2.10.4.5 [OPTIONAL] Respond to the following questions to be considered for piloting a Community Health Worker (CHW) demonstration project………………. 2.10.4.5.1 Why is the Proposer interested in this opportunity?

Since 2011, Louisiana Healthcare Connections (LHCC) has demonstrated our dedication to removing barriers to care and improving health outcomes across the state. We are interested in being selected to collaborate with the Penn Center for Community Health Workers (PCCHW) and the Center for Healthcare Value and Equity (CHVE) at the LSU Health Sciences Center to pilot a Community Health Worker (CHW) demonstration project because we believe that a CHW model, when developed and implemented using an evidence-based and financially sustainable approach, can effectively remove barriers to care and improve the health and self-sufficiency of Louisianans. As a leading Medicaid MCO in Louisiana and leveraging our national Centene support, LHCC has the resources, capacity, and capability to collaborate and implement this CHW demonstration project to improve the health of the targeted Shreveport-area individuals with multiple chronic health conditions or high-risk pregnancy. LHCC will build off of the strength of our current program, where, since August of 2018 in Region 2, we engaged 37% of successfully outreached enrollees with BH needs in Care Management. We commit to the financial and program requirements as outlined in the *Louisiana Demonstration CHW Program Overview* and the *Blueprint for a Louisiana Demonstration CHW Program*.

Shreveport is an Important Market for LHCC

Currently we have 969 LHCC enrollees with two or more chronic conditions and 65 enrollees with high-risk pregnancy residing in the zip codes listed for this CHW pilot.

LEVERAGING THE STRENGTH OF OUR CHW PROGRAM

LHCC's CHW program was designed and implemented to address SDOH, promote prevention and health education, and be tailored to the specific cultural and linguistic needs of enrollees. Our CHWs share community residency and life experiences that help them relate to, and build trust with, enrollees in the communities they serve. CHWs are an integral part of our approach to advancing population health to identity and remove SDOH barriers – such as housing, transportation, food insecurity, personal safety, and economic stability (including employment and education). Through our CHW program, CHWs outreach to enrollees through both our care management and population health activities – ultimately reporting to our CHW Supervisor. Our Population Health Department will manage this pilot for the CHW demonstration project, with our Vice President of Population Health as the primary contact point to oversee this program.

LHCC's CHW Program Aligns with IMPaCT Pennsylvania

In support of our interest in being selected to implement this pilot program, below we demonstrate how our current CHW Program model is evidence-based, scalable, and able to expand and serve the target population – in part because of the way our CHW program model closely aligns with the PCCHW's IMPaCT model and approach

Recruiting and Hiring. Similar to the IMPaCT model, we seek and recruit CHW candidates from innovative and non-traditional sources. We are purposeful and intentional during interviews, seeking to select candidates that exhibit characteristics and behaviors shown to be effective when working with enrollees. We detail our recruitment and hiring process including hiring current enrollees as future CHWs below (see Section 2.10.4.5.6).

Standardization. We standardize our training program and technology supports to ensure services and supports are consistent for enrollees and CHWs. Our evidence-based 10-week CHW training program offers multiple methods for different learning styles and comprehensive education relevant for CHWs (see Section 2.10.4.5.5). *Similar to PHCCW's use of HomeBase*, LHCC uses TruCare for analogous functions and to further standardize our supports offered to enrollees.

- TruCare is our participant-centric health management platform for collaborative Care Coordination and Case Management, disease management (DM), and Utilization Management (UM). Using tablet technology, in-field CHW staff (with appropriate role-based access) use TruCare Mobile to deliver services when meeting directly with enrollees to facilitate and document interactions.
- In addition to TruCare, and if needed, CHW staff locate member contact information from Safelink, via PCP outreach, through household members, and via 3rd party online searches.

If LDH prefers the use of PHCCHW's HomeBase as the CHW software and tablet program, LHCC will work with our national Centene IT team resources to integrate our current IT systems with HomeBase, if needed**.**

Clinical Integration. As detailed below in Section 2.10.4.5.4, through our fully-integrated model of care, all LHCC departments collaborate – as appropriate to their functional areas – on the enrollee's Plan of Care.

- Our CHWs support Care Management to confirm enrollees receive necessary services through activities such as embedding CHWs in hospitals and with providers (see Section 2.10.5).
- CHWs are central to LHCC's Population Health efforts and support these activities through events such as health fairs or proactive and preventive health activities (see Section 2.10.4).

