UMPQUA HEALTH ALLIANCE

Welcome

Meeting Structure:

- Participants should join the audio portion of ZOOM via phone or computer audio, **not both**. Video is optional.
- Please remain on mute during the presentation.
- Feel free to use the chat window to ask questions.
- We will open at the end of the presentation for questions

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April 12th, 2021

Traditional Health Workers

Traditional Health Workers:

- Help individuals in their communities, providing physical and behavioral health services.
- THWs can improve patient and provider experiences while enhancing patient-centered care.
- They go beyond the clinical aspect of care and can help break down barriers that may exist for the patient.
- THWs are essential in supporting patients with medically complex conditions during and in between doctor visits.
- An effective THW workforce consists of individuals who are from the community they serve, who have shared “lived experiences” and are representative of the population served.

There are **5 types** of Traditional Health Workers:

•**DOULA:** A (Birth) Doula is a birth companion who provides personal, non-medical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.

• **PSS:** A Peer Support Specialist is any [range of] individuals who provide supportive services to a current or former consumer of mental health or addiction treatment.

• **PWS:** A Peer Wellness Specialist is 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.

• **PHN:** A Personal Health Navigator is an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions.

• **CHW:** A Community Health Worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.

There are **4 identified types** of Peer Support Specialists:

a. **Recovery Peer:** A person in addiction recovery with at least two years of sobriety who provides support services to people seeking recovery from addiction.

b. **Mental Health Peer:** A person with lived experience of mental health who provides support services to other people with similar experiences.

c. **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.

d. **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**.

THWs serve as the intermediaries that link clinical services to practical actions in the community to address the Social Determinants of Health.

Traditional Health Workers

Health and Social Service Systems

Benefits of integrating THWs?

Care (quality, availability, reliability

- A diverse workforce able to provide culturally responsive education and solutions
- Improves coordination of addiction, mental, and physical health
- Higher engagement rates and patient satisfaction
- Higher levels of psychosocial support and improved attachment

TRIPLE

COST (lower, contain, affordability)

- Reduce no show rates
- Lower emergency room visits
- Shorter average labor lengths and decreased use of pain relief medications and interventions
- Lower costs for ancillary systems

