CalAIM Experiences: The Community-Connected Workforce

The community-connected workforce — which includes community health workers/*promotores*, perinatal workers, behavioral health navigators/peer counselors, family caregiver coaches, and violence prevention professionals — plays an important role in the implementation of CalAIM.

Members of the community-connected workforce often share lived experiences with the people they serve. For example, they may have a shared cultural background, a similar immigration experience, a history of homelessness or incarceration, a mental health condition, or an experience of recovery from substance use disorder. In the context of CalAIM (California Advancing and Innovating Medi-Cal), they often play an outreach or connecting role in Enhanced Care Management (ECM) and/or help deliver Community Supports like Housing Transition Navigation or Sobering Center services. In addition, behavioral health peer support specialists are a new category of provider that was introduced for the specialty behavioral health system through CalAIM; the community health worker (CHW) and doula benefits, though not part of CalAIM, were introduced and implemented in 2022 and 2023 respectively.

In 2024, CHCF conducted a survey of people implementing CalAIM programs.[*] This fact sheet explores data specific to respondents from organizations that deploy community-connected workers in their CalAIM programs. The goal is to better understand how their experiences differ from respondents in organizations that have not deployed the community-connected workforce.

Methodology

On behalf of the California Health Care Foundation (CHCF), Goodwin Simon Strategic Research (GSSR) conducted an online survey of 948 CalAIM implementers from August 9 to September 16, 2024, to explore their experiences of and outlooks on CalAIM. CHCF published the survey in December 2024.

Respondents who report having fewer than 30% of their patients, clients, or members enrolled in Medi-Cal or who were not familiar with CalAIM were not included in the full survey. This report focuses on the findings for leaders whose organization employs community-connected workers.

Table 1 shows leaders by organization type. It compares all those who completed the survey to those who reported that their organization employs community-connected workers.

[*] In the survey, the community-connected workforce is referred to as the community-based health workforce.

Table 1. Respondents' Organization Types

Type of Organization	Leaders Overall (*n* = 447)	Leaders Employing Community-Connected Workers (*n* = 302)
Physical health services provider	38%	39%
Behavioral health services provider	16%	20%
Social services provider	30%	25%
Managed care plan	5%	6%
Advocacy organization or member association	5%	5%
Carceral facility or legal/judicial service provider	2%	1%
Other	4%	4%

Source: CHCF/GSSR Survey of CalAIM implementers (August 9–September 16, 2024).

This fact sheet references the following subgroups of respondents from the survey:

- Leaders of organizations employing community-connected workers (*n* = 302)
- Leaders of organizations employing CHWs/*promotores*/community health representatives (*n* = 202)
- Leaders of organizations employing behavioral health navigators/peers/peer counselors (*n* = 190)
- Leaders of organizations employing perinatal workers (*n* = 59)
- Leaders of organizations that do not employ any community-connected workers (*n* = 117)

Organizations may employ more than one type of community-connected worker. Note that all differences in this fact sheet are statistically significant unless otherwise noted.

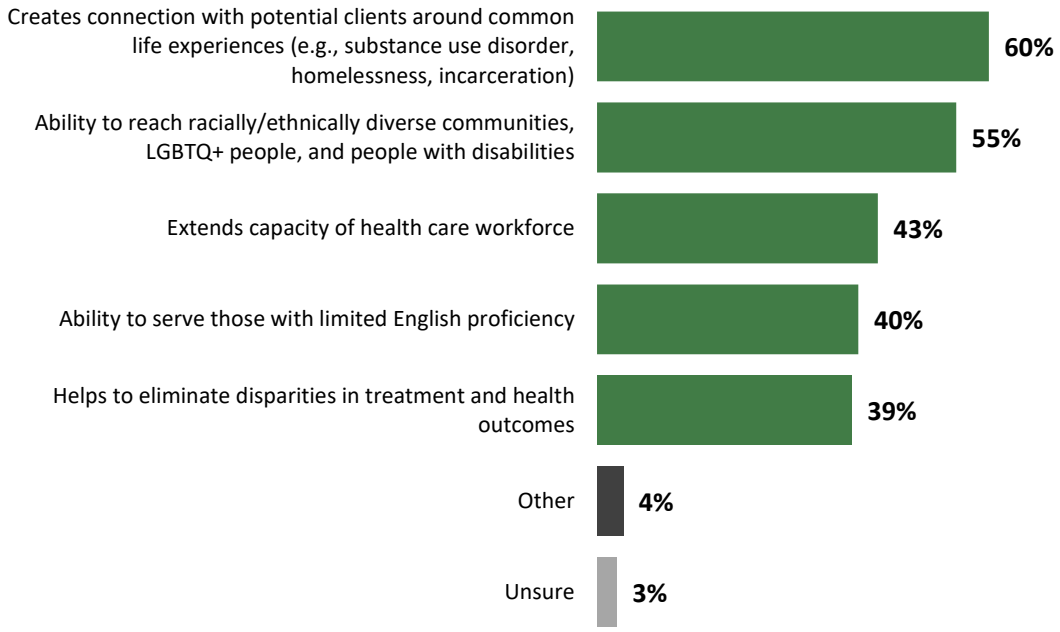
Key Facts About Organizations Employing Community-Connected Workers

About two-thirds (68%) of leaders report that their organization employs at least one community-connected worker, with 45% employing CHWs/*promotores* and 43% employing behavioral health peer navigators.