Patient Centered. Our CHW program is designed as a single, seamless approach to be applied across all population health, care, and disease management efforts. In this way, CHWs support clinical metrics including those listed in the pilot program, such as: hospital admissions (patient/neonate), chronic disease control (HBA1c, BMI, SBP, smoking), pre-term births, infant mortality, and access to primary care. CHWs offer person-centered care and act as the bridge to the coordination of all PH, BH, social, and community-based supports.

***Scientifically Proven*.** LHCC developed our CHW program using national best practices and evidence-based programs to focus on delivering face-to-face, person-centered care by removing barriers to care and addressing social determinants of health (SDOH).

2.10.4.5.2 How many CHWs does the Proposer currently employ? In what parts of the state?

EMPLOYING SUFFICIENT CHWS TO ENSURE STATEWIDE COVERAGE

LHCC employs 18 CHWs to serve the entire state and ensures adequate coverage in all nine regions. We continually expand and evolve our CHW model of care meet the evolving needs of enrollees, and *separate from the CHW pilot*, we will double our current CHWs to 36 total, by January of 2020, offering increased in-person supports to enrollees and providers in every region in Louisiana. Additional information regarding our CHW staffing is within Section 2.10.2 below.

CHW's receive weekly engagement and direction from a CHW Supervisor to discuss challenges, ensure enrollee needs are addressed and met, and confirm seamless continuity of care. The CHW reports directly to a CHW Supervisor who receives training and support from our national Centene CHW Training Program. The CHW Supervisor answers directly to a Senior Director of Integrated Case Management, who is a PhD LCSW. For the CHW pilot, we will follow the organizational structure identified in the Blueprint.

2.10.4.5.3 What is the Proposer's CHW/member ratio?

We will use a staffing ratio of at least 1/100 for enrollees in our CHW Program.

2.10.4.5.4 What are the main activities in which the Proposer's CHWs are currently engaged?

ENGAGING CHWS IN POPULATION HEALTH AND CARE MANAGEMENT ACTIVITIES

Our CHWs expand the reach of our model of care and are critical strategic partners to our medical management team, our Case Management department, and serve key functions that are integral to our population health approach. LHCC CHWs are a consistent community presence*, boots on the ground*, that ***engage enrollees where they are*** through activities designed to eliminate barriers to health and wellness including the following:

• Cultural mediation between communities and health and human services • Culturally appropriate informal counseling and health education • Advocating for individual and community needs • Ensuring enrollees receive necessary services • Building individual and community capacity • Providing direct services • Conducting in-person, holistic assessments to understand enrollee needs, preferences, and socioeconomic barriers	• Assessing healthy living barriers and care through attending and conducting home visits • Scheduling and providing multiple reminders for enrollees of medical and BH office visits • Accompanying enrollees and participate in office visits and advocate for enrollees with providers • Arranging for and providing social services and surrounding support • Identifying the reason for a missed appointment and mitigating any barriers to care

• Serving as a key knowledge source for services and information needed for enrollees to have healthier, more stable lives	• Providing enrollees with training in self-management skills and with someone they can trust by being reliable, non-judgmental, consistent, open, and accepting

CHW Activities that Engage Enrollees Across the Spectrum of Needs

CHWs are connected with enrollees within their assigned geographic area and deploy activities designed to support specific interventions that have been identified as relevant through data collected across LHCC departments, Health Risk Assessments, and referrals from the Call Center or providers. These activities are informed by a deep understanding of their assigned neighborhoods (where they live *and* work) and tailored to the enrollee(s) needs.

CHW Activities that Support Population Health. Using data from Centelligence, Community Health Needs Assessments, and other data-based studies, CHWs identify hotspots within neighborhoods where there is the greatest need for health and/or social supports such as housing, food insecurity, transportation, personal safety, education, and employment. They help implement LHCCs targeted Population Health interventions, collaborating with neighborhood partners and community-based organizations, relying on best practices, and monitoring results outcomes and results. CHWs support community-wide events – such as health fairs – and conduct enrollee-specific events such as Baby Showers and Health Days.

Further guiding CHW activities are ***recurring Community Needs Assessments.*** These assessments create a snapshot of CHW program outcomes and critical community needs. Key data markers consider areas such as maternal health, chronic disease, physical activity, or school violence and bullying. CHW activities address SDOH, such as the availability of fresh vegetables in the neighborhood's stores.

