Care Coordination/ICC Learning Collaborative

May 19, 2022

The session will begin shortly. While you're waiting, please answer the following question:

There are a variety of categories of Traditional Health Workers – How many different types can you name? Which types have you worked with directly?

(Post your answers in the chat box)

Oregon Health Authority

Learning Collaborative (LC) Format

12-month, virtual learning community and forum to support CC/ICC

- Sessions are **not** being recorded
  - Open, candid communication – but please no PHI
  - Session materials will be posted to the OHA Transformation Center- Care Coordination page after each meeting
- LC limitations and plan for ongoing communication to participants
- Input is welcome between sessions:
  - Jackie.Wetzel@state.or.us (OHA Transformation Center)
  - Dsimnitt.dsc@gmail.com (LC Facilitator)

Zoom Logistics

Throughout this learning collaborative, please:

- Use your webcam whenever possible
- Mute your microphone unless you are speaking
- Use the ‘raise hand’ function to share information or ask a question
- Add information and questions to the chat
- If you are having technical Zoom issues, send a chat message directly to Tom Cogswell
- Participate! Collaborate! Engage!

Please do not put your call “on hold” if you are dialed in.

Traditional Health Workers Overview in Oregon: Oregon's Model

Abdiasis Mohamed, THW Program Manager

Oregon Health Authority | Office of Equity & Inclusion

OREGON LEGISLATIONS

- **HB 3650 (2011)** Requires State to establish criteria, descriptions, and education/training requirements for community health workers, peer wellness specialists, personal health navigators, and other providers not regulated by the State
- **SB 1580 (2012)** Requires utilization of these health care workers in Health Systems Transformation
- **HB 3407 (2013)** Establishes the THW Commission to advise the Oregon Health Authority on THW policy and program issues.

More Oregon THW Legislation

- **HB2024 (2015)** Adds oral health training requirement for certification of all THWs
- **HB 2304 (2017)** Adds Peer Support Specialists and sub-worker types (Family and Youth Support Specialists) to THW Commission

Traditional Health Worker Types

- **Community Health Worker**: a trusted, trained community member who promote, advocate and organize for improved health in their communities.
- **Peer Wellness Specialist:** an individual who has lived experience with a psychiatric condition(s) plus intensive training, who works as part of a person-driven, health home team, integrating behavioral health and primary care to assist and advocate for individuals in achieving well-being.
- **Peer Support Specialist**: an individual who provide supportive services to a current or former consumer of mental health or addiction treatment.
- **Doula**: a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.
- **Personal Health Navigator**: an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.

Traditional Health Worker Continued

Family Support Specialist: A person with experience parenting a child or youth who has experience with substance use or mental health who supports other parents with children or youth experiencing substance use or mental health.

Youth Support Specialist: A person with lived experience with substance use or mental health treatment who also had difficulty accessing education, health or wellness services who want to strictly provide support services with people under the age of 30

Driving Forces Behind Increased Use of Traditional Health Workers

Q: How do we better ensure provider cultural responsiveness, language accessibility, a diversified workforce, and access to critical services across the state within a CCO and its provider network that reflects the population served by the CCO?

Policy goal	Recommended Strategies

Enhance integration and utilization of Traditional Health Workers to ensure delivery of high quality, and culturally and linguistically appropriate care to improve health outcomes	• Implement recommendations of the THW Commission, including requiring CCOs to:
	  • Create plan for integration and utilization of THWs
	  • Incorporate alternative payment methods to establish sustainable payment rates for THW services
	  • Integrate best practices for THW services in consultation with THW commission
	  • Designate a CCO liaison as a central contact for THWs
	  • Identify and include THW affiliated with organizations listed under ORS 414.627 in the development of CHAs and CHPs

How are the services of THWs reimbursed?

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

OREGON

Coordinated Care Organizations

Traditional Health Workers

CBOs

PCPCHs

Hospitals

QUESTIONS?

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

THW Commission Website: http://www.oregon.gov/oha/oei/Pages/thw-commission.aspx
Subscribe to mailing list through website for updates.
THW Program information : https://www.oregon.gov/oha/oei/Pages/Traditional-Health-Worker-Program.aspx
HB3311 Report: www.oregon.gov/oha/legactivity/2012/hb3311report-doulas.pdf

Alicia Bublitz
Program Administrator, Community Doula Program

Raeben Nolan
President, Oregon Doula Association

Personal Health Navigator (PHN)

Bethany Pettinger

Oregon THW Commissioner, PHN

Population Health Specialist, Columbia Pacific

What is a PHN?

