

# COMMUNITY HEALTH WORKER FOR PUBLIC HOUSING RESIDENTS REQUEST FOR PROPOSALS (RFP) QUESTIONS AND ANSWERS

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From the October 18, 2016 Pre-proposal conference meeting

1. Q: The RFP indicates selected sites where services will be provided. Are there more than these?

A: Page 10 of the RFP outlines most of the properties where the community health workers will work. We have provided location, address, approximate residents and demographics of each of these properties. The Health Department is working on a comprehensive initiative in these buildings, including active living, healthy eating and now CHW services. We have selected these buildings and have been working with them for a while. The CHW services will be part of this initiative. The Health Department is in the process of selecting two additional properties where CHWs will work.

2. Q: I haven't had a chance to look at the information on the selected buildings yet, but is there an estimated number of diabetes or hypertension problems in these buildings?

A: No, we don't have this data but we know anecdotally that the percent of residents with hypertension number is very high.

3. Q: My question is regarding the reimbursement. For a place like the Volunteers of America, which is not a clinic and doesn't have doctors, it talks about being approved by a doctor in order to get a reimbursement. Did anyone think of how that might work for a place like the VOA which is not clinic-based? I am just trying to figure how we might be able to get reimbursement when we are not the person's primary provider. What is the thought around that?

A: The thought is that you will be partnering with a clinic or independent provider--it could be a doctor, a nurse or nurse-practitioner, or physician's assistant. You could partner with an agency that can do the billing and have a contracted relationship with them or you could hire your own medical director who can provide the clinical oversight that is needed to seek reimbursement.

4. Q: But if the medical director is not a person's specific physician, will he be able to authorize payment for a community health worker?

A: Yes, the system would have to be set-up so that you would get a referral from the resident's primary care provider and have some kind of mechanism to communicate with their providers to get those referrals. You will need to provide sufficient clinical oversight of your CHWs to meet the billing regulations in the MN Health Care Program CHW Provider Manual (link is in the RFP). You could achieve this capability by having staff within your organization provide oversight, or set-up contractual relationships to achieve it. This is really breaking new ground, so we're looking for agencies to build new capabilities while also following the rules in the Provider Manual. There are examples of making this work in other states. For example, the Pathways model in Ohio utilizes a Community Hub to contract with payers and with community based providers. The Ohio Hub concept is picking-up interest in Minnesota and may become closer to reality by 2018. We are trying to come up with mechanisms that follow the guidelines from MN Department of Human Services but also capitalize on organizing ourselves to access these opportunities and possibilities.

5. Q: As a follow up, my concern is whether or not we have to have almost a half-time staff person who is trying to figure out how we can get reimbursed as opposed to paying to the community health worker. This being a very complex process, I am trying to figure out how-- in a year or two--we can actually bill for this.

A: I don't think this will be a half-time person in any way. The Health Department will be available to help you explore, select and pursue different options. Policies, procedures and opportunities will be evolving in 2017. The selected agency won't be on its own to figure out how to get these reimbursements, there will be a lot of learning and support. We are looking for an agency interested in engaging in that process.

6. Q: Is there any specific person identified at DHS who we could would be helping or working on the reimbursements?

A: No one person is identified at this point. There is a person who we work with at Department of Human Services regarding the grant implementation. We haven't talked to DHS about identifying a specific person to work with on the project. There are a lot of different groups working toward CHW reimbursement for community based service providers. We will continue to participate in these broader planning efforts and help the selected agency figure this out together. There will be a lot of support with this project.

7. Q: You mentioned additional locations, when will they be identified? Who will identify them and will they be in North or South Minneapolis?

A: They are not yet selected, but will be selected by January 1<sup>st</sup>. The Minneapolis High Rise Representative Council and the Minneapolis Health Department are co-chairs of an Active Living Committee that includes representatives from the MPHA buildings, VOA social workers, Minneapolis Public Housing Authority and others. This committee will select the additional buildings.

8. Q: My understanding is that there isn't a Pathway specific to diabetes or hypertension. So, when you are measuring patients' self-care outcome, are you measuring education Pathway or is there another way you are expecting measurements?

A: The Pathways are kind of an overlay to a variety of health issues that people may be

facing and the Pathways represent different social deterrents that may not be specific to a given condition. We may build some additional measurements above-and-beyond the current Pathways. For example, we could look at the Education Pathway and build in specific information when that Pathway is used for diabetes, prediabetes or hypertension. We might also look to the Medical Referral and Social Service Referral Pathways, and measure specific linkages that are related to diabetes, prediabetes or hypertension. There may be other tools we will use to add to the current Pathways, and get data on clients' improvements in self-management of their condition.

9. Q: In year 1, is there a requirement for a medical oversight, presence or a different person who provides supervision?

A: In year 1, clinical oversight of the CHWs is not required. General supervision of them as employees is required in both year 1 and year 2.

10. Q: In terms of forming partnership, are you open to a partnership between agencies?

A: We would welcome an application that proposes partnerships. There might be some areas where partnership may be required or advantageous for support and delivery of service, though only one of them is likely to be able to seek reimbursement for the services.

11. Q: Following up on locations, are you encouraging one group to serve all locations or are they able to decide which location might be a better fit for them?

A: The selected agency must be able to serve all selected locations.

12. Q: Will priority be given to an organization that is seeking reimbursement service when selecting the organization or is it not relevant because of the help and support you are willing to give?

A: Current ability to seek reimbursement is only one factor that will be considered. The selection process takes other measures into account as well. Details of selection criteria are outlined on pages 6-7.

13. Q: Can we use the funding for the purchase of appliance/equipment, or teaching materials for support in class, or supplies?

A: Yes, you can. Page 17 provides details on what the funding can be used for. Program materials are allowed; unfortunately you cannot purchase blood pressure measuring cuffs with these funds.

14. Q: Can we purchase weight scales?

A: Yes. You may purchase equipment up to \$5,000 with prior approval. You can buy items for the use of the Agency and your CHWs but you cannot use the funds to purchase items for individuals (examples: scales for every participant, incentives, etc.).

15. Q: Do you anticipate that this funding will go beyond year two or do you think that agencies will have to figure out how to bill to cover all their costs?

A: Our grant from the Minnesota Department of Health ends September 2018. There is a potential for carryover but is not guaranteed. There is always the potential of getting additional grants and the Minneapolis Health Department will try to obtain some. There may be possible public funding through foundations or organizations like Medica, United Ways, and Medtronic etc.

16. Q: Do we have to serve 100 persons for the 2<sup>nd</sup> year or could the number decrease?

A: The 2<sup>nd</sup> year is for 9 months and there may be adjustments because it is not a full year; however, we don't want to see a drastic drop in the individuals served. We are providing up to \$80,500 in year 2 with the expectation that you'll provide the same level of service and obtain reimbursement for at least some of it. There is medical assistance reimbursement currently available. The hourly reimbursement is greater than the average hourly salary of community health workers. If you design your delivery model strategically you may be able to cover some of your supervision and other administrative costs as well as the CHWs' hourly salaries.

17. Q: Do you know what the average hourly pay is for CHWs?

A: It is between \$17 and \$22.

18. Q: What is the reimbursement rate per hour?

A: The Medical Assistance CHW reimbursement rate is approximately \$20 per 30-minute unit of face-to-face services (for 1:1 services). The rate is lower per client for group interventions (see the RFP for specific payment rates). Reimbursement is only available for face-to-face time the CHW spends with clients.

19. Q: That is the maximum for units?

A: Medical Assistance allow up to 24 30-minute units per month (12 hours per month).