHWs) who work within Central Health. The hospital district is newly licensed to provide medical services so staff are reviewing job descriptions and exploring how CHWs can continue to provide services within their scope in a variety of settings, including clinical teams. Learning about these changes was very encouraging because they will likely yield an increase in the number of sustainably funded CHWs employed by Central Health. That said, the expansion appears limited to employees and would neither include any opportunities for nonprofits to contract with Central Health for CHW services, nor would it affect the number of CHWs employed by healthcare providers who serve MAP participants.

NEXT STEPS

APH and Central Health are both working to increase the number and impact of CHWs within their organizations. Current Austin City Council members have shown interest in CHWs and expressed support for increasing the number of CHWs in the community. However, at this point, there is no clear champion or organized community coalition committed to advocating for different, more expansive employment/contracting or grant-funded models that could benefit residents through CHWs employed by nonprofit organizations.

Building a broad-based coalition to increase investments in community-based CHWs through the city and county could still be on the table, but only as a long-term strategy. Since city and county funding is necessarily short-term, reflecting budget cycles, these advocacy efforts would need to be sustained over time.

As noted in the detailed findings above, any efforts to increase city funding for CHWs (whether by employees or contractors) through APH would have to begin with external stakeholders and partners building the case and advocating for change during February and March, in line with the City Council's budget process. An alternative approach would be to explore whether city entities other than the health department might be open to employing or funding CHWs (e.g., the Electric Department where CHWs could help with bill assistance, or the Police Department where CHWs could be part of response teams or help with referrals).

Advocacy for increasing funding for CHWs through Central Health would need to start in January and continue through May, since the budget is submitted in June or July and voted on in August. The budget year starts in October. As the Central Health representative pointed out:

> *It's a great idea getting things approved through the city and the county. You just have to make sure it's in their priorities, because if it's not in their priorities, it's not going to get approved and they're not going to add funding for it.*

WORKING WITH FQHCS TO INCREASE ACCESS TO CHWS

Since the two representatives from FQHCs who participated in the interviews were both enthusiastic about pursuing ways their systems could find more sustainable funding for CHWs, the consultants first followed up with them. One had since moved to another job. The other approached her clinic's leaders, and reported that they believe they have already maximized funding for CHWs.

Next, the consultants met with representatives from the Texas Association of Community Health Centers (TACHC), the statewide organization that supports and advocates for FQHCs. At that point — having ruled out the renegotiating of encounter fees as a viable option for funding CHWs because the strategy is related to Medicaid — the consultants focused the discussion on the other FQHC strategy, categorizing CHWs as "enabling services" under HRSA Section 330 grant funding. TACHC representatives clarified that implementing this strategy would not increase the total amount of the 330 grant funds received, which depends solely on federal appropriations. It would just mean renaming pieces of the existing pie.

Takeaways from the more general conversation that followed include:

- TACHC has observed that FQHCs fund CHWs in a variety of ways: grants, unrestricted funds, and operating budgets.
- Most FQHCs assign and pay for CHWs for specific roles (e.g., leading cooking classes as part of chronic disease management, making follow-up phone calls after clinical visits, or providing patient/family education on behavioral health).
- TACHC is working to increase awareness of the role of CHWs on care teams, where services are bundled and can include CHW costs.
- Most FQHC locations are probably closed systems that prefer the CHWs to be employees under their own umbrella instead of contractors.
- Concrete ROI data would help TACHC promote the use of CHWs.

NEXT STEPS

While both of the specific FQHC strategies tested (related to encounter fees and 330 grant funding) hit dead ends, a potential opportunity remains. Of the three FQHCs in Austin, two have funded numerous CHWs with grants and subsequently transitioned their positions to sustainable general operations. One of those, CommUnity Care, a separate but affiliated 501(c)(3) organization of Central Health, has had notable success integrating CHWs into clinical teams, where the clinicians have become their greatest cheerleaders. Austin is sitting quietly on a successful FQHC CHW funding model, which could be replicated in other FQHCs as well as private primary care clinics, if only a passionate leader and motivated team would decide to take up the charge.