A Personal Health Navigator, or PHN, is an individual that works within a care provider entity or health system. PHNs are patient advocates, community resource experts, and adept at navigating the healthcare eco-system. Navigators remove barriers to healthcare access & positive health outcomes. They partner with their clinical peers to increase the knowledge of socio-economic disparities & the practice of holistic, person-centered care.

PHN Scope of Practice

Care Coordination System Navigation

- Coordinate with involved systems of care and community resources
- Assist with referrals and appointments
- Coordinate care with other healthcare coordinators in the community
- Contribute to care team planning
- Promote person-centered care
- Assist with transitions and phases of care

Outreach and Direct Service

- Conduct outreach to clients to engage and maintain them in care
- Connect clients to the appropriate level of care
- Assist with enrollments in insurance, specialty care and social service programs
- Provide social services and/or community resource connections

Coaching and Social Support

- Assist clients with setting goals for care
- Promote social support and/or relationship building

Advocacy, Organizing, & Cultural Mediation

- Advocate for clients within the health system
- Connect clients to culturally appropriate health resources
- Promote effective communication between clients and care providers

Education

- Educate clients about the health care system and how to advocate for oneself
- Connect clients to available health education in the community
- Provide health information in ways clients can understand and act on
- Participate in curriculum development and train new PHNs
- Educate other health professionals about role and value of PHNs

Assessment, Evaluation, & Research

- Evaluate the availability of health services in the community
- Collect and use information from and with clients to connect them to resources
- Document client encounters and outcomes
- Track and maintain community resource and health outcome data

Bill & Michael's Story

Need: Bill, a 72-year-old Vietnam veteran, was recently diagnosed with prostate Cancer and struggling with juggling treatments, transportation, and help in his home. The logistical suffering bubbled over in a show of frustration, during a recent appointment. The Oncologist placed an internal referral for Navigation support.

Potential PHN Intervention:

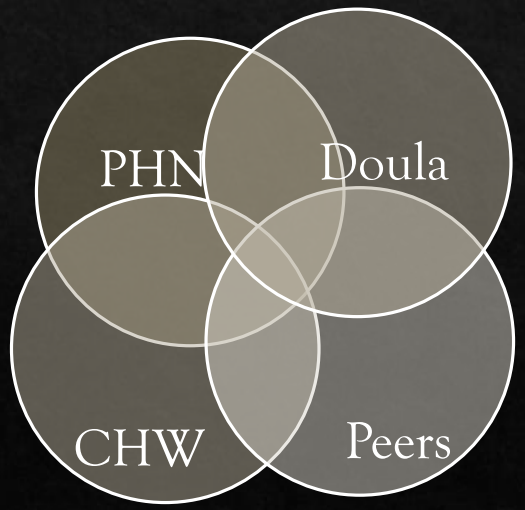
- Treatment organization and healthcare advocacy
- Teach self-advocacy and provider communication methods
- Healthcare literacy education
- Consistent care planning with multi-disciplinary team
- Connection to ACS for volunteer assistance
- SNAP Application Assistance
- Warm connection to counselor for grief and cancer counseling
- Warm connection to Cancer Support Group
- Warm connection to long-term care as needed
- Social connections to people/groups with similar hobbies/interests

PHN Integration within a Care Team

- Be aware of existing roles that overlap in scope
- Be intentional with how would-be clinical colleagues are included in the implementation process… get their buy-in!
- Honor the PHN role and scope, ensuring colleagues understand the "why"
- Create and train all care team staff on PHN escalation pathways
- Beware of the potential want to turn the PHN role into an administrative assistant
- Look for all opportunities for PHN to work at top of scope
- Consider training and qualifications thoughtfully

Learn to find comfort in scope overlap

Efforts spent in team building, understanding a shared mission, and developing reliable workflows and role expectations can make all the difference!



Thank you for your time!

What questions may I answer?