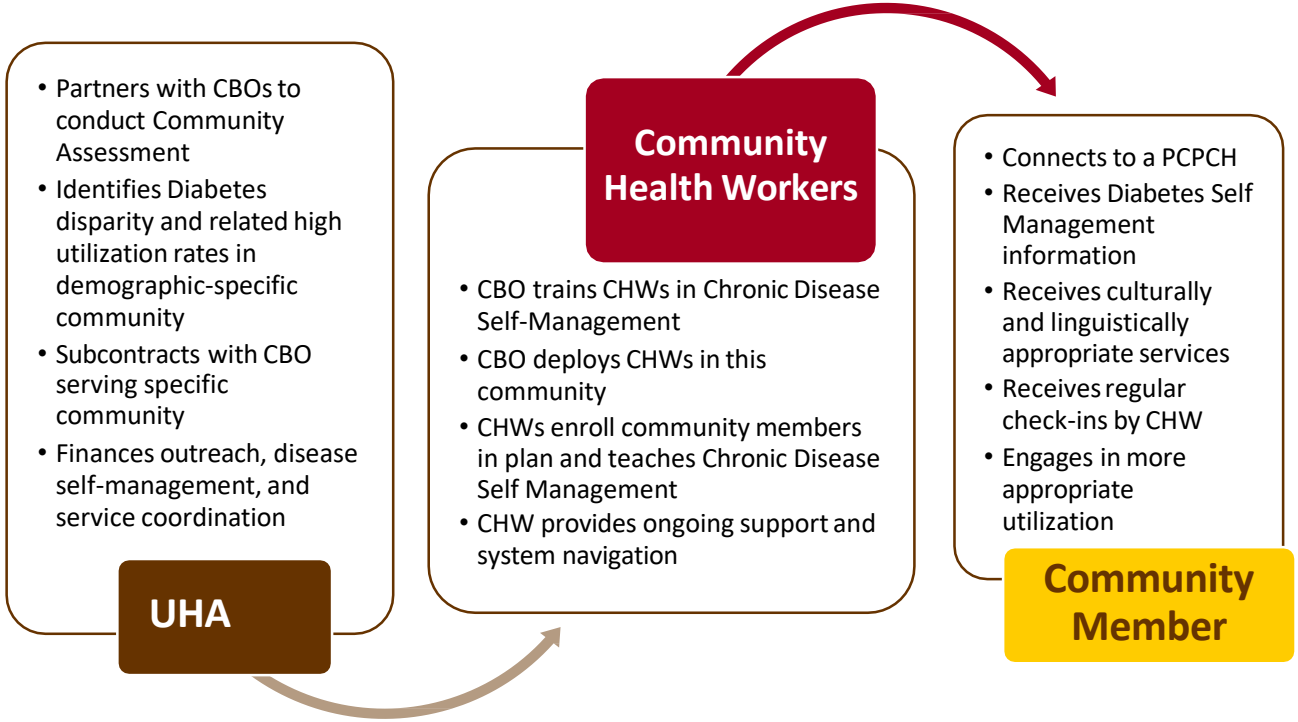
AIM

HEALTH (improve lifelong health)

- Support preventative care and early treatment
- Promote and engage consumers in self-management
- Role model a recovery lifestyle
- Improved overall health/wellness
- Lower rates of acute care episodes
- Address social determinants of health

Examples for Integrating THWs

Public Health



Community Health Workers

- CHWs are a trusted member of the community.
- CHWs specialize in serving rural and frontier communities, either as a paid employee or as a volunteer with a local health care system or community-based organization.
- CHWs are prepared to assist members of the community to improve their health and increases the capacity of the community to meet the health care needs of its residents and achieve wellness.
- CHWs can assist patients with accessing food, housing and financial services in supporting the patient's economic stability.
- CHWs may provide peer counseling and guidance on health behaviors and provide direct services such as first aid or blood pressure screening

Lisa Ketchum
UHA's Behavioral Health CHW

What Does A Community Health Worker Do?

- Connect members with up-to-date community resources and follow through to ensure successful outcome
- Encourage self sufficiency at individual pace
- Meet members in their living environment within safety protocol until goal is reached
- Help member with paperwork (housing, SSI/SSD,SNAP, birth certificate, ID) to improve overall heath outcome
- Accompany member to appointments to provide advocacy and ensure individual understanding of information
- Loaner phone program
- Collaborate with community resources
- Utilize Health Related Services (FLEX)
- Many other tasks related to social determinants of health and individualized need

I feel blessed to have the ability to serve the community I grew up in and Love while making life changing differences, one member at a time

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SUCCESS STORIES

Member 1:

- Special Health Care Needs
- Bedridden for 2.5 years
- Last recorded weight was 700lbs
- Unable to bear weight, bend at waist, hip and knees
- Local orthopedics denied based on current diagnosis and record of weight
- His initial barrier to obtaining a 2nd opinion at OHSU is that he needs to obtain an accurate weight

What do you suggest?

CHW was able to coordinate transportation, get weight on the drive through scales of Douglas County Farmer's CO-OP landscaping and fertilizer Center in Wilbur, while retaining dignity and privacy for the member. New weight was 280 thus allowing forward motion in his health care.

-Update-

Member is now no longer bed ridden and able to stand with custom leg braces, sit in a wheel chair and continues to lose weight. He is set to have his first knee replacement next month. He states getting the updated weight "CATAPULTED" his care forward and has allowed him to regain his life." He is forever grateful.

Member 2:

- Special Health Care Needs
- Severe & Persistent Mental Illness
- Homeless
- History of Substance Abuse

What do you suggest?

CHW Assisted member with housing application, on SSD. Connected with SNAP, HRS submission for application fee and deposit fees. Attended his interview for housing via Zoom. Advocated/highlighted member's newfound positive direction in life and identified deficits so full picture could be seen.

Member was approved for housing on the spot. He currently remains In stable housing.

