Traditional Health Workers: Oregon's model

Goals & Objectives of this Presentation:

- Define the types and roles of Traditional Health Workers (THWs) in Oregon
- Understand the role of Oregon's THW Commission
    - THW certification and registry enrollment
- Hear about opportunities for improving integration of THW's in our health system

Traditional Health Worker Types

- **Community Health Workers**: Trusted, trained community members who promote, advocate and organize for improved health in their communities.
- **Peer Wellness and Peer Support Specialists**: Have personal experience in the mental health system and/or with recovery from addictions. Training for PWSs is longer and includes a focus on holistic health promotion.
- **Doulas**: Provide physical and emotional support, knowledge and individual advocacy for families before, during, and after childbirth
- **Personal Health Navigators**: Connect people to existing health services and manage medical utilization.

Continuation of Traditional Health Worker's definition

- **Family Support Specialist:** is an individual who Provides Support services to and has experience parenting a child who is a current or former consumer of mental health or addition treatment, and facing or faced difficulties in accessing education, health and wellness services due to mental health barriers
- **Youth Support Specialist**: is an individual who based on a similar life experience provides supportive services to an individual who:
  - Is not older than 30 years old,
  - Is current or former consumer of mental or addiction treatment; or
  - Is facing or has faced difficulties in accessing education, health and wellness services due to a mental health or behavioral health barriers

Opportunities for Integrating THWs

Public Health

- Partners with CBOs to conduct Community Assessment
- Identifies diabetes disparity and related high utilization rates in demographic-specific community
- Subcontracts with CBO serving specific community
- Finances outreach, disease self-management, and service coordination

CCO

Community Health Workers

- CBO trains CHWs in Chronic Disease Self-Management
- CBO deploys CHWs in this community
- CHWs enroll community members in plan and teaches Chronic Disease Self Management
- CHW provides ongoing support and system navigation

- Connects to a PCPCH
- Receives Diabetes Self Management information
- Receives culturally and linguistically appropriate services
- Receives regular check-ins by CHW
- Engages in more appropriate utilization

Community Member

Integrating CHWs Into Health Systems

OLD MODEL

- Partners with CBOs to conduct Community Assessment
- Contracts with CBO serving specific community
- Finances outreach, disease self-management, and service coordination

CCO

Community Health Workers

- Trains CHWs
- Deploys CHWs
- CHWs enrolls community members in health plans and provides tailored support services
- CHW provides ongoing support and system navigation

- Connects patient to a PCPCHC
- Patient receives tailored culturally and linguistically appropriate services
- Patient engages in more appropriate health services utilization

Community Member

Opportunities:

- Contracting standards and payment model
- Consistent quality assurance infrastructure
- Outcomes measurement and evaluation tools for population health and individual interventions

Integrating CHWs Into Health Systems

Community Member

- Connects to a PCPCH
- Receives tailored culturally and linguistically appropriate services
- Engages in more appropriate health services utilization

CBO

- Conducts community needs assessment
- Trains CHWs
- Deploys CHWs
- Enrolls community members in health plans and provides tailored support services
- Provides ongoing support and system navigation

CCO

- Determines intervention
- Contracts with ORCHWA

ORCHWA

- Establishes standardized contract and payment model
- Provides quality assurance and training
- Conducts outcomes measurement

New Model

Investment in Oregon Community Health Workers

2017-2019 HealthShare of Oregon capacity-building investment

ORCHWA business plan focused on:

- State-wide approach to foster deeper integration of CHWs into their local health systems
- CHW workforce development
- Technical assistance for CBOs, providers, and payers

The Power of Community Health Workers (CHWs)

- Video: Together, We Support Community Health: The Power of CHWs

https://www.youtube.com/watch?v=JtIY7CQf-EU

What is peer support?

- Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful.

- Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain.

Mead, Hilton, & Curtis, 2001

What is a Peer Support Specialist (PSS)?