Bethany Pettinger

pettingerb@careoregon.org

Liliana Herrera Acosta
Sergey A. Nazarov

Community Health Navigator

Kaiser Permanente

Onboarding/orientation

OHA-Assister Training

Shadowing other navigators (non-UPENN)

10 day highly interactive training provided by UPENN

Got certified as CHN under THW umbrella

Refresher trainings with close supervision

OHA 90-hour CHW training

Success stories

LS

- *Homeless, Russian-speaking Immigrant, Medically Complex*
- *Got housed, learned how to schedule medical appts*
- *Got connected to case management in the community*

Success stories

Maria

- *Immigrant*
- Chronic ailments
- Not familiar with US health care system
- Food insecurity, Financial strain
- Connect with resources
- Help navigate healthcare system

Barriers

Barriers experienced in:

- Organizations are not familiar with community health navigators
- *Hard to get adequate training and develop specific skills due to wide scope of practice and unique client needs*

CHNs and CLAS

Providing	Providing community resources navigation to Russian-speaking clients • The case of VL
Providing	Culturally specific support • Culturally specific Latino Community Health Navigator • Connected patient to culturally specific program • Provided interpretation support

QUOTES FROM OUR PATIENTS

"I call him my hero."

"There was a period where I did not engage but she remained persistent."

" I never felt so cared for."

" Never have I ever come across anyone so dedicated."

"I was provided with support that I never thought I needed."

"She helped me walk through some of my problems."

"She exhibited genuine interest in helping me."

"This is a great support for people like me who is alone."

Other details you would like to share

Patient-centered goals and support. CHNs do not force or make patients follow clinicians' recommendations or treatment plan unless this is meaningful and important for patients themselves and patients say that they **want to** proceed in that direction.

CHNs are here to help patients to set specific, realistic patient-centered goals and guide patients to the appropriate resources, tools and techniques to help them reach their goals and promote successful outcomes in their socioeconomic, emotional and/or physical aspects of their life.

Questions

Tammi S. Paul

Family Support Specialist

Deputy Director, Oregon Family Support Network

Onboarding/orientation

- Family Support Specialist (FSS) Foundations training (42 hours)
- Wraparound Foundations and Family Partner Orientation (48 hours)
- FSS Workforce Shadowing (24-40 hours)
- FSS Supervision every other week
- Clinical consultation monthly
- FSS Competency coaching as needed

Success Story

Barriers

- Getting hired as a THW
  - FSS certification is based on the lived experience as a parent/primary caregiver of a child/youth experiencing mental health or behavioral health challenges, however, it is more importantly about how a **FSS uses** their lived experience that makes them successful
- Being accepted as a valuable contributor in the position (either within your organization or other people/teams you work with),
  - Family members who become Family Support Specialists are often seen as not having formal education or other professional lived experience. This is often a myth and leads to FSS's being underutilized, restricted in their role or undervalued by other team members.
- Pay issues, training, etc.

Peer support specialist (PSS) details

Please understand each peer support specialist (PSS) specialties (Adult MH, Adult Addictions, Family, Youth) and that although the principles of the peer work are similar that the context, lived experience and workforce competencies are different.

The role of the Family Support Specialist can make the job of the Care Coordinator easier by more quickly building trust based on shared lived experience and more flexibility to work with families when/where they are available. The FSS aligns with the family and partners with the Care Coordinator.

Care Coordination/ICC Learning Collaborative

We are currently taking a short break.

We will resume the session soon.

If you'd like to get started on the session survey, you may do so here:

https://forms.office.com/r/04KiNbbERS

Oregon Health Authority

Clay Peterson
Executive Director
Project ABLE

Bob Johnson

Community Health Worker

Orchid Health Clinic - Oakridge

Onboarding/orientation

- *Pilot program to introduce a Community Health Worker at Orchid Health, a rural primary care clinic in 2020.*
- *Training done at Benton County Health Department.*
- *Trusted member of the community with lived experiences.*
- *Currently CHW's in 4 Orchid Health Clinics.*

Barriers

- Integrating into current provider workflow.
- Patient visit pre-scrub to identify SDoH concerns.
- Rural Lane County with few local resources available.
- Most resources 45 miles away in Eugene/Springfield area.
- Currently not paid consistently for CHW visits by CCOs.

