

Community Health Workers: Supporting a People-Centered Workforce

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Building a People-Centered Health System



Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. We advocate for public policies that support better health, better care and lower costs to ensure affordable, high quality, people-centered care for all.

Building a People-Centered Health System – one which achieves better health, better care and lower costs – requires the use of innovative workforce models that ensure access to community-based services, deliver coordinated care, address social determinants of health and advance health equity. Community health workers (CHWs)—as part of a provider care team and connected to the broader community—are critical to achieving these goals, and are an important workforce that state and federal policymakers can and should help advance and support.

Why Are Community Health Workers so Important?

CHWs help individuals navigate the complex health care system, receive primary and preventive care, maintain healthy behaviors and manage chronic conditions in culturally and linguistically relevant ways. In the important move to alternative payment models (APMs), including Accountable Care Organizations (ACOs), this workforce model becomes even more essential. As trusted members of the community with a close understanding of local needs and resources, CHWs are critical to improving access and delivering comprehensive care to the underserved as well as advancing population and community health. CHWs have such great impact because they come directly from the neighborhoods where vulnerable populations live.

Team-based, collaborative care is a key component of improving the efficiency and effectiveness of the health care system, including integrating primary and preventive care with social and economic support services. This is particularly important to integrating care to meet behavioral health needs. Health systems are increasingly seeking high-value, innovative models that include CHWs to achieve these goals and build a more people-centered workforce.

Evidence of CHW Impact

- 3:1 return-on-investment resulted from CHWs identifying Medicaid-eligible individuals who were at risk of nursing home placement, and instead arranging for those individuals to receive home and community-based care in the Tri-County Rural Health Network program in Arkansas.
- Significant reduction in emergency department visits and inpatient admissions, with savings of more than \$2 million, resulted from support services provided to high resource-consuming Medicaid members through Molina Healthcare of New Mexico.

What Can Policymakers Do?

Align Federal and State Initiatives to Support the Use of CHWs

Recommendations:

- Fund CHWs as part of alternative payment model testing at both the state and federal level, including through patient-centered health home development, chronic care models, ACOs, State Innovation Model (SIM) and other Center for Medicare and Medicaid (CMMI) initiatives.
- Support the development of common metrics, program evaluation, data collection and research on the cost-effectiveness and impact of CHWs on patient and population health outcomes, patient and caregiver satisfaction and access to health care and community-based services and supports.

Community Health Workers (CHWs)

- Support health information technology, predictive modeling, and analytics – including electronic health record systems – that can identify high-risk patients who need to be connected to a CHW and track patients' progress and care plans.

Structure Financing to Support a People-Centered Workforce

Recommendations:

- Support payment mechanisms to provide reimbursement for CHWs through state Medicaid programs, including incorporating into managed care contracts and pursuing other opportunities through the recently changed federal Medicaid rule related to delivery of preventive services.
- Invest in CHW workforce development through the Health Resources and Services Administration (HRSA), similar to current workforce training investments in physicians, nurses and public health.
- Ensure that reimbursement levels are appropriate and financing mechanisms support this workforce.

Think Comprehensively About Workforce Development Opportunities

Recommendations:

- Develop a national certification and licensure model that states can adopt, using successful models like Ohio as an example.
- Support education and training that connects to the certification program, focusing on core skills and competencies and aiding in the development of integrated care teams that include CHWs and other non-traditional care providers.

Innovative Uses of Community Health Workers at Trinity Health Ministries

At [Mercy Health in West Michigan](#), the "Pathways Community HUB Model" – developed with the Agency for Healthcare Research and Quality (AHRQ) and utilized in communities nationwide – has demonstrated proven outcomes. The Pathways Community HUB infrastructure ensures that at-risk individuals are served in a timely, coordinated manner and connected to meaningful health and social services. The Community Hub ensures that those at greatest risk within a community are identified and that an individual's medical, behavioral health, educational and social risk factors are addressed. This hub coordinates points of entry and outcome tracking of at-risk individuals, serving to bring together health care providers, social service agencies and health care payers. CHWs – assigned to assist adult Medicaid or Medicare beneficiaries who have chronic health conditions plus social and other challenges – use evidence-based Pathways (protocols) to identify and resolve challenges with the social determinants of health, including housing, food and education. At Mercy Health, they have been able to cut their frequent flyer (six or more annual visits) 30 day Emergency Department (ED) readmissions rate by almost half, resulting in significant savings as well as more coordinated care for these at-risk patients. The Health Project, part of Mercy Health, is one of three Michigan communities to pilot this model, demonstrating significant success in integrating community linkages with the health care delivery system. The State of Michigan has prioritized this important model in its State Innovation Model (SIM) blueprint.

At [Mercy Medical Center, part of Trinity Health – New England, in Massachusetts](#), CHWs are an integral part of the delivery model aimed to improve the care of patients presenting to the Mercy Emergency Department (ED) with a primary behavioral health need. The goals of this model are three-fold: improve behavioral health care in the ED; provide warm linkage to community-based services following an ED episode; and create a more effective multi-setting and longitudinal system to meet behavioral health needs over time, utilizing a registry of care plans and service referrals including the utilization of data. A CHW interacts closely with the behavioral health nurse to support effective assessment as well as transition to the next appropriate level of care for patients. This CHW establishes a trusting relationship with the patient, assesses community-based service needs, and helps the patient access services to meet those needs.

Digital Access: <http://advocacy.trinity-health.org/> • advocacy@Trinity-Health.org • #PopHealth #CommunityHealth #CHW

Mission: We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Core Values: Reverence • Commitment to Those Who Are Poor • Justice • Stewardship • Integrity