A person with lived experience of mental health and/or addictions challenges who provides assistance, support, and encouragement.

A PSS may engage in these common activities with the peers they work with:

- Advocacy
- Experiential sharing
- Building community
- Mentoring/coaching
- Connecting to resources
- Socializing/self-esteem building
- Systems navigation

Generally, a PSS splits their time 60/40 between doing direct peer support and indirect work (e.g. meetings, documentation, resource connection).

Opportunities for integrating thw's

- Partners with CBOs to conduct Community Assessment
- Identifies peer support disparity and related high utilization rates in demographic-specific community
- Subcontracts with CBO serving specific community
- Finances outreach, support activities, utilization within other systems (jail, child welfare, hospital, etc.)

CCO/County

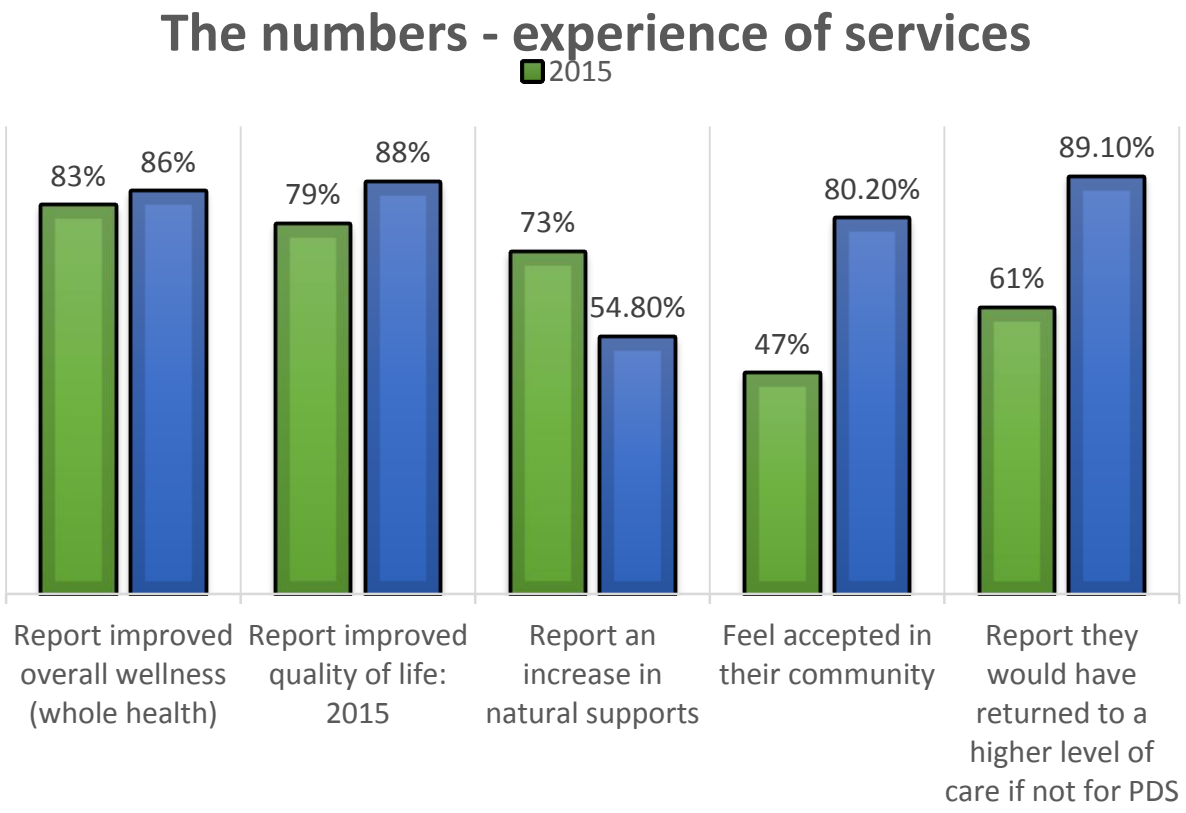
Community Based Organization

- Trains Peers to provide support and navigation of systems
- Deploys Peers in this community
- Peer meets individuals where they're at and supports them in exploring new wellness and recovery goals
- Peer provides ongoing support and system navigation moving with the individual even through provider changes and across systems