See Figure 1 for leaders' reasons for employing at least one community-connected worker.

Figure 1. Reasons to Employ Community-Connected Workers Vary

Q: FROM YOUR PERSPECTIVE, WHICH OF THE FOLLOWING ARE THE MOST IMPORTANT REASONS THAT YOUR ORGANIZATION EMPLOYS COMMUNITY-CONNECTED WORKERS? YOU MAY SELECT UP TO THREE ITEMS BELOW.



Notes: See detailed topline document for full question wording and response options. Asked of leaders who report including community-connected workers in their program (*n* = 302).

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Important Reasons to Employ Community-Connected Workers – Subgroup Findings:

- Leaders of organizations employing behavioral health navigators are more likely to cite 'creates connection with potential clients around common life experiences' (66%, compared to 60% among leaders of organizations employing community-connected workers overall).
- Unlike other groups, leaders of organizations employing perinatal workers cite 'ability to reach racially/ethnically diverse communities, LGBTQ+ people, and persons with disabilities' as their most common reason to employ community-connected workers (69%, compared to 55% overall).
- While it is not their top reason, leaders of organizations employing CHWs/*promotores* are more likely than others to cite 'ability to serve those with limited English proficiency' as a reason to employ community-connected workers (45%, compared to 40% overall).

Organizations Employing CHWs/*Promotores*

Leaders of organizations employing CHWs/*promotores* report more positive experiences with CalAIM than leaders of organizations that do not employ any community-connected workers.

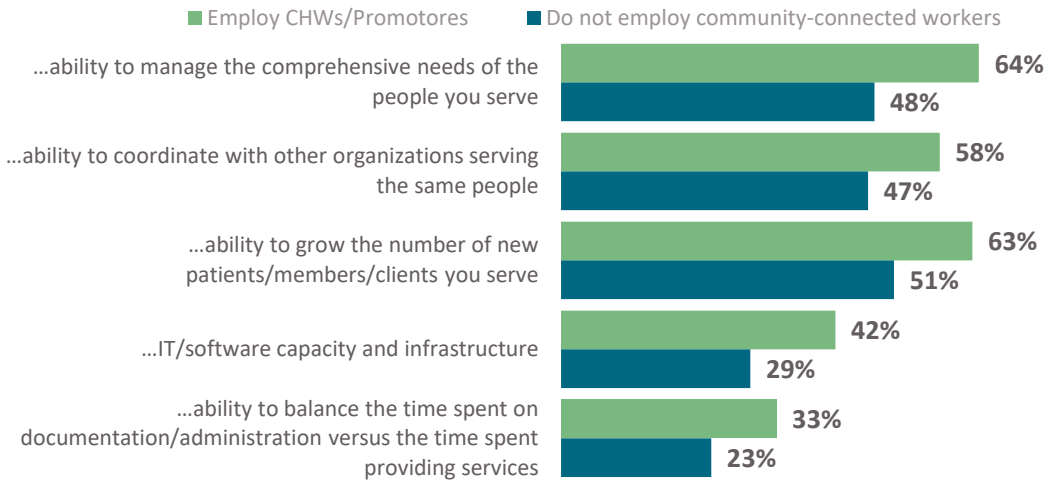
Leaders of organizations employing CHWs/*promotores* are more likely than leaders of organizations that do not employ any community-connected workers to:

- Report improvement for specific racial, ethnic, or language populations, including:
  - Latino/x populations (49% report their overall experience of care has gotten better, compared to 38% at organizations without community-connected workers)
  - Black populations (38% better, compared to 25%)
  - Populations whose primary language is not English (43% better, compared to 33%)
- Report improvements for the populations of focus that they serve, including:
  - Individuals experiencing homelessness (59%, compared to 41%)
  - Individuals with serious mental health and/or substance use disorder (SUD) needs (49%, compared to 37%)
  - Pregnant and postpartum individuals (39%, compared to 22%)
  - Children and youth involved in child welfare (37%, compared to 23%)
  - Children and youth enrolled in California Children's Services (CCS) or CSS Whole Child Model with additional needs beyond the CCS condition (34%, compared to 18%)
- Report confidence ('very' or 'somewhat confident') that CalAIM processes and procedures will get better over time (71%, compared to 52%)
- Report organizational improvements due to CalAIM outside of finances and staff recruitment or retention (Figure 2)

Figure 2. Leaders of Organizations Employing CHWs/*Promotores* Are More Likely Than Leaders Who Do Not Employ Community-Connected Workers to Report Organizational Improvements

Q: NOW THINKING ABOUT YOUR OWN ORGANIZATION, PLEASE INDICATE WHETHER YOU PERSONALLY THINK EACH OF THE FOLLOWING HAS GOTTEN BETTER OR WORSE AS A RESULT OF CALAIM — OR IF IT HAS STAYED ABOUT THE SAME.

