Traditional Health Workers: Oregon’s model

Community Health Workers, Peer Support Specialists, Family Support Specialist, Youth Support Specialist, Peer Wellness Specialists, Personal Health Navigators, and Doulas

Individuals and Communities

Health and social service systems
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 addiction 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

- 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

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

Public Health

- 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

CCO

Community Member
Integrating CHWs Into Health Systems

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

**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

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

**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
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).

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.
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.)

**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

**CCO/County**

- 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**
- 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
Just a Little Bit of Data

The numbers - experience of services

- Report improved overall wellness (whole health): 83% in 2015, 86% in 2016
- Report an increase in natural supports: 73% in 2015, 54.80% in 2016
- Feel accepted in their community: 47% in 2015, 80.20% in 2016
- Report they would have returned to a higher level of care if not for PDS: 61% in 2015, 89.10% in 2016

- 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

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

Community Based (CBO) or Peer-Run Organization (PRO)

- Trains local family members to be certified and provide support and navigation through child/family-serving systems
- Deploys Family Support Specialists (FSS) in the community
- FSS meet individuals where they are and supports them working with providers and in exploring new wellness goals
- FSS provides ongoing support, parenting related skills coaching and system navigation moving with the individual across systems even when provider changes

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

CCO/County

Community Member
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,
MEET OWEN...
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...

Referral

Team Assessment
Incl FSS

FSS provides follow up

Current Patient

FSS support need identified

FSS provides follow up
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
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

Dougla

- Identifies a woman who entered the country as a refugee, who is 4 months pregnant and has experienced refugee-related trauma
- Enrolls woman in Plan
- Connects woman to culturally specific behavioral health services

CCO/PCPCH

- Serve on health care team
- Referral for THW services made by licensed provider
- Doula provides support before, during and after pregnancy
- Refers woman for services addressing refugee related trauma issues

Community Member

- Is enrolled in Plan
- Connects to PCPCH
- Receives culturally and linguistically appropriate care
- Receives behavioral health and doula services
- Poor birth outcomes averted

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

Office of Equity and Inclusion Website:

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