- Connects to other services if the individual requests this type of support
- Receives culturally and linguistically appropriate services
- Receives regular check-ins by the peer
- Engages in more appropriate and cost effective utilization

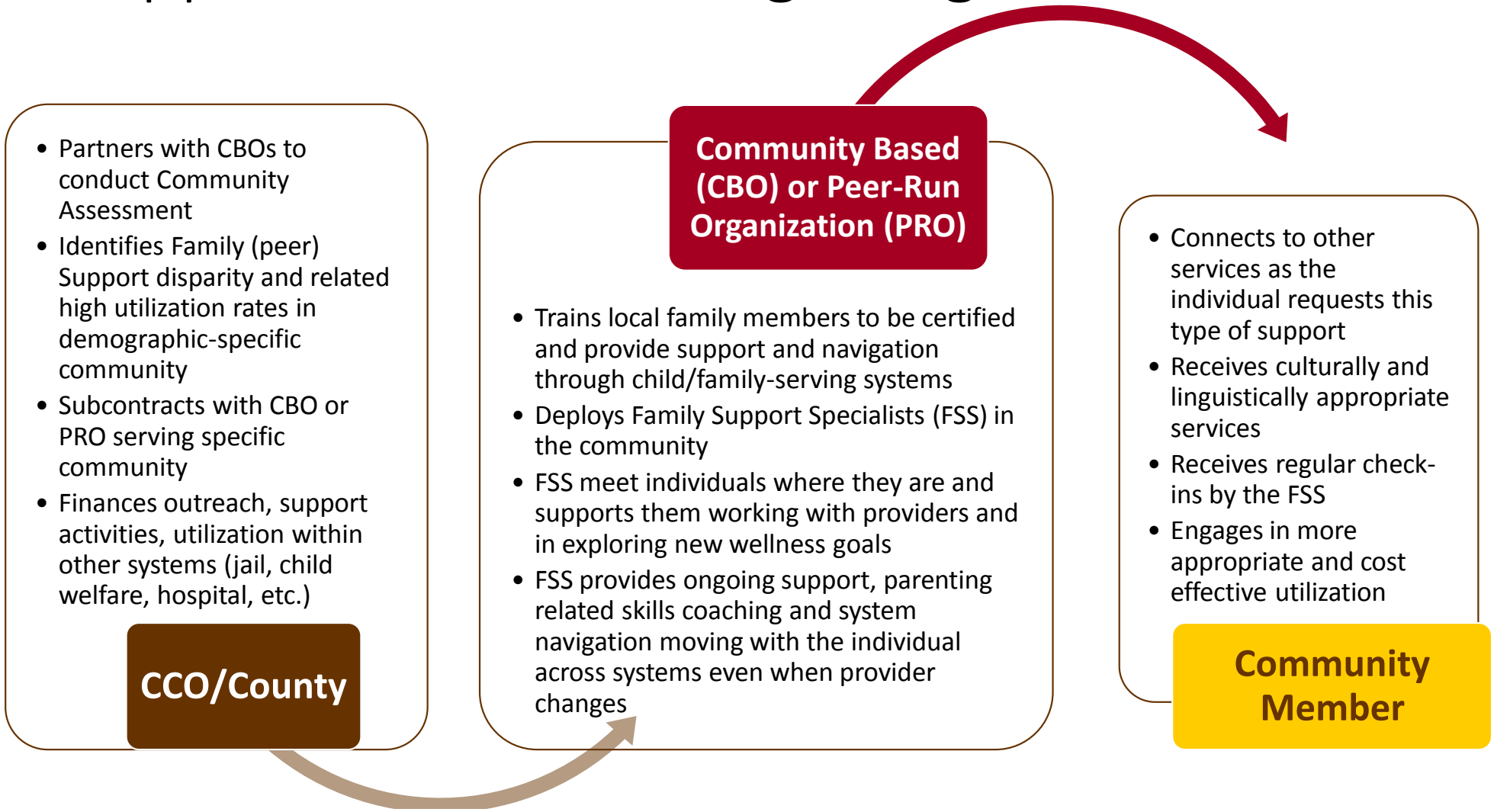
Community Member

Just a Little Bit of Data



- Estimated cost savings to Jail: $1,288,710
- Estimated cost savings to child welfare: $720,400
- Estimated cost savings to system based on Warm Line calls: $283,000
- Cost of Peer Services 2016: $2.2 mil

Opportunities for integrating THW's



Major Outcomes of Family Support

Dispels

- Shame and isolation based on “my child has a problem”
- Blame that the parent did something to cause the problem
- Fear of “asking for help”

Increases

- Knowledge about services and available care
- Skill to communicate family’s needs with providers
- Parental confidence in their ability to care for their child
- Partnership with providers, family and other supports

What Can a Family Support Specialist Do?

- Provide **support** for the parent to be confident in their skills
- Share the applicable portion of their life experience to **foster hope**
- Assist the parent with effective communication skills
- **Connect** parent with local resources, services and public benefits
- Assist in **understanding information** about children's behavioral and physical health prevention and treatment
- **Coach** skills related to parenting and positive self-care
- **Prepare** family members for planning, treatment team and other meetings
- Attend meetings, as requested
- Assist parents to identify natural supports
- Connect parents to other parents or caregivers
- **Mentor** and coach family members to be self-advocates

Medicaid Billing Codes for Family Support

- H0038 for Peer Support,
- T1016 for Case Management,
- H2014 Skills Training and Development,
- G0177 Training and educations services related to the care and treatment of the patient’s disabling mental health,
- H2023 Supported Education/Employment and
- H2021 Wraparound,