Success stories

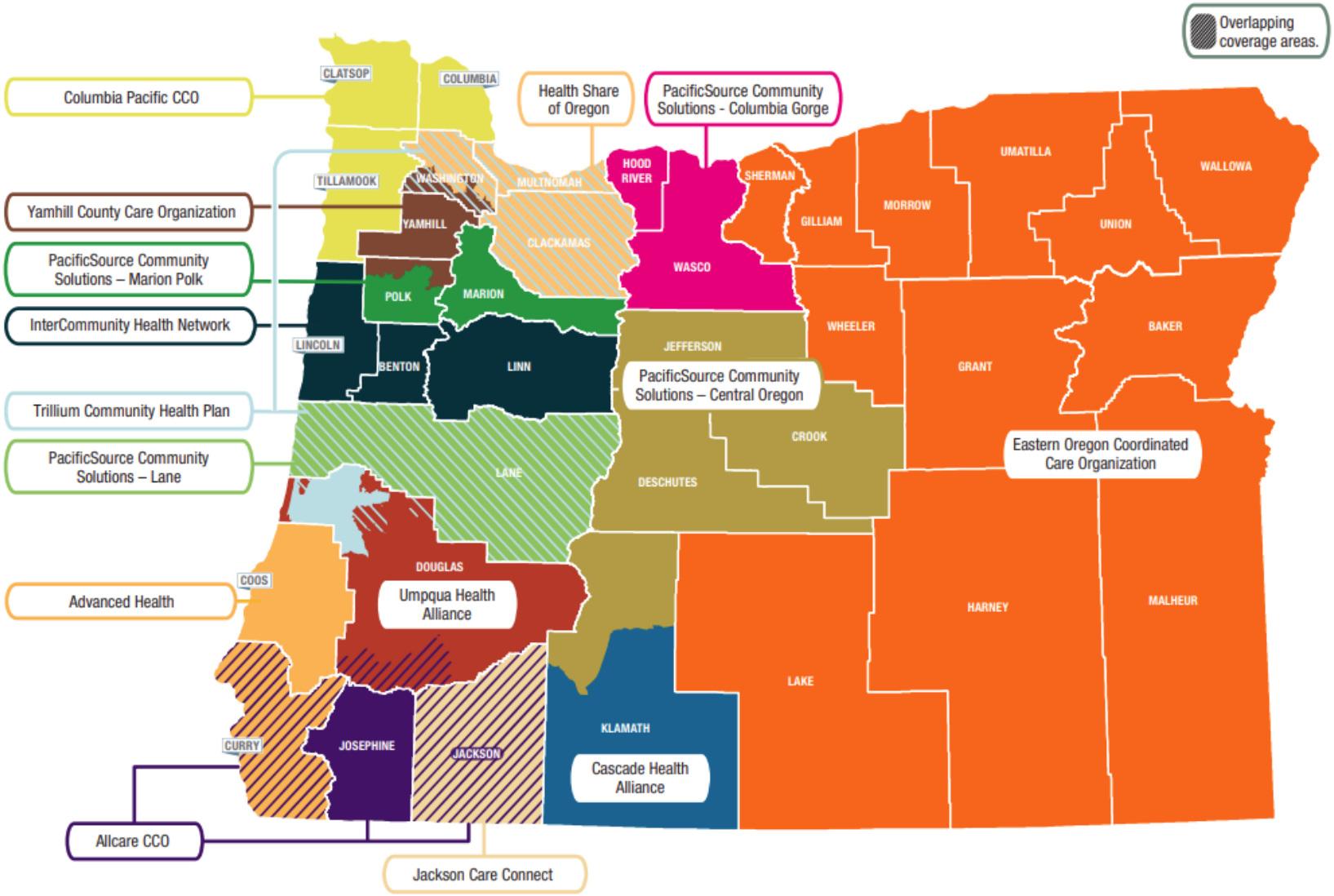
- Orchid is an integrated health model which has Medical, Nursing, Behavioral Health, and Community Health Worker under one roof.
- Male with active substance abuse issues seen periodically as a patient for over a year by medical provider with occasional BHC visits.
- Began seeing BHC/CHW weekly with some improvement.
- Patient makes decision to enter treatment program with successful outcome.

Questions?

