SDOH Partner Meeting: Advancing Health Equity With Community Health Workers

Tuesday, August 9, 2022, from 1:30-3:00 PM

Meeting Summary

- More than 100 people representing organizations that lead and support Health Equity, Community Health Workers (CHWs) and/or related work contributed to the meeting. Staff from MDHHS facilitated the meeting and breakout sessions.
- Participants were provided a SDoH Strategy Phase I update, and an overview of what to expect in Phase 2, including a focus on Health Equity and aligning and expanding CHW related efforts.
- Our partners from MiCHWA (Michigan Community Health Worker Alliance) presented on their important work, and collaborative projects with MDHHS
- MDHHS also provided an update on the language in the FY23 Omnibus Budget Bill (Passed June 30), the factors in Medicaid CHW policy development, and methods of engagement that will be used throughout the policy development process.
- Participants were asked to join one of three breakout sessions, where each group shared their feedback on key findings from intern and U of M graduate student Ellie Jorling's environmental scan report.
- Feedback from each breakout session was captured and compiled. Input will be synthesized and incorporated into the overarching Strategy.

Discussions

In breakout sessions, participants discussed key findings of an environmental scan of CHWs.

Key findings include:

1. CHWs are critical component of the SDOH Strategy: they connect their communities with health and social services.
2. Funding issues: CHWs are overworked and underpaid, and should be paid with Medicaid funding, since there is precedent in other states.
3. CHW certification requirements differ across sectors and employers. To ensure equitable access to quality services and continuity in coverage, an effort to standardize or align requirements for CHWs is necessary.

Participants were broken up into 3 breakout sessions and asked:

1. What are your initial thoughts regarding the key findings?
2. What barriers exist to maintaining and expanding the CHW workforce in Michigan?
3. Are there other factors or opportunities that should be considered?

Summaries from these discussions is below.

For questions or comments about the overall Social Determinants of Health Strategy, please contact MDHHS-SDOH-PolicyandPlanning@michigan.gov.

Breakout 1

1. **What are your initial thoughts regarding the key findings?**
    - Integral parts of community and very helpful for patient empowerment
    - Supports some standardization on training so that employers know what core competencies to expect
    - The ability of CHWs to be billable should increase the number
    - Variations in pay based on location
    - Use MICHWA's base training
    - "Underpaid + Overworked" Findings may be truer for CBOs. BCBS has 50 CHWs that have been able to spread the work and paid well (CHWs start at $50k @ BCBS Complete)
    - Hopes for flexibilities on training requirements. Believes that BCBS Complete CHW trainings are just as good as MICHWA's
    - Agree on flexibilities on ways to train, but believes state still needs standardization on certifying the curricula submitted from various organizations

2. **What barriers exist to maintaining and expanding the CHW workforce in Michigan?**
    - Need for Spanish speaking workers (*mentioned twice*) +
    - Representation within diverse communities, for example aging populations and LGBTQ populations (*mentioned twice*)
    - **Risk**: Doctors + Nurses claiming to be CHWs without training or being able to represent the community
    - Better integration/collaboration with clinical care team, including physicians
    - Recruitment and training
    - Many potential CHWs lack formal training because they can't afford training before employment
    - Career pathways and long-term growth strategy not established

3. **Are there other factors or opportunities that should be considered?**
    - Higher pay for people who can pass language test for bilingual
    - Supporting CHWs who are paid through other programs BESIDES Medicaid (Katie Commey)

Breakout 2

1. **What are your initial thoughts regarding the key findings?**

- The work with MDHHS with 5 state motivation communities are often overlooked with lessons learned on implementing CHWs in the community, and the cost savings that the shires showed in utilizing CHWs (Lori Kunkel Greater Flint Health Coalition)
- I thought they were spot on (unknown)