CAROL CRISWELL
FAMILY NAVIGATOR PROGRAM MANAGER
PROVIDENCE HEALTH & SERVICES, SWINDELLS RESOURCE CENTER

MEET OWEN…

PROVIDENCE SWINDELLS RESOURCE CENTER/HEALTH SHARE OF OREGON PARTNERSHIP…

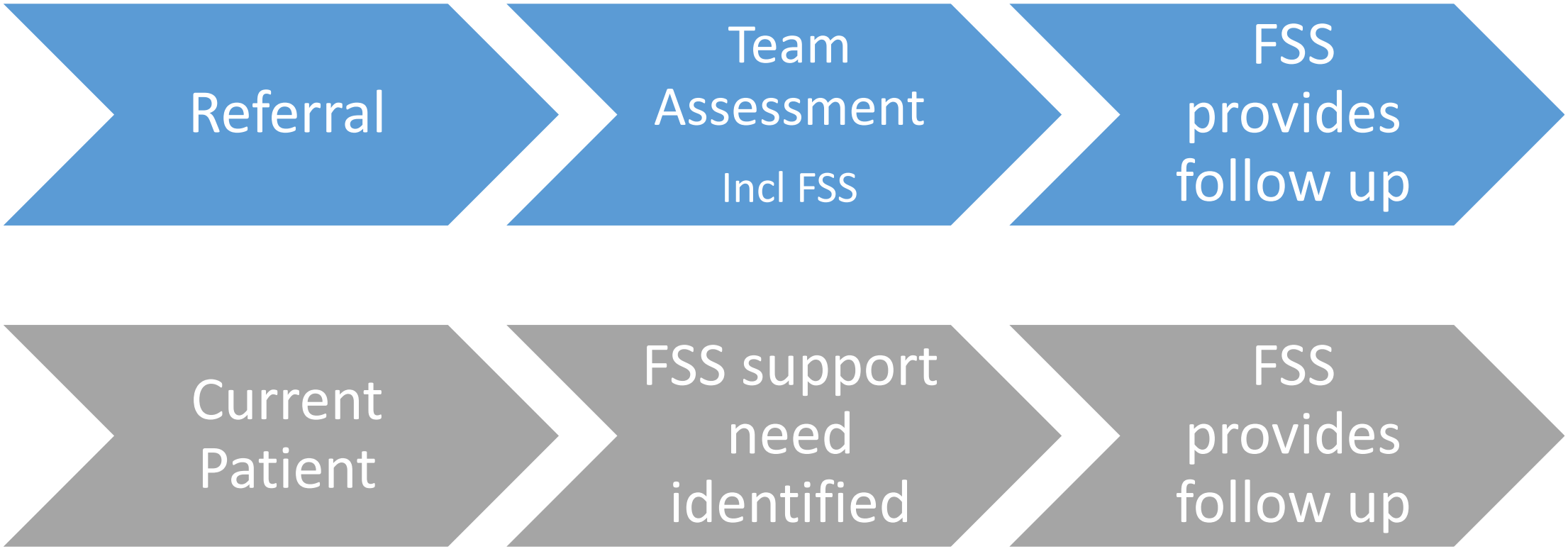
- → WHAT IS SWINDELLS?
- → TWO YEAR PILOT PROGRAM - 6/1/16-5/31/18
- → BUILDING A FAMILY NAVIGATOR PROGRAM!
- → Y1 – 2 FNS AT PCDI
- → Y2 – 1 FN AT VGC
- → STATE CERTIFIED TRAINING PROGRAM

Stories…

+

=

CLINIC FLOW – TWO PATHS…



WHAT WE'VE LEARNED…

WHAT FAMILIES TELL US:

- "It is nice to talk to someone who really 'gets' it."
- "Thank you for helping me feel less alone."
- "I feel better." "I feel understood."