CHW Activities to support Enrollees in Tier 1: Low Risk/ Condition Management. These enrollees are low risk, but have prevalent chronic conditions (asthma, bipolar disorder, cancer, COPD, diabetes, hypertension, serious mental illness, substance use) requiring targeted education, medication adherence support, health coaching, and/or other interventions to ensure access to recommended care. CHWs collaborate with CMs to support enrollees in scheduling transportation and appointments, access to our 24/7 nurse advice line, reminders for gaps in care, and linking them to resources that address SDOH.

CHW Activities to support Enrollees in Tier 2: Rising Risk/ Case Management. These enrollees require support to address a pattern of care that suggests instability and risk for high use of PH or BH acute services. In addition to the supports in Tier 1, CHWs collaborate with Care Managers to coordinate disease management, post-discharge planning, school-based health, early intervention, and connection for special health care needs including BH and/or PH condition specific DM/CM and health coaching. They receive in-home assessments and telephonic outreach by our clinicians, and face-to-face outreach from CHWs.

CHW Activities that Address Enrollees in Tier 3: High Risk/ Complex Case Management. Tier 3 enrollees require our highest-intensity care management approach to address high and consistent use of inpatient, rehab facility, or ED services. CHWs collaborate with Care Managers to deliver and coordinate highly focused attention to support their clinical care needs and to address SDOH. Through our Transitions of Care program, CHWs help reduce admissions and readmissions by conducting hospital and home visits to high-risk enrollees for 90 days after discharge. During these visits, CHWs provide enrollees with a pre-programmed cell phone (if needed), help them navigate available resources, establish ongoing outpatient and PCP services, address social barriers to accessing care, and ensure they have picked up prescribed medications. CHWs also engage pharmacists via videoconference during enrollee home visits to complete medication reconciliation.

2.10.4.5.5 How are the Proposer's CHWs currently trained? What are the minimum training requirements?

TRAINING CHWS USING OUR COMPREHENSIVE TRAINING PROGRAM

LHCC ensures that CHWs, supervisors, and program directors successfully complete training on core competencies relevant to their roles. We leveraged Centene's existing, evidence-based CHW Training Program to develop our 298-hour training curricula for Louisiana. Through this comprehensive training, LHCC equips CHWs for effective, culturally competent direct-to-enrollee, field-based service. We developed our training with the guidance of national public health organizations such as the CDC and the Office of Public Health. Our trainers

are experienced in Care Management, health literacy, enrollee engagement, cultural competency, and community health. LHCC will support CHWs and their supervisors with LDH-approved work practice manuals.

Minimum CHW Training Requirements

LHCC's comprehensive training curriculum ensures that CHWs are adequately equipped to serve enrollees in the community; understand all privacy laws and HIPAA provisions and can demonstrate all core competencies as required in the Model Contract 2.6.3.2.6. Our foundational CHW training program offers 23 modules, with topics including those listed in figure 2.10.4.5.5. Through 218 classroom hours and 80 practicum hours, over 10 weeks, trainers teach CHWs how to leverage tools and technology to assist enrollees, active listening and motivational interviewing techniques, and modeling behavior.

Figure 2.10.4.5.5 CHW Required Training Topics	
• Cultural Competency	• SDOH
• Poverty Training	• Trauma-Informed Care
• Listening Skills	• Interpersonal Skills
• Customer Service Provision	• Conflict Resolution
• Behavior Change Counseling	• Flexible Problem Solving
• Safety Training in the Field	• HIPPA
• Health Clinical Topics	• Advocacy Skills
• Case Management	• Documentation
• Motivational Interviewing	• Business Writing
• Writing and Presenting Case Study	• Organizational Skills
• Teaching Skills/ Health Coaching	• Self-Management Skills
• Service Coordination	• Capacity Building Skills

For the pilot program, *CHW staff will receive additional training* to provide peer support counseling in areas such as prenatal care and management of chronic conditions.

2.10.4.5.6 Does the Proposer have a process to ensure that its CHWs are trusted by the communities they serve?

ENSURING THAT CHWS ARE TRUSTED BY THE COMMUNITIES THEY SERVE

To ensure CHWs are trusted in the communities they serve, we use local recruitment and hiring processes and track responses on enrollee and provider satisfaction surveys.

Recruiting and Hiring CHWs that Align with Enrollees

Through our hiring and recruitment process, LHCC ensures that CHWs share sociodemographic characteristics with enrollees. Our first step is to use hotspotting capabilities to target neighborhoods that would most benefit from CHW support, indicated by, for example high SDOH needs such as "food deserts." We then utilize health and employment fairs in these targeted areas with the intent to outreach to and recruit potential or future CHWs within our LHCC enrollee population. We also offer a program for our LHCC enrollees to become CHWs in the communities where they live.