YOUR ORGANIZATION'S . . .



Notes: See detailed topline document for full question wording and response options. Totals may not add to 100% due to rounding. Ranked by Total Better. Shows those who responded "Much Better" or "Somewhat Better." Excludes those who answered "Not Applicable" for each item.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

Experience of Care for Those Served

Leaders of organizations employing community-connected workers are more likely than leaders of organizations that do not to report improvement in their clients' experience of care due to CalAIM (62% say overall clients' experience of care has gotten better, compared to 46% among leaders who do not employ community-connected workers).

Data Exchange

Leaders of organizations employing community-connected workers are more likely than leaders of organizations that do not employ them to get information at least 'some of the time' through an electronic health records system (64%, compared to 46%) or a health or community information exchange (53%, compared to 37%).

Leaders who employ community-connected workers have similar experiences of comprehensiveness, accuracy, and timing of information sharing as leaders of organizations that do not employ them. **However, they are more likely than leaders of organizations that do**

not employ community-connected workers to have higher expectations about getting information immediately (19%, compared to 10%).

Organizational Characteristics

Leaders of organizations employing community-connected workers are more likely than leaders of organizations that do not employ them to:

- Lead organizations with more full-time employees (FTEs) (63% have 100+ FTEs, compared to 52% of organizations that do not employ community-connected workers)
- Have participated in the Whole Person Care pilot project or the Health Homes Program (39%, compared to 27%)

Leaders of organizations employing community-connected workers are more likely than leaders whose organizations do not to provide ECM and Community Supports (29%, compared to 18%) or to provide ECM only (25%, compared to 15%).

Leaders of organizations that provide ECM and employ community-connected workers are more likely than leaders of organizations that do not employ them to be contracted to serve the following populations of focus:

- Individuals with serious mental health and/or SUD needs (70%, compared to 47%)
- Children and youth involved in child welfare (48%, compared to 29%)
- Children and youth enrolled in CCS or CCS Whole Child Model with additional needs beyond the CCS condition (43%, compared to 18%) (see Table 2 below)

Additionally, among respondents contracted to provide ECM, leaders of organizations employing CHWs/*promotores* are more likely than leaders of organizations that do not employ community-connected workers to serve individuals experiencing homelessness (81%, compared to 63%).

Table 2. Populations of Focus Served Among Leaders of Organizations Providing ECM

Population of Focus	Leaders of Organizations Employing Community-Connected Workers (*n* = 161)	Leaders of Organizations NOT Employing Community-Connected Workers (*n* = 38)
Individuals experiencing homelessness	75%	63%*
Individuals at risk for avoidable hospital or ED utilization (formerly "high utilizers")	72%	66%*
Individuals with serious mental health and/or SUD needs	70%	47%
Children and youth involved in child welfare	48%	29%
Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model with additional needs beyond the CCS condition	43%	18%
Pregnant and postpartum individuals; birth equity population of focus	39%	26%*
Individuals transitioning from incarceration	37%	24%*
Adults living in the community and at risk for LTC institutionalization	28%	32%*
Adult nursing facility residents transitioning to the community	24%	18%*

*These results are suggestive but not significantly different from leaders employing community-connected workers.

Notes: Percentages may not add up to 100% because each organization may serve multiple Populations of Focus. *ED* is emergency department; *SUD* is substance use disorder; *LTC* is long-term care.

Source: CHCF/GSSR 2024 Survey of CalAIM implementers (August 9–September 16, 2024).

About the Authors

Goodwin Simon Strategic Research (GSSR) is an independent opinion research firm with decades of experience in polling, policy analysis, and communications strategy for clients in the public and private sectors. GSSR founding partner Amy Simon, partner John Whaley, senior research analysts Nicole Fossier and Yule Kim, and independent researcher Jill Laufer all contributed their thought leadership on this survey research in collaboration with the California Health Care Foundation.

About the Foundation

The California Health Care Foundation is an independent, nonprofit philanthropy organization that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the health system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. Health equity is the primary lens through which we focus our work at CHCF. CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system. For more information, visit www.chcf.org.