WORKING WITH PRIVATE HEALTHCARE PROVIDERS TO INCREASE ACCESS TO CHWS

During the interviews, several participants mentioned that the Baylor Scott & White healthcare system employs a large number of CHWs and suggested that the consultants contact them to learn more about their model and assess whether it could be replicated in other healthcare systems in the Austin area.

The consultants met with a BSW representative, who described the system's fast-growing commitment to CHWs. BSW first experimented with CHWs in a role for diabetes management. From that single CHW funded by Merck, the system expanded to four CHWs in 2004, and to 12 in 2011, when CHWs were hired with grant funding as navigators to connect unfunded patients seen in emergency rooms to BSW's community clinics. By 2014, BSW had developed five CHW job codes and employed 30 CHWs. By 2017, the system employed 100 CHWs, all funded through the operating budget.

Currently CHWs play the following roles:

- Navigation
- Chronic disease education
- Outreach
- Home visits
- Various roles in the BSW Quality Alliance, the Medicare ACO affiliated with the system

The BSW representative credits the growth of the CHW workforce primarily to the leadership of the CHW Development Council, which meets annually at the beginning of the year. The council has two subcommittees: career development/continuing education and best practices/program evaluation. Over the years, the CHW program has enjoyed strong support from the medical director, vice president of community health, and CEO. The BSW representative believes the model can be replicated and offered the following lessons learned:

- There must be a well-versed champion — someone to answer questions and address certification.
- Do not focus strictly on ROI. Administrators would never ask about ROI before deciding to hire a nurse. Just hire the CHWs. Their value will become clear. The CHWs complement the interconnected teams, and patients love them.
- CHWs allow social workers and nurses to work at the top of their license, doing the things only they can do. Let the CHWs do the referrals and follow-ups.

The representative also suggested that whoever explores this strategy with other private healthcare providers should look at the annual Community Health Needs Assessments that charitable hospitals must complete. Usually some needs relate to social determinants of health, but healthcare systems rarely have staff to help patients address these issues. This gap could be a starting point for a discussion about the value of hiring CHWs.

After talking with the BSW representative, the consultants met with representatives from another Austin-area private healthcare system to share the research findings, give a general overview of how BSW employs CHWs, and determine if they would be amenable to expanding the use of CHWs in their system. The representatives showed interest in the research findings and a general appreciation for the value of CHWs. Their healthcare system employs a number of navigators who are not called CHWs, but function similarly and may or may not be certified CHWs. Certified CHWs do work with children covered by the Medicaid health plan offered through the system.

Other takeaways from the discussion included:

- None of their hospitals have identified CHWs as part of their strategy to address the social determinants of health identified in the system's Community Health Needs Assessment.
- Representatives were not aware of any contracts with CHWs within their system but pointed out that because of the variations in job titles, there might be employees doing similar work.
- Several times during the discussion, the representatives brought up the need for a more standardized language and terminology related to CHWs, so that there is a common understanding of who they are and what they do. They felt it would be beneficial for someone to take on this endeavor.
- From these representatives' perspectives, people who are uninsured/underinsured are the most likely to benefit from interaction with CHWs. Based on this assumption, the representatives felt that Central Health, the authority responsible for safety net healthcare, would need to lead the initiative, and that any expansion of the CHW workforce would best happen in the public sphere. They did not show any interest in replicating the work BSW has done to integrate more CHWs into their own system.

NEXT STEPS

The Phase 2 explorations of this strategy led the consultants and clients to two very different examples: BSW, which has excelled at integrating CHWs systemwide, and another major local system that uses CHWs in more limited numbers and capacities and is unlikely to change that approach. Much like the conclusion drawn for the FQHC strategies, the opportunity to replicate BSW's success exists but would require the right champion stepping up to organize the effort.