- "I didn't realize I had done anything."
- "I feel like I have a plan now, thank you."

WHAT PROVIDERS TELL US:

- "It's been so great for me to be able to think out loud with the FSS…to help me figure out priorities for kids and families."
- "Family Navigators never let us forget that patients are always part of a system."
- "Family Navigators connect with families when professionals cannot, due to shared experiences, their willingness to listen (for as long as needed), and ability to help find real solutions to problem."
- "Family Navigators serve as the bridge between professionals and patient families."

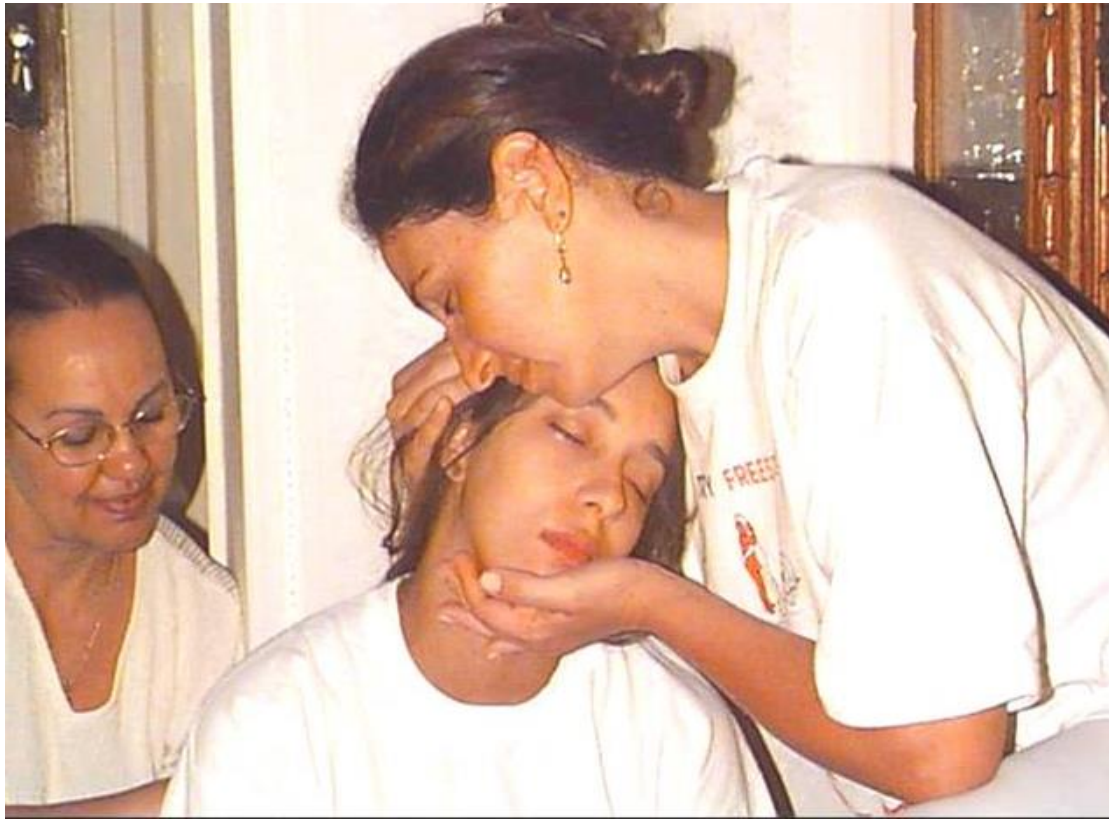
What is a Birth Doula?

