

Integrating Community Health Workers into Team-Based Care

Vision: Increase Access, Improve Quality, and Decrease Costs to Transform Communities and Promote Economic Development

Benefits

- Link medical home and population health issues
- Reduce disparities, improve cultural competency
- · Emerging evidence of cost effectiveness
- ACA, payment reform, and integration opportunities for care delivery innovation

Settings

- PCMHs/health homes (LADHS, LADMH, LADPH, CP clinics, school-based clinics, mental health/substance use clinics)
- Hospital/ED discharge and care transitions
- · Rehabilitation/skilled nursing facility
- Wellness Centers
- Community (CBOs, home-based care, street)

Training and Certification

- Students from local communities with lived experience reflecting patient populations
- Competency-based approach
- Work-based learning
- Mentorship
- Apprenticeship leading to certification

Patients

- High-risk pregnant women and newborns
- Homeless
- Mental health issues
- Substance use disorders
- Chronic conditions
- Frequent utilizers
- Persons with disabilities
- Seniors
- AB 109 releasees
- Dual eligibles

Possible Roles and Responsibilities

- System navigation
- Care coordination/management
- Health coaching
- Community outreach and engagement
- Benefits outreach, enrollment, retention, and utilization

Financing

- Grants
- Government General Fund
- Private sector budgets
- Medicaid (i.e., MAA, managed care)
- Mental Health Services Act funds
- Section 330 grants
- Federal Medicaid rule preventive services
- ACA opportunities (i.e., health home option)

Expected Outcomes

- Increase clinician productivity and panel size
- Increase understanding and appropriate use of medical home and managed care system
- Reduce inappropriate hospitalization/ED use and hospital readmissions
- Improve health outcomes
- Increase patient satisfaction
- Improve worker satisfaction and outcomes
 - Increase employment opportunities