FINAL CONSIDERATIONS

Beyond the next steps above for the three strategies carried forward, the interactions with the interview participants, core planning group, and representatives of the organizations involved in Phase 2 brought to light a number of general activities that could strengthen the foundation for CHWs in Travis County:

- Build a coalition to raise general awareness about the value of CHWs to potential funding sources and entities that could benefit from using CHWs. Perhaps the coalition could develop a marketing campaign: What Are CHWs?
- Explore what it would take to develop a common language and terminology around CHWs. Each organization is defining titles, roles, and scope differently. State certification was a good first step, but it leaves much leeway and opens the door to confusion, making it harder for entities to collaborate.
- Start a concerted effort to compile and analyze local data related to CHWs. CHWs are active and making an impact in a variety of settings in Travis County. Some employers are probably collecting data. Bring the data together to create a compelling picture of the value of CHWs.
- Organize and advocate for some of the Medicaid strategies.
  - In the short term, a small group of people could identify 1115 waiver demonstration projects in Travis County, explore opportunities to maximize the use of CHWs in these projects, and find ways to collect local data to help support future investments in CHWs. Participants perceived this as one of the most feasible Medicaid strategies.
  - For a longer-term proposition, form a broad coalition to push for a Medicaid state plan amendment. Achieving this policy change would result in a wide-scale increase in funding for CHWs in preventive health roles compared to the smaller impacts of implementing changes organization by organization and facility by facility. Participants want this change to happen, even if they believe it is not currently feasible.

  Note: There is good news on this front. In May 2023, as this project was wrapping up, the Texas legislature passed HB 1575 with bipartisan support. The new law establishes Medicaid reimbursement for nonmedical case management services provided by CHWs and doulas, with the goal of improving outcomes

for pregnant women and their children. This is a monumental first step for Medicaid policy change because it requires HHSC to add CHWs as a provider type in Medicaid. This change could also produce data showing the benefits of CHWs and potentially pave the way for broader policy changes.

- Acknowledge that as things stand, the CHWs most likely to be sustainably funded are those working within organizations in the healthcare, health insurance, and governmental spaces where general operating funds, grants, or both can cover costs. Currently there are few reimbursement mechanisms in place to help healthcare providers pay for CHWs, but policy changes could open up that opportunity in the future. Nonprofit organizations that employ CHWs to provide general, less clinical services (e.g., outreach; education; assistance with transportation, housing, and other social determinants of health; translation; and healthcare navigation), and especially organizations that serve smaller segments of the population based on culture and language, currently have limited funding options that are labor intensive and tenuous. These options include:
  - Relying on grants and donations, with the former being challenging because foundations often prefer to fund start-up or demonstration projects while expecting the organization that receives the funds to sustain costs after the grant period; and the latter challenging because of the time and effort involved in soliciting donations from each individual and company.
  - Establishing partnerships and business relationships with healthcare facilities and systems, health insurance companies, and government entities to explore ways to fund CHWs. This is again challenging because of the complexity of shared finance mechanisms and the preference of these types of entities to employ their own CHWs rather than fund them through an outside organization.
- Share the findings of this study widely so that healthcare providers, insurance companies, and governmental entities understand that if they want to lift up the whole community through the positive force of CHWs, they will need to provide ongoing resources to fill the funding gaps.

ACKNOWLEDGEMENTS

Finally, as consultants, we want to recognize and appreciate the many people who made this exploration possible:

- Core planning group members, busy community leaders who made time to meet on Zoom and share their expertise and experience
- Many critical thinkers in Texas and across the country whose work and online presence allowed us to compile a list of potential strategies to test with stakeholders
- Interview participants, to a person passionate about the value of CHWs and each working in their own way to expand the pool and multiply the impact
- The professionals who gave us their time and shared their insights as we entered the project's second phase
- Our clients at AACHI, Hailey Easley and Thanh Bui, who invited us to the table

APPENDIX A: PROJECT PROPOSAL

Austin Asian Community Health Initiative
Sustainable Financing for Community Health Workers — Proposal
Dr. Wanda Thompson and Jacquie Shillis

GENERAL APPROACH

We will use the following approach to developing a sustainable financing model for CHWs for the Austin, Texas, area:

RESEARCH AND PLANNING

1. Research existing materials.
2. Identify key stakeholders and content experts and collect/compile input from them.
3. Plan with clients and key stakeholders (core planning group).

