InterCommunity Health Network CCO

2022

IHN-CCO THW Orientation Toolkit

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Introduction

The Traditional Health Worker (THW) Orientation Toolkit is a “one-stop” document that contains all the necessary information for a THW organization and individual THWs to be successful when engaging with the community. This document will be updated with relevant information on a regular basis with support from IHN-CCO and the Delivery System Transformation Committee’s Traditional Health Worker Workgroup.

Section 1: Definitions

Traditional Health Workers (THWs) are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members. THWs have historically provided person- and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for patients, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health.

There are five types of THWs that are utilized in the community:

Community Health Worker (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. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

Peer Support Specialists (PSS)
A Peer Support Specialist (PSS) is an individual with shared lived experience with substance use and/or mental health who provide supportive services to a current or former consumer of mental health or addiction treatment.

a. Recovery Peer: A person in addiction recovery with two years abstinence 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.

Peer Wellness Specialists (PWS)
A Peer Wellness Specialist (PWS) 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.

Personal Health Navigators (PHN)
A Personal Health Navigator (PHN) is an individual who provides information, assistance, tools, and support to enable a patient to make the best health care decisions. Also known as Patient Health Navigators.

Birth Doulas
A Birth Doula is a birth companion who provides personal, nonmedical support to birthing person's and families during pregnancy, childbirth, and postpartum experience.

Section 2: Scope of Practices

All THW types have different scopes of practices due to the type and nature of work; however, there are common responsibilities and roles that apply to all THWs. Below is a graphic that describes these common responsibilities among all THW types. In cases where a provider is asked to render services outside of the scope of practice, the organization should provide appropriate resources and support to help the provider better serve the patient's needs.

OHA General Scope of Practice

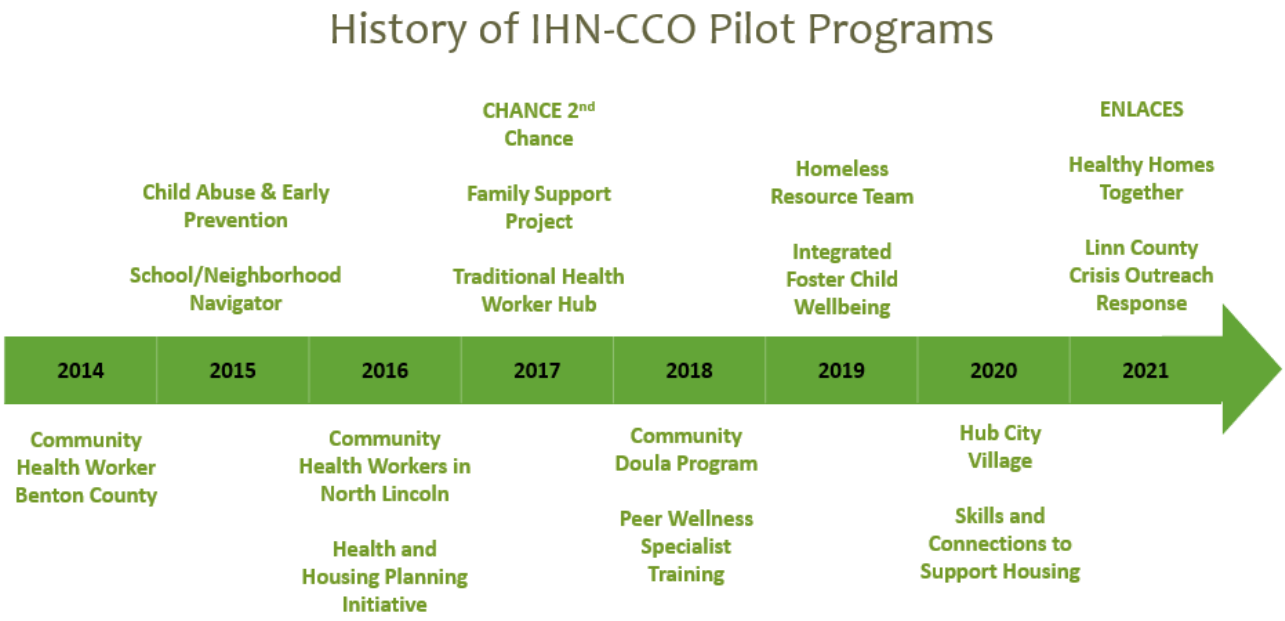
See [OHA's Traditional Health Worker Toolkit] for scope of practices specific to each THW type.

Section 3: THW Organization Environmental Scan

IHN-CCO has a long history of working with THW programs in the Benton, Lincoln, and Linn regions, as they have continuously organized pilot programs and worked with organizations of all types and varieties. IHN-CCO anticipates continuing these trends as they look to ensure members are receiving the quality care they need.