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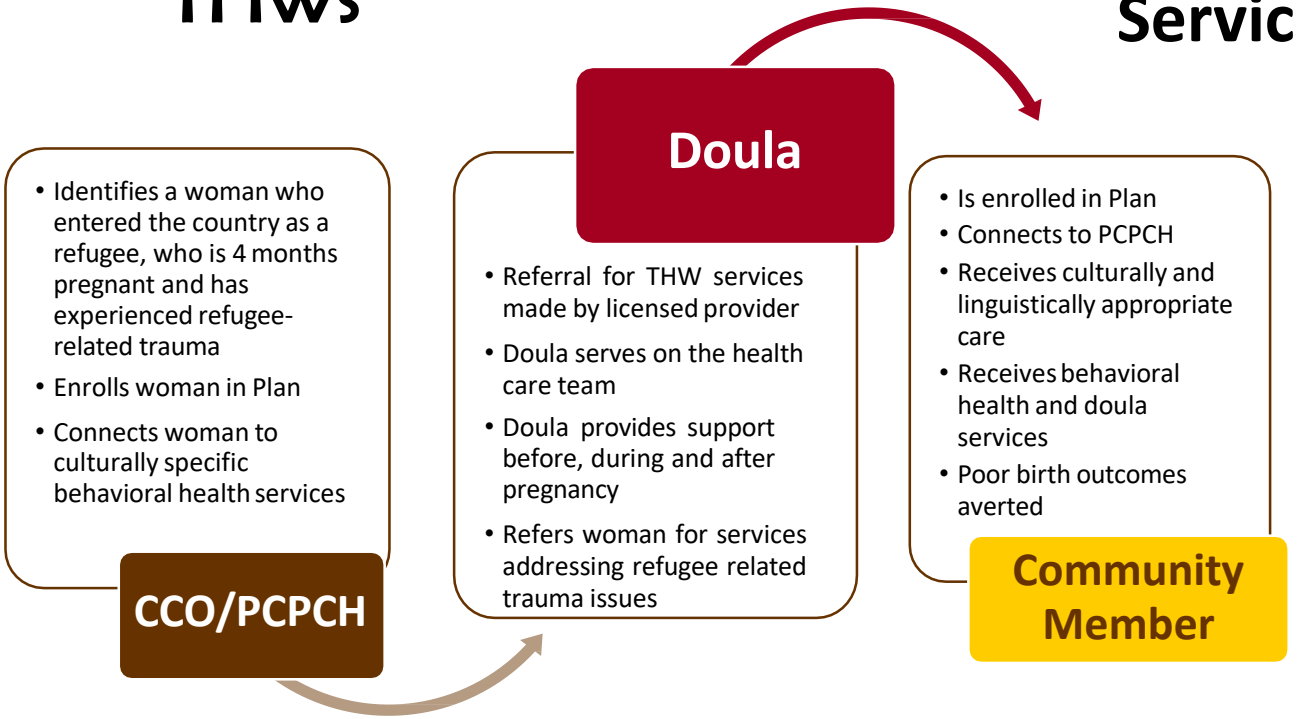
UHA Referral Pathway

Call	Fax	Email
Customer Care 541-229-4842	Case Management 541-229-8180	Casemanagement @umpquahealth.com

Examples for Integrating THWs

Clinical Services



Examples for Integrating THWs

- 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

Peer Support Specialists

- CBO 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

Mental Health &/or Addictions

- 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 utilization

Community Member

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THW training, certification, and employment process.

Step 1)

Complete OHA-Approved Training Program

- Traditional Health Workers must complete an Oregon Health Authority (OHA)-approved training program to qualify for state certification.
- This applies to community health workers, peer wellness specialists, personal health navigators, peer-support specialists, and doulas.

Step 2)

Complete Certification and Registry process

Step 3)

Become an Oregon Medicaid Provider

Criteria for becoming a Certified Traditional Health worker or renewing your certification

You must meet **all of the** criteria below to become certified by the Oregon Health Authority:

- Be at least 18 years old
- Not be listed on the Medicaid provider exclusion list
- Have successfully completed all training requirements for certification
- Submit all required documentation and a completed application
- Pass a criminal background check
- Complete Oral Health training

The following documents must be prepared before submitting for review:

1. Traditional Health Worker Full Certification and Renewal Application
2. Copy of your training certificate from an OHA-approved training program
3. Clear copy of a government-issued identification

THW Registry

- To apply to become a THW, please submit your application and supporting documents via email to thw.program@dhsoha.state.or.us.
- Once you are certified with the Oregon Health Authority (OHA), you will be added to the state registry.
- The registry is a reliable, trusted source for finding a traditional health worker in Oregon.
- Traditional Health Worker Registry- https://traditionalhealthworkerregistry.oregon.gov/Search

To Become an Oregon Medicaid provider

Following Traditional Health Worker Registry, your next step is to obtain a unique National Provider Identifier (NPI) and enroll as an Oregon Medicaid provider:

- **To obtain an NPI**: Apply on the National Plan and Provider Enumeration System website. For reference, the taxonomy code for CHW is 172V00000X.
  Website: https://nppes.cms.hhs.gov/#/

- **To enroll as an Oregon Medicaid provider**: complete form OHP 3113. Enter provider type 13, specialty code 601. Include your NPI and a copy of your OEI certification.
  Link to form: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3113.pdf

- To learn more, visit the OHP provider enrollment page:
  https://www.oregon.gov/OHA/HSD/OHP/Pages/Provider-Enroll.aspx

How Can I Become a CHW?

1. Complete an approved training program; **or**

2. Provide documentation that you have worked or volunteered as a Traditional Health Worker for at least 3000 hours in Oregon from January 1, 2004 to June 30, 2019; **or**

3. If you have completed some or all of the certification training requirements, you may be able to count previously completed training toward certification.

Training online

EST 1961
SOUTHWESTERN
AN OREGON COMMUNITY COLLEGE

Southwestern Oregon Community College
8-week course - within 3 months after completion you can register for your certification with the state

THW Employment

- Roles need to be clearly defined and understood by all team members
- Supervision should be specific to the THW worker type
- CHWs are required to be supervised by existing licensed practitioners and perform services for them within the licensed practitioner's scope of practice.
- Additional on-site training/continuing education should be provided or verified through employer (20 hours every 3 years to maintain certification).
- The Office of Equity and Inclusion's (OEI) website provides definitions and scope of practice of THW worker types.

THW support and supervision standards at minimum will include:

- **Provide mentoring**, which supports THWs to develop as ethical professionals, and the support that helps THWs deal with potential re-traumatization and vicarious trauma.
- Excellent support and supervision in promoting the retention of THWs and increases their effectiveness, thus promoting health and well-being in the communities THWs serve.
- **Cultivate** a network of resources to share with the THW team
- **Act** as a link between the THW team and larger health and social service systems
- **Support** the team to maintain ethical standards
- **Foster and support** the professional development of THWs and encourage their involvement in system change opportunities
- **Practice** cultural humility and openness to learning about other communities, beliefs, and practices

THW Payment Model

- Future alternative payment structures may include case rates, per-member-per-month rates, or capitation agreements that include the use of THWs.

- Value-based payment (VPB) will be evaluated and possibly implemented in Patient-Centered Primary Care Home (PCPCH) contracts to encourage PCPCH practices to employ and incorporate THWs on their primary care teams.

- THW payment models will be developed based on the recommendation and core principles set forth by the Office of Equity and Inclusion (OEI).

- UHA will ensure payment models are sustainable, support THWs practicing at the top of their certification, community and equity-driven, and not solely contingent upon short-term outcomes to attract additional contracted THWs .

In Summary

- Umpqua Health Alliance is committed in promoting and encouraging THWs on primary care teams.
- Our efforts will include models of contracting with community-based organizations for THW services, as well as other models of integration.
- The THW Liaison will support the ongoing education and training of THWs, especially in the areas of health equity, cultural competency, and social determinants of health.
- UHA will foster and support the development of peer networks for THWs to connect with others doing similar work.

Open Discussion:

- How do folks feel about THW integration and what do you believe our community needs are?
- Do you envision barriers with our efforts towards THW integration?
- What should we consider when promoting and integrating THWs?
- Any feedback or suggestions as we work towards developing a robust network of THWs?

Additional Resources:

Current information about THW services, resources and THW availability can be found at these links:

- THW Training Resources: https://www.oregon.gov/oha/OEI/Pages/THW-OHA-Approved-Training-CEU.aspx
- THW Certification Resource: https://www.oregon.gov/oha/OEI/Pages/THW-Training-Certification-Requirements.aspx
- OHA's Traditional Health Worker Toolkit (THW scope of practice and many other resources): https://www.oregon.gov/oha/OEI/THW%20Documents/Traditional-Health-Worker-Toolkit-2019-Final.pdf
- UHA Case Management page: https://www.umpquahealth.com/case-management/

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UHA Contact

If have any other questions regarding this presentation, please do not hesitate to contact:

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THANK YOU

References

Kangovi, S., Mitra, N., Grande, D., Huo, H., Smith, R. A., & Long, J. A. (2017). Community health worker support for disadvantaged patients with multiple chronic diseases: a randomized clinical trial. *American journal of public health*, *107*(10), 1660-1667.