WORKGROUPS

4. Recruit workgroup leaders and members.
5. Convene workgroups at a kickoff meeting.
6. Facilitate a series of workgroup meetings to develop targeted strategies and recommendations.

COALITION BUILDING

7. Convene workgroup members and other invited stakeholders to organize around action plans and chart next steps.

During the research phase, the consultants will hear from people who have already been exploring potential financing mechanisms for CHWs. Building on these findings, up to four workgroups will be formed to strategize for specific scenarios, for example: changes to Medicaid, changes to policies for federally qualified health centers, changes to managed care contracts, demonstration projects.

Workgroups will be formed around what interview participants consider the most feasible ideas. The process is designed to give workgroup members the connections and tools they need to do a deep dive into opportunities for a given scenario, while also keeping a focus on the big picture and the intersections in the work through coordination with the core planning group.

PHASE 1: RESEARCH AND PLANNING (MONTHS 1-4)

During this phase, consultants will:

- Conduct background research (information provided by client, national research, and experience of other states)
- Form a core planning group and conduct a kickoff planning meeting (could be virtual)
  - Review scope of project, goals, roles
  - Agree on process
  - Identify additional key stakeholders and content experts
- Conduct in-depth phone/video interviews and compile findings
- Present the findings to core planning group (could be virtual)

PHASE 2: WORKGROUPS (MONTHS 5-12)

During this phase, consultants will:

- Identify and recruit members for up to four workgroups
- Facilitate a joint workgroup kickoff meeting and up to six monthly meetings for each workgroup. Each workgroup will develop recommendations for specific calls to action related to a CHW funding strategy.
- Monthly meetings with the core planning group (could be virtual) to share workgroup progress, explore opportunities, and troubleshoot.

PHASE 3: COALITION BUILDING (MONTHS 13-18)

During this phase, consultants will facilitate a kickoff coalition/project culmination meeting. A broader group of stakeholders will hear about the research findings and workgroup recommendations and ideally commit to moving the recommendations forward. The consultants will:

- Conduct planning meetings with clients and workgroup leaders to prepare for the culmination meeting.
- Facilitate culmination meeting for all workgroup participants and any stakeholders they want to invite
- Each workgroup presents recommendations and calls to action
- Consultants facilitate discussion of next steps

APPENDIX B: SELECTED RESOURCES USED FOR BACKGROUND RESEARCH

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APPENDIX C: INTERVIEW GUIDE

DATE:

PERSON BEING INTERVIEWED:

CONTACT INFO:

Thank you for taking the time for a phone call. As _____ explained in his/her email, we are working to develop more reliable, sustainable funding for Community Health Workers in Travis County. The initial phase of this project includes interviews with key stakeholders such as yourself. We are interested in hearing different perspectives about what strategies you think might work, as well as any thoughts about challenges and barriers. These insights will help us organize workgroups around the most feasible options.

This is not a test; there are no right or wrong answers. If you do not know the answer to one of my questions, something does not apply, or you would rather not answer, just say so and we'll move on. The interview should take about 45 minutes.

This is a confidential conversation. That means what you say will not be connected with your name or organization. The findings from the interviews will be summarized without identifiers. I will be taking detailed notes as we talk. If it is OK with you, I would like to record the interview to make sure I don't miss anything. If you are not comfortable with recording, that's fine too.

> *If willing to record the call: Great, thank you. I'm going to ask you to call me back at a different number, which will be forwarded to the cell phone that I am using now. This system ensures your consent because 1) you have to take action by calling me, and 2) I can only hit the button to activate recording on incoming calls. Here's the number: _____.*

> *Once reconnected, hit #4 to record and announce: This is _____ and I am interviewing _____. _____, do you consent to this conversation being recorded?*

Thank you. Do you have any questions for me before we start?