- “BIRTH DOULA means a birth companion who provides personal, nonmedical support to women and families during a woman's pregnancy, childbirth, and postpartum experience”

  (OAR 410-180-0305)

- “A COMMUNITY-BASED DOULA is a woman of and from the same community who provides emotional and physical support to a woman during pregnancy, birth and the first months of parenting.”

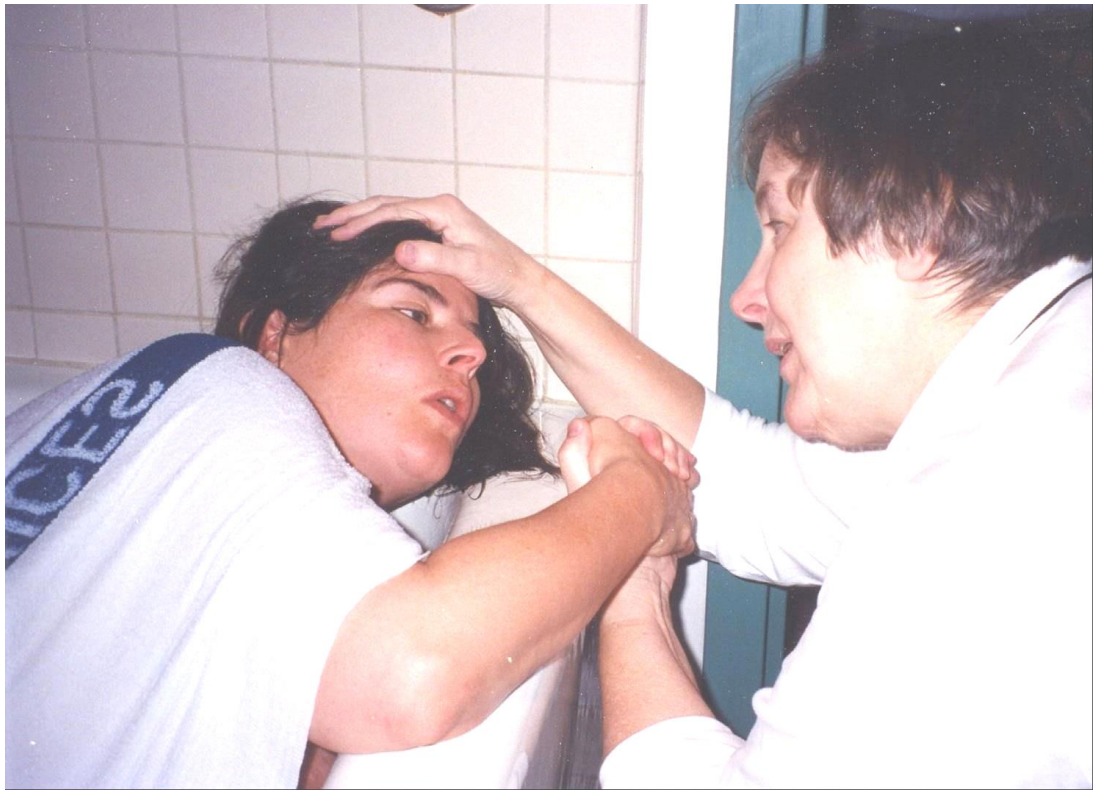
  (HealthConnect One, 2014)