AJPH RESEARCH

Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial

Sherya Kangovi, MD, MS, Nandita Mitra, PhD, David Grande, MD, MPA, Haiwang Huo, PhD, Robyn A. Smith, BS, and Judith A. Long, MD

Objectives. To determine whether a community health worker (CHW) intervention improved outcomes in a low-income population with multiple chronic conditions.

Methods. We conducted a single-blind, randomized clinical trial in Philadelphia, Pennsylvania (2013–2014). Participants (n = 302) were high-poverty neighborhood residents, uninsured or publicly insured, and diagnosed with 2 or more chronic diseases (diabetes, obesity, tobacco dependence, hypertension). All patients set a disease-management goal. Patients randomly assigned to CHWs also received 6 months of support tailored to their goals and preferences.

Results. Support from CHWs (vs goal-setting alone) led to improvements in several chronic diseases (changes in glycosylated hemoglobin: −0.4 vs 0.0; body mass index: −0.3 vs −0.1; cigarettes per day: −5.5 vs −1.3; systolic blood pressure: −1.8 vs −11.2; overall $P = .08$), self-rated mental health (12-Item Short Form survey: 2.3 vs −0.2; $P = .008$), and quality of care (Consumer Assessment of Healthcare Providers and Systems; 62.9% vs 38%; $P < .001$), while reducing hospitalization at 1 year by 28% ($P = .11$). There were no differences in patient activation or self-rated physical health.

Conclusions. A standardized CHW intervention improved chronic disease control, mental health, quality of care, and hospitalizations and could be a useful population health management tool for health care systems.

Trial Registration. clinicaltrials.gov Identifier: NCT01900470. (*Am J Public Health*. 2017; 107:1660–1667. doi:10.2105/AJPH.2017.303985)

Policymakers, including the Department of Health and Human Services, have expressed a need to shift away from single-disease paradigms toward population health interventions. This shift is driven by a growing public health concern: nearly 1 in 3 Americans is diagnosed with multiple chronic conditions[1] and more than 65% of health care spending is associated with care for this population.[2] Low-income and minority individuals are more likely to have multiple chronic conditions and to suffer worse outcomes than their advantaged counterparts.[3,4]

A large body of literature suggests that community health workers (CHWs), trained laypeople who share socioeconomic background with patients, can effectively improve chronic disease outcomes.[5–10] However, with few exceptions,[11] many previous CHW interventions have been disease-specific,[12] focusing, for instance, on asthma self-management, diabetes education, or cervical cancer screening. This disease-specific approach, likely a consequence of disease-based grant funding, can cause fragmentation for patients with multiple chronic conditions.[13]

The study team created IMPaCT (Individualized Management for Patient-Centered Targets),[14,15] a CHW intervention that can be applied across diseases to address "upstream" socioeconomic and behavioral barriers. The intervention was designed by a community–academic–health system working group to use qualitative participatory action research with high-risk patients. In a previous randomized clinical trial of hospitalized patients with a variety of diseases,[16] this intervention improved posthospital access to primary care, mental health, and quality of care while decreasing recurrent hospital readmission. IMPaCT has been adapted for various patient populations, including outpatients with multiple chronic conditions.[14]

In this study, we present findings from a clinical trial of 302 outpatients with multiple chronic conditions, randomized to chronic disease goal-setting with their primary care provider versus goal-setting plus support from a CHW. We hypothesized that a non–disease-specific CHW intervention could improve control of different chronic diseases, as measured by glycosylated hemoglobin (HbA1c), body mass index (BMI; defined as weight in kilograms divided by the square of height in meters), systolic blood pressure (SBP), and number of cigarettes per day. We also hypothesized that the CHW intervention would improve prespecified secondary outcomes: achievement of chronic disease management goals, self-rated health, patient activation, patient-reported quality of primary care, and all-cause hospitalizations assessed by statewide claims data.

ABOUT THE AUTHORS

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Correspondence should be sent to Sherya Kangovi, MD, MS, Perelman School of Medicine, University of Pennsylvania, Division of General Internal Medicine, 1018 Blockley Hall, 423 Guardian Dr, Philadelphia, PA 19104 (e-mail: kangovi@upenn.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

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