BACKGROUND INFORMATION

1. Please tell me a little about yourself and what you do. What is your connection to community health workers?

   Alternative for when we know more about the person already:

   I know that you (describe and acknowledge past work) _____. Would you tell me a little more about that and any other ways you have been involved with community health workers?

QUESTIONS ABOUT STRATEGIES AND APPROACHES

For the rest of our conversation, I want to make sure we have the same understanding of the term "community health worker." If you could please look at the document I sent, Section A includes the language, so you can see it as well as hear it.

> The American Public Health Association describes community health workers as "frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."
>
> Our project's core planning group members noted that
>
> "Community health workers should be racially and ethnically representative of the communities we're trying to serve; with similar lived experience. Training social workers and other professionals to do this work is negating what the CHW model is trying to leverage."
>
> And finally, for our purposes, CHWs may be people who are certified by the state, as well as those who are employed in a CHW role and working toward their certification.

So, when I refer to community health workers, that's what I mean. Any questions?

Great, let's get started. We know a lot of work has been done, locally and statewide, around increasing and expanding the use of community health workers. Because previous workgroups and reports have identified a lack of sustainable funding as a particularly stubborn challenge, this project focuses narrowly on funding for CHWs in Travis County.

To give you some local context for our conversation, if you would look at Section B in the document, you'll see data from the state health department about where community health workers are employed in Travis County. This information is important because funding streams for community health workers might vary by employer category. It's likely an undercount because it only reflects certified CHWs — not those who are working on certification — but it gives us a general idea of the employer groups.

We know that community health workers play different roles, ranging from helping people get access to healthcare and navigate the system, to educating and coaching people to better manage chronic disease These roles may affect funding streams as well.

1. My first question is: Does your organization employ or contract with community health workers, and if so, what roles do they play?

   If yes,
   How do you fund them?
   What metrics do you use to demonstrate their value?
   Are your funding sources adequate?
   Are you doing any work to try to increase funding? What are you trying?

   If not, tell me about any experience, involvement, or knowledge you have related to funding for community health workers.
   What is the setting?
   What roles do the CHWs play?
   How are they funded?

2. Let's talk about specific strategies. I'm going to mention some strategies we learned about from researching and from talking to other stakeholders, and I want your take on their feasibility. If you're not familiar with the strategy or do not have enough information to assess the feasibility, just say so, and we will move on to the next one. Every response, even "I don't know," is useful information. The strategies are listed in Section C of the document so you can follow along as I go through the list.

   Probes for each:
   On a subjective scale of 1 to 5, where 1 is very feasible and 5 is not at all feasible, how feasible do you think this idea is?
   (If they say "not feasible" [4 or 5]," ask, "What makes you say it's not feasible?" and stop there.)

   If they say feasible [1, 2, or 3], ask:
   What do you think it would take to implement it? What would have to happen?
   What data would be needed?
   What barriers do you see?
   What people or groups do you think would need to be involved?

Strategies related to Medicaid

- Medicaid state plan amendment
- Changes to the state's 1115 waiver
- Legislation to categorize community health worker services as quality improvement costs instead of administrative costs in Texas Medicaid managed care contracts
- Policy/practice changes to require or incentivize Medicaid managed care providers to offer services from community health workers

Strategies related to other healthcare coverage

- Policy/practice changes in private-pay or employer-provided health insurance to include services from community health workers
- Pooled funds from third-party healthcare payers
- Working with accountable care organizations to identify ways to increase access to CHWs for people covered by Medicare
- Working with the city and county to increase access to CHWs for people in the Medical Access Program

Strategies related to healthcare providers

- Changes to prospective payment system (federally qualified health centers)
- Policy changes to internal financing mechanisms of private healthcare providers (hospitals, primary and specialty care)

Strategies related to nonprofit organizations

- Grants from foundations and governmental entities
- Private donations
- Contracts

New business models

- Partnerships and agreements through public-private partnerships (for example, pooled funds from local foundations, nonprofits, FQHCs, and local governmental entities)

3. Can you think of any other strategies I have not mentioned?

4. After we identify the strategies key stakeholders believe are the most feasible, could we contact you about participating in a workgroup that would meet monthly for six months to begin to look more deeply into a few of the ideas?