IHN-CCO's Delivery System Transformation Committee also has a Traditional Health Worker Workgroup that supports the advancement and development of THWs in the transformation of healthcare to advance the Quadruple Aim. This workgroup also serves as a place community partners can come to receive support with utilization of THWs.

Since 2013, IHN-CCO Transformation has partnered with 22 community partners for 32 Traditional Health Worker programs. Organizations such as CHANCE, Samaritan Health Services, Benton County Health Services, and Family Tree Relief Nursery have partnered with Transformation on multiple pilot programs.
IHN-CCO has led a variety of transformation pilot programs spanning nearly over a decade, with each program designed to meet the different needs of IHN-CCO members. Some pilot programs have led to full-time partnerships, demonstrating the efficacy of an IHN-CCO partnership. Below is a timeline describing a sample of IHN-CCO's pilot project relationships since 2014:



Many organizations in the IHN-CCO region provide THW services. The list below includes IHN-CCO contracted organizations and more. This is not a full and comprehensive list, but these organizations are possible resources for any organization looking to work with THWs.

- ABC House
- Albany Fire Department
- Albany Partnership for Housing and Community Development
- Benton County Health Department
- Casa Latinos Unidos
- C.H.A.N.C.E. Recovery
- Corvallis Housing First
- DevNW
- Disability Equity Center
- Family Assistance and Resource Center Group
- Family Tree Relief Nursery
- Heart of the Valley Birth and Beyond
- Lincoln County Health and Human Services
- Lincoln County Sheriff's Office

- Linn County Department of Human Services
- North End Senior Solutions
- Olalla Center
- Samaritan Health Services
- Willamette Nutrition Source

IHN-CCO looks to continue their work with THW organizations and to continue to help provide care for IHN-CCO members in need.

Section 4: Certification Requirements

A THW must be certified by the state of Oregon; this process comes at a cost, but the THW can be eligible for reimbursement.

To qualify for reimbursement under the Oregon Health Plan, THWs must be certified by the Oregon Health Authority (OHA) through successful completion of an approved training program and enrolled in the State's central registry.

In order for someone to be recognized as a THW by OHA, they must attain OHA certification. There are specific OHA requirements a potential THW must fulfill before getting certified. See below for more details.

Community Health Worker, Peer Wellness Specialist, Personal Health Navigator Certification Requirements

(1) To be certified as a community health worker, peer wellness specialist, or personal health navigator, an individual shall:

(a) Complete all required training offered by an Authority approved 80-hour training program for that individual's traditional health worker (THW) type;
- *Link to all approved training programs:* **THW Training Programs**

(b) Complete an Authority approved oral health training;
- *Link to all approved oral health training programs:* ***Traditional Health Worker Oral Health Requirements***

(c) Complete all application requirements to be in the state registry;
- *Link to all application requirements to be in the state registry:* ***How to Become a Certified Traditional Health Worker***

(d) Complete the Authority certification process; and
- *Link to all application requirements to be in the state registry:* ***How to Become a Certified Traditional Health Worker***

(e) Be successfully accepted into the state registry.

(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Peer Support Specialist Certification Requirements

(1) To be certified as a peer support specialist, an individual shall:

(a) Complete all required training offered by an Authority approved 40-hour training program for peer support specialists by specialization;

- *Link to all approved training programs:* **THW Training Programs**

(b) Complete an Authority approved oral health training;

- *Link to all approved oral health training programs:* ***Traditional Health Worker Oral Health Requirements***

(c) Complete all application requirements to be in the state registry;

- *Link to all application requirements to be in the state registry:* ***How to Become a Certified Traditional Health Worker***

(d) Complete the Authority certification process; and

- *Link to all application requirements to be in the state registry:* ***How to Become a Certified Traditional Health Worker***

(e) Be successfully accepted into the state registry.

(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body may be granted reciprocity or receive equivalent credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Birth Doula Certification Requirements

(1) To be certified as a birth doula, an individual shall:

(a) Complete all required training specified in OAR 410-180-0375 through:

(A) An Authority approved birth doula training program; or

- *Link to all approved training programs:* ***THW Training Programs***

(B) A combination of programs that results in meeting all the requirements through equivalent credit.