2. What barriers exist to maintaining and expanding the CHW workforce in Michigan?

- The variation in language/titles of CHWs
- A lot of staff turnover because staff don't get paid enough for the work. It is hard work. Medicaid and other reimbursement help with that, but that is a barrier overall (Jennifer).
- Echo sentiment above—a lot of turnovers during pandemic—feedback was:
    - Organization/administrative level: it is so much work to get claims reimbursed/reconcile the billing—many pulled out of the CHW work
    - Individual level: pay not enough
- It is really important to make sure that the billing process is not a burden, and is easy as possible
- Certification process might inhibit certain organizations from engaging CHWs
- Medicaid currently funds health plans to hire CHWs—confusion on a community based vs. a health plan based CHW and how Medicaid will use this term consistently, so we all understand what we are talking about.
- McLaren HealthPlan: We contract with community CHWs when they will contract with us
- We need to make sure that Medicaid funding provides at least as much as current contracts if not more, to be sure that we are not losing funds and workforce
- Some health plans are good about contracting with community CHWs, while others are not at all—we should incentivize those that are since CHWs have really proven their worth & value
- Who will pay CBOs for CHWs in the future?
- Will there be funding opportunities for Community Based Organizations from MDHHS—sharing of opportunities, etc.

3. Are there other factors or opportunities that should be considered?

- Excited to see how the Doula program will fit into this model—they are being set up like a CHW—will they end up getting a CHW certification, or how will that look?
    - Also—how might recovery coaches fit in also—how can we better support all our support systems/workers
    - Happy to see Doula program getting recognition, but would like to learn more about the Doula workforce and how to get in contact with one/them
- We need to agree upon a standard definition, and outline of where to find resources
    - Who is included, and who gets what training?

    - It would be great to expand upon training and opportunities
    - We do need to be careful about being sure that CHWs stay the local CHWs who know the communities they are working with
    - CHWs need to be respected as a profession and compensated accordingly
    - From chat: Ensuring that we stay true to the definition of CHWs and not Social Workers of MAs or other higher-level professions being designated as CHWs
- From Chat: Wonder if there can be a collaboration between federal and state. Is there any hope to help a small sample size of recipients of Food, Cash and Housing by requiring them to be helped by a CHWs monthly if they receive benefits. Seeing a disturbing amount of unrest in the homes of beneficiaries receiving Food, Cash and Housing. I do not foresee a change in behavior or health unless they receive more than Food and money to help them with daily living. They need monthly help from CHWs.
-

Breakout 3

1. **What are your initial thoughts regarding the key findings?**
    - Key findings align with what at United has seen
    - Concerns about funding, salary range
    - Experiences: certain trainings garner more pay than others
    - Fund staff to assist with housing crises – also aligns with what they have seen
    - Would support credentialing of these staff for Medicaid reimbursement
    - Many of these agencies don't bill Medicaid – how to make sure they can benefit
    - My first thought is how this integrates nicely with the narrative about building Public Health Infrastructure (e.g., discussions in community re monkeypox, covid, etc). CHWs could be conceived of as an important piece to [re]building the infrastructure and public image of PH.
    - Important as criteria is set for training that we don't establish barriers to entry to CHW workforce
    - Lived experience is essential – often a barrier to other experiences like college

2. **What barriers exist to maintaining and expanding the CHW workforce in Michigan?**
    - CHW is an avenue for folks without access to other professions or who can't go to school, professionalization can erect barriers to entry
    - CHWs don't feel valued – underpaid
    - Hearing their CHWs are stressed and overworked
    - Feel underutilized
    - When looking at credentialing – being very careful to set the bar at an attainable level
    - Can CHWs work under a social worker to provide a supportive structure?
    - Outreach staff – move through community looking for runaway girls – trained with Narcan use and how to have conversations around SUD, sex, etc.

3. **Are there other factors or opportunities that should be considered?**

- CHWs are excellent additions to many diverse teams in many sectors that touch health through social and non-clinical focus. I think that one barrier to CHW workforce development also exists in sectoral differences. For instance, how do local CBOs who are not otherwise linked with Medicaid or healthcare specifically reimbursed for their quality efforts in moving community health?

Next steps:

- Input from these breakout sessions will be thoroughly reviewed and incorporated into the overall strategy as it is refined.
- Additional engagement opportunities will be available to provide input for the development of the innovative phase 2 Strategy. To stay updated with SDOH Strategy efforts, please subscribe to the SDOH Newsletter.