Maria Tafolla
Equity, Diversity, and Inclusion
Portfolio Manager
Health Share of Oregon

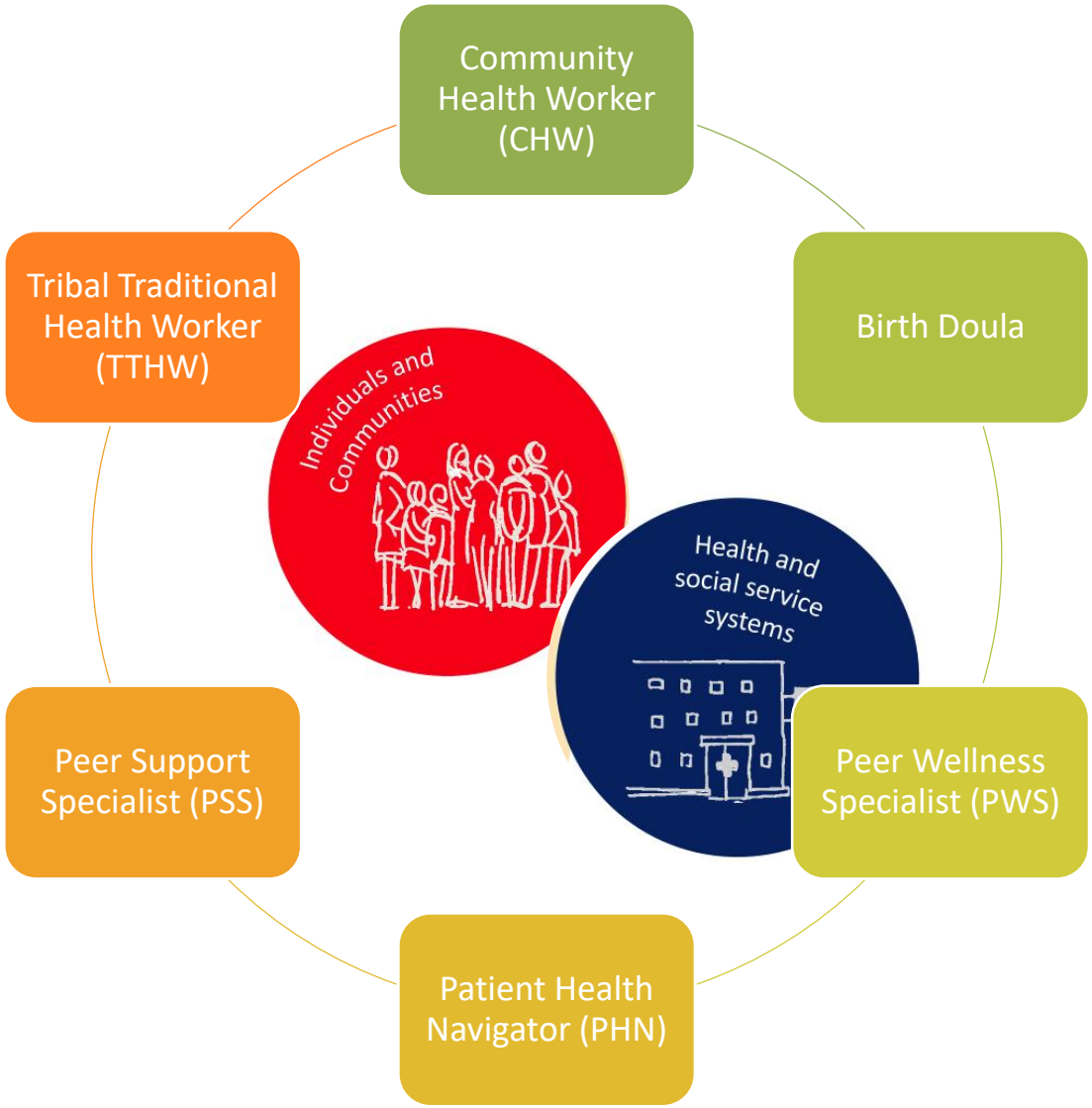
Coordinated Care Organization 2.0 Service Areas

Oregon Health Authority



health share

Traditional Health Workers (THW's)



THW Integration and Utilization Plan 2020-2024

Integrate THWs into the delivery of services;

Communicate to Members about the scope of practice, benefits, and availability of THW services;

Communicate to Providers about the scope of practice, benefits, and availability of THW services

Measure baseline utilization and performance over time

Increase member utilization of THW's

Implement OHA's Office of Equity and Inclusion THW Commission best practices which includes Contracting with Community based organizations;