- *Link to combination of programs meeting requirements via equivalent credit (scroll down to middle of page):* ***Resources for completing State Doula Certification***

(b) Complete an Authority approved oral health training;

- *Link to all approved oral health training programs:* ***Traditional Health Worker Oral Health Requirements***

(c) Be CPR-certified for children and adults;

(d) Create a community resource list on an Authority approved form;

(e) Document attendance at a minimum of three births and three postpartum visits using an Authority approved form;

(f) Complete all application requirements to be in the state registry;

- *Link to all application requirements to be in the state registry:* ***How to Become a Certified Traditional Health Worker***

(g) Complete the Authority certification process; and

- *Link to all application requirements to be in the state registry:* ***How to Become a Certified Traditional Health Worker***

(h) Be successfully accepted into the state registry.

(2) Individuals who hold national or non-Oregon state certification and are in good standing with their certifying body may be granted reciprocity or receive equivalent

credit for previously completed training. The Authority shall determine the criteria for reciprocity and equivalent credit.

Traditional Health Worker Continuing Education Requirements

(1) To maintain certification status, all THWs shall complete at least 20 hours of Authority approved continuing education during every three-year renewal period.
(a) *Link to CEU requirements and additional information:* ***THW Continuing Education***

(2) Family support specialists and youth support specialists shall complete at least 40 hours of Authority approved continuing education during every three-year renewal period. Two topics must be included within the 40 hours:
(a) The application of "means counseling" and "safety planning;"
(b) The use of lived experience and ethical practice.
(c) *Link to OHA approved Continuing Education Programs:* ***THW Continuing Education***

(3) Continuing education hours taken in excess of the total number required may not be carried over to the next renewal period.

(4) Requests for approval of continuing education courses may come from the hosting organization or from a certified THW attending the training or event.

Section 5: Provider Validation, Contracting, and Billing

Provider Validation

OHA has specified processes and supervision requirements for each type of THW to attain their respective credentials. Completing the OHA enrollment forms is required **along with IHN-CCO's internal provider validation process.**

IHN-CCO requires a provider validation process to adhere to OHA guidelines. The application includes elements from Oregon Practitioner Credentialing Application (OPCA) and other OHA-required supplemental support (e.g., cultural competency training, background check). Below is the full IHN-CCO process flow of the provider validation process.

1. **THW Provides Background Checks to IHN-CCO**
   - THW will provide a background check along with any additional documentation
   - THW may have to request a copy of the background check from OHA
   - If THW is not able to receive a copy, a final fitness letter is acceptable

OHA tends to have delays when providing background checks, particularly for Doulas. As a workaround, Doulas can provide a Final Fitness letter that confirms that OHA did a background check and deemed them able to practice. This can delay credentialing as the background check is needed for a full and complete application. Credentialing process will happen within 90 days of a completed application.

2. **THW Fills Out IHN-CCO's Provider Validation Form**
   - Application contains various questions including basic demographics, practice information, work experience, professional liability insurance, and **NPI & DMAP numbers***
   - Application includes OPCA questions, including Attestation forms, release forms, and Attachment A forms (describes any past or current professional liability claim or lawsuit)

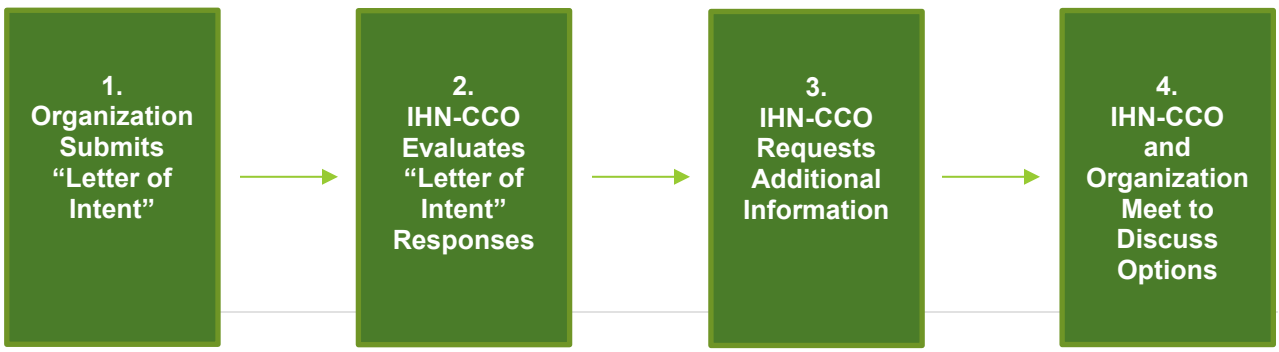
     ***Note: Attaining NPI & DMAP numbers are separate OHA processes that must be completed in order for THWs to submit claims. The first step is applying for a NPI number that is then used for the DMAP number application. (link: OHA Provider Enrollment Webpage)**

3. **THW Fills Out Non Delegate Roster Template**
   - This form collects THW's name, NPI number, organization name, billing address, physical address, contact information, and cultural competency trainings. See Appendix for template.