   If yes: Thank you so much. We will keep you on our list of folks to contact. Do you have any ideas for who should be included in the workgroups?

   If no: Understood. Do you have any ideas for who should be included in the workgroups?
   We know six months won't be long enough to fully implement the workgroups' ideas, so the project also involves a bigger gathering (hopefully in person) after they finish their work. It will be a way to learn about the workgroups' recommendations, discover which strategies have broad support, and help folks organize next steps. Would you like to be invited to that meeting?

FINAL THOUGHTS

5. OK, we are almost done. This is my last question. And you can refer to Section D of the document. When we think of the key stakeholders for community health workers in Travis County, they fall into five main categories:
   - Health insurance/managed care companies
   - Organizations, mostly nonprofit, that provide health-related or social services, including outreach and navigation
   - Local governmental entities
   - Healthcare providers
   - Foundations

   If you were to design a new system for Travis County where some or all of these players collaborated in a new way to create more sustainable funding for community health workers, what would that look like? Who would need to be involved?
   If you want to think about this question or any of the others, please feel free to email me your thoughts in the next couple weeks, or we can set up another call.
6. Anything else you would like to add? Any lessons learned or advice? Anyone else you think I should talk with?

Thank you so much for your time!

APPENDIX D: INTERVIEW PARTICIPANT HANDOUT

A. DEFINITION OF COMMUNITY HEALTH WORKER

The American Public Health Association describes community health workers as "frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."

Community health workers should be racially and ethnically representative of the communities we're trying to serve; with similar lived experience. Training social workers and other professionals to do this work is negating what the CHW model is trying to leverage.

CHWs may be people who are certified by the state, as well as those who are employed in a CHW role and working toward their certification.

B. TRAVIS COUNTY EMPLOYERS OF CERTIFIED CHWS*

Health insurance/Managed care/Medicaid	49
Nonprofits/Social services	39
Healthcare providers	27
State/Local governmental entities	15
Educational institutions	7
Total	**137**

*Certified CHWs employed with these organizations may work in positions other than CHW.

C. SPECIFIC STRATEGIES

1-5 scale: 1 = very feasible. 5 = not at all feasible.

Strategies related to Medicaid

- Medicaid state plan amendment
- Changes to the state's 1115 waiver
- Legislation to categorize community health worker services as quality improvement costs instead of administrative costs in Texas Medicaid managed care contracts
- Policy/practice changes to require or incentivize Medicaid managed care providers to offer services from community health workers

1-5 scale: 1 = very feasible. 5 = not at all feasible.

Strategies related to other healthcare coverage

- Policy/practice changes in private-pay or employer-provided health insurance to include services from community health workers
- Pooled funds from third-party healthcare payers
- Working with accountable care organizations to identify ways to increase access to CHWs for people covered by Medicare
- Working with the city and county to increase access to CHWs for people in the Medical Access Program

Strategies related to healthcare/public health providers

- Changes to prospective payment system (federally qualified health centers)
- Policy changes to internal financing mechanisms of private healthcare providers (hospitals, primary and specialty care)
- Increased investment in CHWs at city/county health departments

Strategies related to nonprofit organizations

- Grants from foundations and governmental entities
- Private donations
- Contracts with healthcare providers (public and private)

New business models

- Partnerships and agreements through public-private partnerships (for example, pooled funds from local foundations, nonprofits, FQHCs, managed care organizations, and local governmental entities)

D. KEY STAKEHOLDERS

- Health insurance/managed care companies
- Organizations, mostly nonprofit, that provide health-related or social services, including outreach and navigation
- Local governmental entities
- Healthcare providers
- Foundations
- Community health workers