THW Liaison Role

Increase

Support increase member access to THWs

Provider Awareness of THW Types

Inform

Inform building alternative payment models that provider livable wages

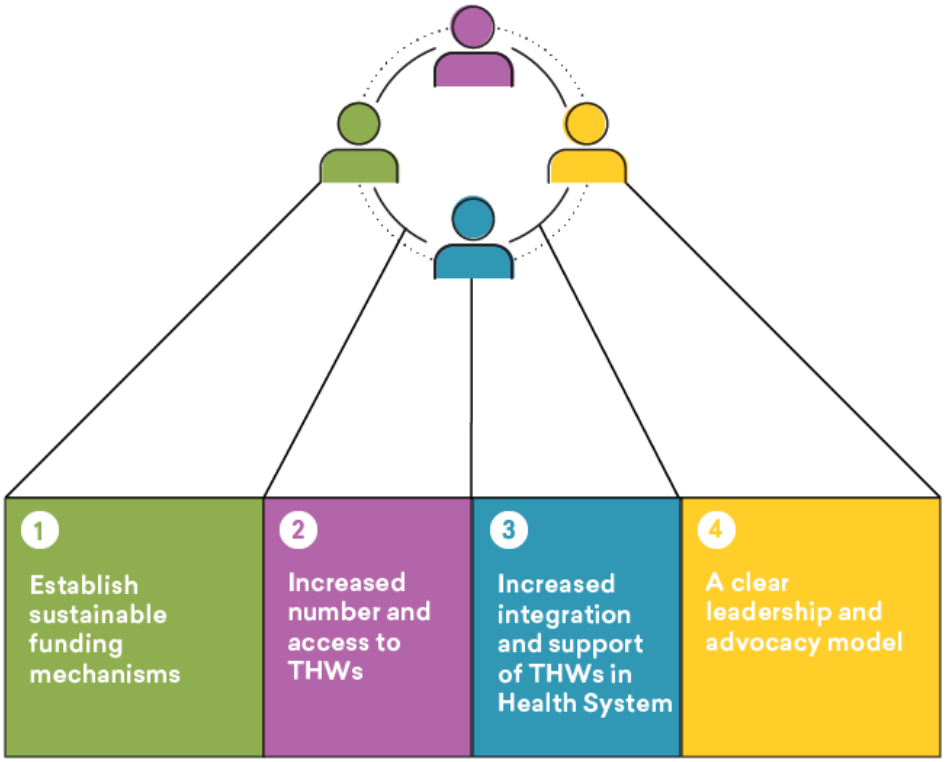
Collaborate

Collaborate with the OHA THW Commission to share workforce needs

Health Share's Collective Vision

All Health Share members have access to a THW of their choice, in the setting they thrive in. THW's are honored and respected by the health system for serving marginalized communities that ultimately help them reach their highest health outcomes.

Accomplished by a reconstruction of health systems, it's policies, and funding mechanism that honor THW's



Questions?

Our Partners

ADVENTIST HEALTH PORTLAND

CENTRAL CITY CONCERN
HOMES HEALTH JOBS

CLACKAMAS COUNTY

CareOregon

KAISER PERMANENTE

LEGACY HEALTH

Multnomah County

OHSUHealth

PROVIDENCE
Health Assurance

OHSU
TUALITY HEALTHCARE
An OHSU Partner

WASHINGTON COUNTY OREGON

Upcoming Sessions

- **June 16: Pediatric Care Coordination**
  - Family preservation demonstration project overview
  - Transitions of care
- **July 21: OHA Data for CC/ICC**
  - Collective tool
  - Children's Health Complexity Data
  - Other/recommendations/data wish list
- **Aug 18: Combined Session with PCPCH Practices**
  - Overview on program approaches and strategies for coordinating care
  - Successes and challenges of coordination between CCOs and PCPCHs
- **Sept 15: Continued Discussion on OARs/Contract Requirements (TENTATIVE)**

Child and Family Behavioral Health Learning Opportunity

8-session virtual training series on treating eating disorders

Dates and speakers (sessions are noon to 1:15 p.m.)

- June 8: Therese Waterhous
- July 13: Whitney Trotter
- August 10: Therese Waterhous
- August 31: Q and A with Therese Waterhous (not eligible for CEU)
- September 21: Therese Waterhous
- October 12: Melissa Grossman
- November 16: Melissa Grossman
- December 7: Therese Waterhous

For more information go to: https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/Training.aspx

THANK YOU!

See you next month
June 16, Noon – 2pm

Please provide session feedback here:

https://forms.office.com/r/04KiNbbERS

Or using the QR code function on your phone:

Oregon Health Authority