IHN-CCO will collect the names of THWs from contracted entities and validate their certification in the State's registry. IHN-CCO will also report the names of THWs as contractually required when reporting IHN-CCO's network adequacy to OHA.

Contracting

IHN-CCO has an outlined high-level process when partnering with potential THW organizations. There are three types of contracts: alternative payment methodology, fee for service, and value-based payment. Depending on the nature of the proposal and other factors, some additional steps may need to be taken beyond the outlined process. This is to help ensure that IHN-CCO is partnering with organizations that are aligned with community goals and can address member needs throughout the Benton, Lincoln, and Linn regions. Below is the IHN-CCO contracting process flow that depicts the necessary steps for organizations.



1. **Organization Submits "Letter of Intent"**
    - Interested organizations will fill out an online form, which will be captured in IHN-CCO's internal system upon submission. Join the Samaritan provider network (samhealthplans.org)
    - Other examples of "Letters of Intent":
        - Referral from IHN-CCO staff
2. **IHN-CCO Evaluates "Letter of Intent" Responses**
    - Main criteria is to ensure that the interested organization: (1) is a good fit (2) addresses a community need, (3) has feasible sustainability plans, (4) can be funded by current IHN-CCO resources, and (5) addresses Social Determinants of Health (SDoH) and health equity needs
3. **IHN-CCO Requests Additional Information**
    - Other information that may be required includes:
        - Organization contact information
        - Description of the innovative service proposed
        - Target population
        - Objective outcomes
    - Additional information should support and report on objective outcomes on a consistent basis. Examples include:
        - Member details
        - Touch data
        - SDoH Touch data
4. **IHN-CCO and Organization Meet to Discuss Options**
    - The three payment models are:
        - **Alternative Payment Methodology (APM)**: Payment method that pays providers for delivering high-quality and cost-efficient care. Oregon's APM program provides participating Health Centers with prospective per-member per-month (PMPM) payments. This allows providers to engage their communities in more patient-centered health strategies.
        - **Fee For Service (FFS)**: Provider is paid a fee based on the OHA Fee Schedule for each particular service rendered, essentially paying providers for volume and quantity of services provided, regardless of the outcome.
        - **Value Based Payment (VBP):** Payment to a provider that is based on quality outcomes, or the value that can be produced, through the provision of health care services to CCO members.

Billing

When billing, it is important to note that THWs must be supervised by licensed healthcare professionals, including but not limited to physicians and licensed behavioral health professionals. Youth and Family Peer Support Specialists must be supervised by a Peer Support Specialists Supervisor in addition to clinical supervision. If a member receives peer services for BH needs, the service must be documented in the member's treatment plan by a licensed behavioral health professional.

Billing process flows can differ depending on the type of contract an organization has with IHN-CCO (FFS, VBP, APM). For this reason, outlined below are codes that can be used for billing depending on the type of THW and services provided.

Fee-for-Service Codes

In September 2019, OHA released a document that provides recommended payment models for CCOs looking to integrate THWs in their care delivery continuum. The table below lists the OHA recommended codes for THWs that are paid under the "Itemized Fee-for-Service" payment mechanism.

Code	Type	Description
98960	CHW	SELF-MGMT EDUC & TRAIN 1 PT
98961	CHW	SELF-MGMT EDUC/TRAIN 2-4 PT
98962	CHW	SELF-MGMT EDUC/TRAIN 5-8 PT
97535	CHW	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
99211	CHW	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services
99401	CHW	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	CHW	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	CHW	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	CHW	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	CHW	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	CHW	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	CHW	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	CHW	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99600	CHW	Unlisted home visit service or procedure
G0176	CHW	Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)
H0033	CHW	Oral medication administration, direct observation
H0048	CHW	Alcohol and/or other drug testing: collection and handling only, specimens other than blood
H2016	CHW	Comprehensive community support services, per diem
H2032	CHW	Activity therapy, per 15 minutes
H0038	PSS/PWS	Self-help/peer services, individual, per 15 minutes
G0177	PSS/PWS	Training and educational services, individual, per occurrence
T1016	PSS/PWS	Case Management, per 15 minutes
H2014	PSS/PWS	Skills training and development, individual, per 15 minutes
H2018	PSS/PWS	Psychosocial rehabilitation services, per diem (adults)

H0039	PSS/PWS	Assertive community treatment, face-to-face, per 15 minutes (adults)
H0023	PSS/PWS	Behavioral health outreach service (planned approach to reach a targeted population)
H0046	PSS/PWS	Mental health services, not otherwise specified (adults & children)
H0032	PSS/PWS	Mental health service plan development by non-physician (adults)
H2021	PSS/PWS	Community-based wrap-around services, per 15 minutes (children)

Doula Codes

Doulas have a bundled fee-system that consists of four maternity support visits and services provided on date of delivery. The table below reviews the standard and partial service benefit and codes that OHA recommends.