Having CHWs that are also peers, not only helps ensure enrollees trust CHWs but also benefits enrollees because they learn about and are connected to LHCC's programs from individuals that have a shared perspective and can relate with their experiences – including the challenges they faced or the successes they had.

Training and Education that Help CHWs Build Trust. As detailed in our response to Section 2.10.4.5.5, CHWs receive training on evidence-based techniques intended to build trust with enrollees including active listening, motivational interviewing, and cultural competency.

Monitoring and Assessment to Confirm Enrollee Satisfaction with CHWs

CHW Managers conduct follow-up calls with enrollees to ascertain how the enrollee feels about the CHW. Managers ask targeted questions designed to determine if the enrollee trusts their CHW and if their needs are met. Our enrollee satisfaction surveys inquire about CHW interactions to determine satisfaction with CHWs, including level of trust established.

2.10.4.5.7 What data does the Proposer collect to know if its CHW program(s) is (are) working?

COLLECTING DATA TO ENSURE OUR CHWS PROGRAM IS WORKING

LHCC collects and analyzes data from numerous sources to provide a comprehensive view of the successes, strengths, and opportunities of our CHW program, as demonstrated in the table below. We are creating a CHW scorecard to assist our team analyze outreach outcomes. Table 2.10.4.5.7 describes examples of some of the data we collect and review to determine program effectiveness. To create valid data that is meaningful, we track control groups and not simply pre- and post- intervention data. Nationally, Centene monitors outcomes of all

CHW efforts to establish best practices and benchmarks for future initiatives. If selected for this pilot, we will collect and track data and metrics as identified in the pilot program such as hospital admissions, chronic disease control (HBA1c, BMI, SBP, smoking), pre-term births, infant mortality, and access to primary care.

Table 2.10.4.5.7_Collecting CHW Program Efficacy Data

Data Collected	Objective of Data Collected
CHW productivity and enrollee contact data	Assists CHW Managers assess CHW productivity and link CHW activities and efforts to outcomes.
ED utilization and admissions data for enrollees in tier three care management	Track and trend utilization to determine whether CHW interventions are appropriate and effective. Interventions will be modified, as necessary, to further reduce unnecessary ED use, admissions, and readmissions.
Enrollee and provider satisfaction surveys about CHW satisfaction	Identify strengths and opportunities within the CHW program as indicated by enrollee and provider satisfaction. We enhance CHW education and training efforts, enrollee interventions, and population health initiatives to address opportunities identified.
HNA or basic needs assessment annual data	Determine whether assessment compliance rates are improving. Identify trends, related to SDOH or health and by geographical areas that can be attributed to CHW interventions. **Since August of 2018, we completed 152 *additional* general needs assessments as a result of CHW outreach.**
Tracking improved economic stability	Tracking increasing self-sufficiency and income of Medicaid expansion enrollees, as determined by enrollees no longer eligible for Medicaid and expansion benefits.
HEDIS measures and participation	Track enrollee care gaps to determine whether CHW activities help close or reduce care gaps on the individual and population level.

In addition to the data identified above, our ***recurring Community Needs Assessments*** will create a snapshot of CHW program outcomes and critical community needs. We will use these assessments to guide CHW activities and analyze CHW interventions implemented, assessing the success or opportunities presented by the demonstrated results of these interventions, and creating improvement plans for individual neighborhoods. Through this effort, we will track key outcomes, report results to the Quality Committee, hospitals, and other stakeholders on an ongoing basis and to the community every 1-2 years. LHCC will report findings to LDH, at intervals designated by LDH.

2.10.4.5.8 How are the Proposer's CHWs or other care management staff integrated with providers?

INTEGRATING CHWS AND CARE MANAGEMENT STAFF WITH PROVIDERS

Our clinical Care Management team – which includes CHWs – assist and integrate with hospitals and providers. CHWs serve as a bridge to PCPs or other providers through activities such as attending appointments with enrollees and facilitating communication and trust. As part of our program enhancements, in 2019 LHCC will:

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2.10.4.5.9 Who is the contact person for this application? 2.10.4.5.10 Who is the lead team member who will oversee implementation?

LHCC's VP of Population Health is the contact person for this application and will oversee the implementation of the CHW demonstration project.