Oregon's Community Based Birth Doula Care

- 2-4 prenatal visits in the home
- Attendance at the birth beginning at client's request through the immediate postpartum period
- 2 postpartum visits at home
- Phone contact and referrals as needed
- Back-up doula for continuity of care

Just what does a birth doula do?



- Physical Comfort
- Emotional Support
- Information and resources
- Advocacy

Positive Outcomes

Community-based doula programs improve birth outcomes, infant health, strengthen families, and establish supports to ensure ongoing family success, including:

- Improved prenatal care
- Reduction in preterm birth
- Improved resource usage
- Decrease interventions/Cesareans
- Increased breastfeeding rates
- Increased mother-child interaction
- Improved parenting skills

HealthConnect One
Engage. Train. Change.

Quantitative Research Reviewed

Cochrane Review: Continuous Support for Women during Childbirth (2017)

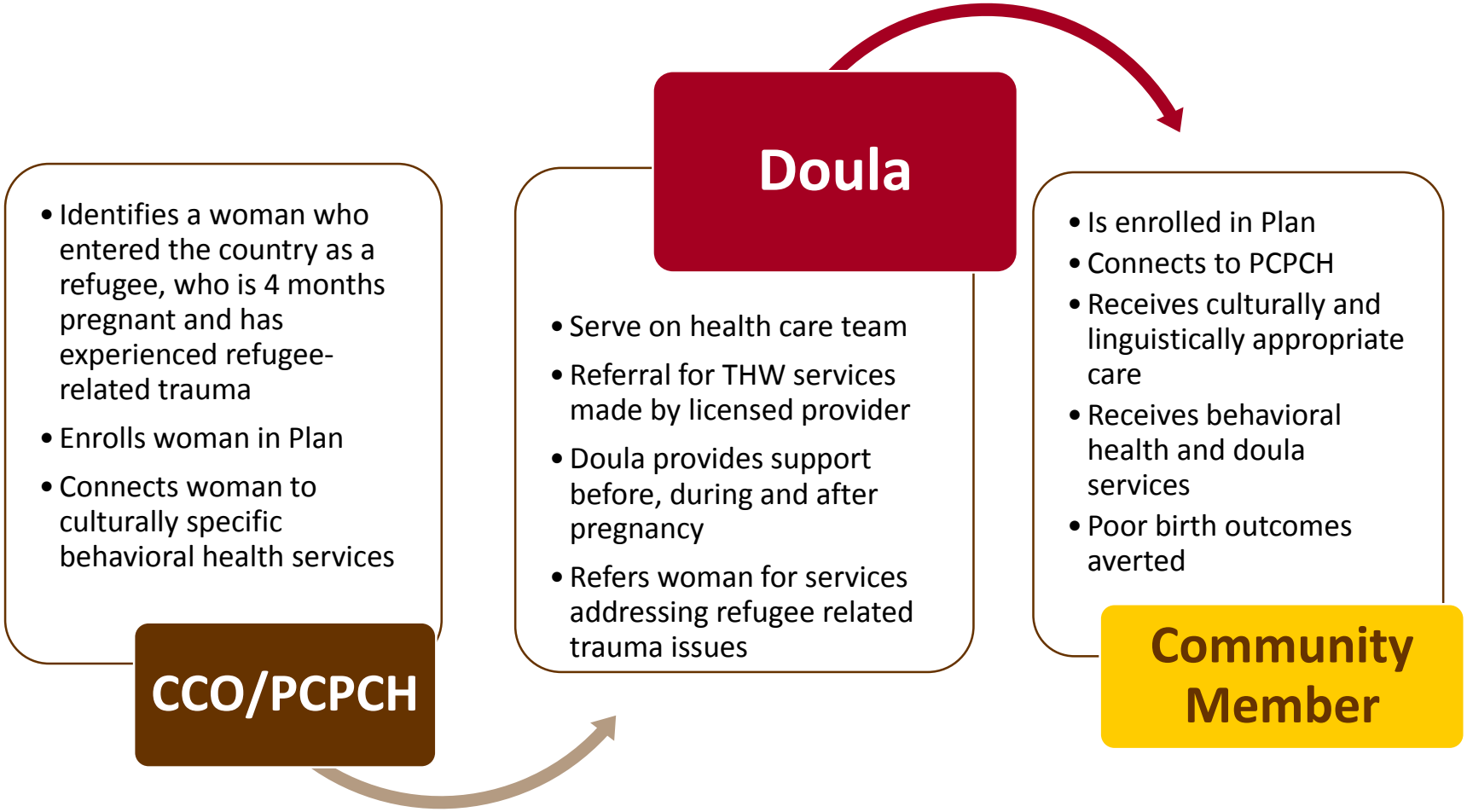
- Decreased use of epidural and other analgesia
- Decreased average labor length
- Decreased assisted vaginal delivery (forceps, vacuum) rates
- Decreased cesarean section rates
- Decreased rates of low 5 min Apgar scores
- Improved patient satisfaction with labor and delivery experience