Standard Doula Benefit Rate and Accepted Codes		
Code	**Type**	**Description**
59400	Doula	Standard doula benefit with support at vaginal delivery
59510	Doula	Standard doula benefit with support at cesarean delivery
59610	Doula	Standard doula benefit with support at VBAC delivery
59618	Doula	Standard doula benefit with support at attempted VBAC/cesarean delivery
Partial Service Rates and Accepted Codes		
Code	**Type**	**Description**
T1016	Doula	Case Management, per 15 minutes
H2014	Doula	Skills training and development, individual, per 15 minutes
H2018	Doula	Psychosocial rehabilitation services, per diem (adults)
H0039	Doula	Assertive community treatment, face-to-face, per 15 minutes (adults)
H0023	Doula	Behavioral health outreach service (planned approach to reach a targeted population)
H0046	Doula	Mental health services, not otherwise specified (adults & children)
H0032	Doula	Mental health service plan development by non-physician (adults)
H2021	Doula	Community-based wrap-around services, per 15 minutes (children)

How IHN-CCO Will Pay Organizations

Depending on the contract developed through the provider validation process, there are different ways IHN-CCO will provide payment to THWs.

Fee-for-service contracted organizations will be required to submit a health insurance claim form, usually referred to HCFA (Health Care Finance Administration) 1500 electronically to IHN-CCO. Claims should be processed by IHN-CCO within 30 days of receipt.

Value-based payment or alternative payment methodology contracts vary, but most likely the organization will be asked to submit touch reports for data tracking and invoices for payments. Invoices should be processed within 30 days of receipt.

Section 6: Recruitment and Retention

Recruitment

When recruiting THWs, organizations must develop and clearly communicate the THW's requirements and responsibilities. Beyond required background and knowledge base for certification, desired qualities are listed below.

A strong THW candidate will demonstrate the following qualities:

- Communication and relationship building skills
- Teaching, training, and capacity-building skills

- Service coordination and member advocacy skills, complemented by a strong knowledge base

Additionally, the following skills are preferred:

- Speaks two or more languages
- Interpersonal skills, such as warmth, sensitivity, and open-mindedness
- Connected with the community and commitment to social justice

Potential Recruitment Strategies

- Reviewing sample job descriptions can provide some ideas for how to convey the requirements and responsibilities to potential candidates.
- In addition to standard questions and discussions of position logistics, interview processes for THWs may also integrate role playing exercises, activities to assess candidate problem-solving processes and skills, and other creative interviewing strategies
- Hiring managers can then compare interview performance against the hiring criteria, incorporating recommendations from community stakeholders when possible.

Sources of Potential Candidates

- Traditional Healthcare Worker Registry

Retention

There are two main strategies organizations can utilize when looking at how to best improve retention practices among THWs. Understanding the importance of supporting THW career development and supporting THWs on an individual level is a key first step to improving retention rates among organizations.

Career-development Strategies for THWs

- OHA requires completion of various training programs in order to attain certification; however, to support further career development, a THW can complete the OHA-approved programs listed in the link below.
  - ***THW Training Programs***
- In order for a THW to renew his/her/they certification, they must complete certain THW Continuing Education Requirements. Below is a link to OHA approved Continuing Education Programs.
  - ***THW Continuing Education***
- IHN-CCO recommends additional trainings for their contracted THWs to ensure preparation and the necessary skills when working with members.
  - **Mental Health First Aid (Adult and Youth)**
  - **Trauma Informed Care**
  - **Patient Centered Counseling**
  - **Health Equity**
  - **Certified and Qualified Interpreter**
- Traditional Health Workers can train to facilitate evidence based self-management programs in partnership with Samaritan's Regional Health Education Hub. There is also opportunity for the THW to learn and experience collecting member information and billing for their services.

Strategies for Increased Support of THWs

- Beyond additional training resources, it is important THWs have access to external organizations for networking resources and other individual questions and concerns.
  - Traditional Health Worker Commission (Oregon Health Authority-Office of Equity and Inclusion)
  - Office of Consumer Activities Oregon Health Authority
  - Oregon Community Health Workers Association
- THWs are at risk for burn out and compassion fatigue in their line of work. The organization can help support their THWs by directing them to self-care resources and trainings (see below for examples).
  - Progol Self Care Tools (provides worksheets and other written exercises to help address certain areas of THW concerns)
    - Burnout

- Compassion Fatigue
- Moral Distress
- Secondary Traumatic Stress

Section 7: Tools and Infrastructure to be Successful

Organization Governance

Program Performance Evaluation: General program evaluation of performance against targets, overall program objectives, and indicators carried out on a regular basis.

Supervision: Supportive supervision is carried out regularly to provide feedback, coaching, problem solving, skill development, and data review.

Individual Performance Evaluation: Evaluation to fairly assess work during a set period of time.

Attractive Incentives: A balanced incentive package includes financial incentives such as salary and bonuses and non-financial incentives such as training, recognition, certification, uniforms, and medicines, etc., appropriate to job expectations**.**

Health Integration

Connections to Health Systems: How the THWs and communities are linked to the larger health system through involvement in recruitment, training, incentives, supervision, evaluation, equipment and supplies, use of data, and referrals.

Referral System: Processes for determining when a referral is needed, a logistics plan in place for transport and funds when required, and a process to track and document referrals**.**

Reporting and Equipment

Documentation and Information Management: How THWs document visits; how data flows to the health system and back to the community; and how data is used for service improvement. IHN-CCO requires all encounter data to be collected through a specified reporting template and submitted to IHN-CCO on a monthly basis.

Proper Equipment and Supplies: The requisite equipment and supplies are available when needed to deliver expected services.

See here for additional information: Building a Community Health Worker Program

Note: Although the above link is specific to CHW programs, the elements listed above can apply to all THW programs looking for proper infrastructure and tools for success.

Section 8: Definitions

Alternative Payment Methodology (APM): Payment method that pays providers for delivering high-quality and cost-efficient care. Oregon's APM program provides participating Health Centers with prospective per-member per-month (PMPM) payments. This allows providers to engage their communities in more patient-centered health strategies.
Coding: Medical coding is the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes.
Credentialling: refers to the process of verifying education, training, and qualified professional history of licensed or certified healthcare provider

Cultural Competency: Being aware of your own cultural beleifs and values and how these may be different from other cultures- including being able to learn about and honor the different cultures of those you work with and serve.
Division of Medical Assistance Programs (DMAP): Division, within the Oregon Health Authority, responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan Medicaid demonstration, the State Children's Health Insurance Program, and several other programs.
Fee For Service (FFS): Provider is paid a fee based on the OHA Fee Schedule for each particular service rendered, essentially paying providers for volume and quantity of services provided, regardless of the outcome.
Oregon Health Authority (OHA): OHA is the Single State Medicaid Agency for Oregon and retains ultimate authority and responsibility for the administration of the Medicaid State Plan.
Health Equity: The equitable distribution or redistribution of resources and power; and. Recognizing, reconciling and rectifying historical and contemporary injustices.
InterCommunity Health Network Coordinated Care Organization (IHN-CCO): Medicaid administrator to those who are assigned a CCO in Linn, Benton, and Lincoln counties.
National Provider Identifier (NPI): Aligns with your DMAP provider ID and is a 10-digit, numeric identifier that does not expire or change, and is administered by the Centers for Medicare & Medicaid Services (CMS).
Reimbursement: The payment that a hospital, healthcare provider, diagnostic facility, or other healthcare provider receives for providing a service.
Value Based Payment (VBP): Payment to a provider that is based on quality outcomes, or the value that can be produced, through the provision of health care services to CCO members.

Fitness and Determination Letter Example

DIRECTOR 'S OFFICE
Office of Equity and Inclusion
Kate Brown, Governor

Oregon Health Authority

421 SW Oak Street, Suite 750
Portland, OR 97204
971-673-1240
971-673-1128
http://www.oregon.gov/OHA/oei/

Thank you for your application for Traditional Health Worker (THW) certification. The Oregon Health Authority has made the following determinations:

You have been approved for the following certifications:
Birth Doula
Effective: Monday, August 9, 2021 to Friday, August 9, 2024

Your registration number is:

As a reminder, you must renew your certifications before your expiration date. You must submit your application to renew no less than 90 days before the expiration date. To renew, you need to complete your continuing education credits required by your certificate.

If you have any questions, please contact OEI at thw.program@dhsoha.state.or.us.

Thank you,

Shelley Das

Shelley Das
Equity & Policy Manager
Office of Equity and Inclusion
Oregon Health Authority

State of Oregon
Traditional Health Worker

Name:
Number:
Effective 8/9/2021
Expires 8/9/2024

Certifications:

Birth Doula

REF: 5122CACB-1693-4A0F-AAAA-743E9E311434

Traditional Health Worker Program
Office of Equity and Inclusion
421 SW Oak Street, Suite 750
Portland, OR 97204
https://www.oregon.gov/oha/OEI/Pages/THW-Training-Programs.aspx

Pursuant to Oregon Administrative Rules 410-180, this card designates that the card holder has completed the requirements to become a Traditional Health Worker.