Improving Health Equity

- State priorities for doula care include:
  - A woman with a racially or ethnically diverse background including, Black/African American, Asian, Pacific Islander, Native American, Latino, or multi-racial;
  - A homeless woman;
  - A woman who speaks limited to no English;
  - A woman who has limited to no family support;
  - A woman who is under the age of 21;
  - Medically high risk clients

Opportunities for Integrating THWs

Clinical Services



“I can do things you cannot, you can do things I cannot. Together we can do great things.”

-Mother Teresa

Questions?

Your CCO Point of Contact

Tracey Robichaud – Tracey.L.Robichaud@state.or.us
- Cascade Health Alliance
- Eastern Oregon Community Care Organization
- Columbia Pacific Coordinated Care Organization, LLC
  PacificSource Community Solution, Inc

Keri Mintun – Keri.A.Mintun@state.or.us
- FamilyCare Coordinated Care Organization
- Health Share of Oregon

Lisa Welch – Lisa.Welch@state.or.us
- Western Oregon Advanced Health, LLC
- PrimaryHealth of Josephine County, LLC
- Jackson Care Connect

Bevin Hansell – Bevin.L.Hansell@state.or.us
- AllCare Health Plan
- Umpqua Health Alliance

Rosanne Harksen – Rosanne.M.Harksen@state.or.us
- InterCommunity Health Network Coordinated Care Organization
- Trillium Community Health Plan, Inc
- Willamette Valley Community Health, LLC
- Yamhill County Care Organization

Office of Equity and Inclusion Website:

http://www.oregon.gov/OHA/oei

http://www.oregon.gov/oha/oei/Pages/health-equity-webinars.aspx

QUESTIONS?

Contact:

THW Commission and Program

• **ABDIASIS MOHAMED**

THW Program Coordinator

Office of Equity and Inclusion

971-673-3389

Mohamed.abdiasis@state.or.us

http://www.oregon.gov/OHA/oei