(cut along dotted line)

Medicaid Provider Validation Application

Samaritan Health Plans

In accordance with state requirements, Samaritan Health Plans requires all Medicaid-eligible, contracted providers that don't otherwise qualify for full credentialing to complete this form and provide supporting documentation to be validated prior to reimbursement for Medicaid claims. This validation process is required to be completed at least every three (3) years to remain as a participating Medicaid provider with Samaritan Health Plans.

Note to providers licensed under supervision (such as licensed interns): Should a license to practice independently be obtained, full initial credentialing will be required to maintain participation status with Samaritan Health Plans Medicaid and to request additional contracted lines of business.

1. Provider Information

Last Name _____ First Name _____ Middle Name _____

Other Names Used _____

Credentials/Certification (check all that apply)

- ☐ Addictions Counselor (CADC I, II, III)
- ☐ Birth Doula (THW)
- ☐ Personal Health Navigator (THW)
- ☐ Mental Health Associate (QMHA)
- ☐ Peer Support Specialist (THW)
- ☐ Community Health Worker (THW)
- ☐ Mental Health Professional (QMHP)
- ☐ Peer Wellness Specialist (THW)
- ☐ Interpreter
- ☐ Other (specify) _____

Area(s) of Interest _____

Certification Number (if applicable) _____

Date of Birth _____ Social Security Number _____ Individual NPI Number _____

Gender _____ Personal Email Address _____

Home/Mobile Phone Number _____

☐ Please check if not currently enrolled with Oregon Medicaid, and assistance with enrollment is required.

Individual Medicaid Number _____

Supervisor Information

For providers whose credential requires them to be clinically supervised for licensure or certification requirements (provider listed must meet the requirements for supervision by the appropriate licensing/certifying board):

Supervisor Name: _____ Supervisor License/Certification No. _____

2. Practice Information

Name of Practice/Clinic _____ Tax ID No. _____

Practice Information (Please attach separate sheets for additional locations)

Effective Date at Location _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____ Group NPI _____

Office Manager Name _____ Email _____

Group Medicare No. _____ Group Medicaid No. _____

Languages fluently spoken by office personnel _____

Please check all that apply ☐ Accepting new patients ☐ Office is wheelchair accessible

Practice Limitations (e.g., age, gender) ☐ Yes ○ No If yes, specify _____

Office Hours of Operation (Open – Close)

Mon _____ Tues _____ Wed _____ Thurs _____

Fri _____ Sat _____ Sun _____

Do you provide 24-hour call coverage? Yes ☐ No ○

If no, please explain how your patients obtain advice and care after hours: _____

Credentialing Information

Contact information where validation materials and correspondence can be sent within your facility.

☐ Check here if validation contact information is the same as the primary practice. Contact

Name _____ Contact Email _____

Mailing Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Billing Information

Mailing Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email _____

3. Qualifications and Competencies

Please provide information of all education and training programs, relevant to obtaining your current/future credential/ certification only. Qualifications and competencies must meet the OHA and state standards for certification and/or licensure. (Please attach separate sheets for additional relevant training programs.)

☐ Check here to indicate that you were grandfathered in to certification without professional education/training program.

Professional Education/Training Program

School/Program Name _____ Degree/Certification _____

From Date (MM/YY) _____ To Date (MM/YY) _____ Study/Major _____

☐ Check here to indicate that you completed the program.

☐ Check here if your training is in process of being completed (please indicate your future graduation date above).

Additional/Post-Graduate Education

School/Program Name _____ Degree Received _____

From Date (MM/YY) _____ To Date (MM/YY) _____ Study/Major _____

☐ Check here to indicate that you completed the program.

☐ Check here if your training is in process of being completed (please indicate your future graduation date above).

Mental Health Experience

This section needs to be completed by a qualified mental health professional. You may use additional sheets of paper, if needed.

☐ N/A - Check here if you meet the criteria outlined in OAR Chapter 309.

Mental Health Work Experience			
Position/Title	Employer/Location	Start/End Date	Hours Per Week

4. Professional Liability Insurance

Please attest to current professional liability insurance, or provide a copy of the insurance certificate. Contractually, all participating providers are required to hold at least $1,000,000 per claim and at least $3,000,000 aggregate amount. If these limits are not able to be met, please provide an explanation on a separate sheet.

Carrier Name _____ Policy No. _____

Month/Day/Year Effective _____ Month/Day/Year Expiration _____

Month/Day/Year Retroactive Date (if applicable) _____

Per Claim Limit _____ Aggregate Amount _____

5. Documentation

Please complete/provide the following documentation:

☐ Please complete the attached Attestation Questions, Authorization and Release of Information, and Attachment A forms from the Oregon Practitioner Credentialing Application (OPCA)

NOTE: Any yes answers to the Attestation Questions must include an explanation from the provider, with a full signature and date.

☐ Evidence of most recent Criminal Background Check (Example: Final Fitness Determination letter)

☐ If the background check is older than two (2) years, check here to confirm it was the last criminal background check run.

☐ Copy of licensure and certification(s) (if applicable)

☐ Professional Liability Insurance (PLI) certificate

☐ **I, attest to completing the required hours for the Oregon Legislature mandated cultural competency continuing education for health care professionals. Number of hours obtained _____.**

Email or fax this form and your supporting documentation to our Credentialing team:

Email: SHSCredentialingHealthPlansOperation@samhealth.org

Fax: 541-768-9771

**Please note, any information that varies substantially from the information verified during the validation process may require follow-up and clarification to proceed with the application process.*

XXI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.**

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES ☐	NO ☐
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐	NO ☐
C.	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*****, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization***** while under investigation or potential review?	YES ☐	NO ☐
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization*** ever been** withdrawn on your request prior to the organization's final action?	YES ☐	NO ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐	NO ☐
G	Have you **ever** voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐	NO ☐
H	Have you **ever** had board certification revoked?	YES ☐	NO ☐
I	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐	NO ☐
J.	Have you ever been charged with a criminal violation (felony or misdemeanor)?	YES ☐	NO ☐
K.	Do you presently use any illegal drugs?	YES ☐	NO ☐
L	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐	NO ☐
M	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES ☐	NO ☐
O.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES ☐	NO ☐

e.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: **Date:**

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed Name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Samaritan Health Plans

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – *CONFIDENTIAL*	
Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.	
Practitioner's Name (print or type):	
Month / Day / Year of the incident: and clinical details:	
Your role and specific responsibilities in the incident:	
Subsequent events, including patient's clinical outcome:	
Month / Day / Year the suit or claim was filed:	
Name and address of insurance carrier/professional liability provider that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Month / Day / Year of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you:	
I verify the information contained in this form is correct and complete to the best of my knowledge.	
Signature:	Date:

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Non Delegate Roster Template Example

Column Name	Required Non-Delegates	Suggested Format/description
RecommendedAction	Y	Add/Term/Change
RecommendedActionReason	N	If change, what changed?
Term date if applicable	N	Must be required if recommended action is Term
Last_Name	Y	
First_Name	Y	
Middle_Initial	N	
Suffix	N	
Prefix	N	
Credentials	N	
NPI#	Y	10 digit numerical value
Primary Specialty	Y	
Secondary Specialty	N	
Primary Taxonomy	Y	alphanumeric value
LegalBusinessName	Y	Should match your W9
Office_name	Y	Name that matches member facing materials
Office NPI Number	Y	10 digits
Tax_ID	Y	9 digit numerical
Physical or billing Address?	Y	
Primary or secondary location?	Y	Type Primary or secondary
Address_1	Y	
Address_2	N	
City	Y	
State	Y	
Zip_Code	Y	9 digit zip code
Phone_number_1	Y	10 digit numerical
Fax_number	Y	10 digit numerical
Gender	N	
Race	N	
Ethnicity	N	
CulturalCompetencyTrainings	Y	Y or N
Additional languages spoken	N	
Medicaid Number	N	
Medicaid Issued Date	N	
Accepting New Patients	Y	Y or N
Open/Closed Updated Date	N	
PsAcceptingNewPatientsWithLimitations	N	
PsAcceptingExistingPatientsOnly	N	
HospBased?	N	Y or N
PCP	Y	Y or N
Specialist?	Y	Y or N

If PCP, Medicaid Capacity?	N	numerical value
State License	N	
State License State	N	
State License Issued Date	N	
State License Expiration	N	
Hospital Privileges	N	
Primary Hospital Affiliation	N	
Board Certified?	N	
Telemedicine	Y	Y or N (if provider is telehealth **only** indicate in this column)
Orig. Cred. Committee Date	N	Original credential date
Recent Reappt Date	N	Most recent crednetiling date if different then Original credential date
LocationEmail	N	free form
OrganizationWebsite	Y	free form
Handicap access	Y	Y or N
EHR Name	N	
EHR certification Date	N	