Traditional health worker scope by worker type

The Oregon Health Authority Traditional Health Worker Commission has outlined the THW scope of practice, below.
It is also available on OHA's website, as part of their Traditional Health Worker toolkit, which you can find at *link.careoregon.org/oha-thw-toolkit*

THW types	Care coordination system	Outreach & direct service	Coaching & social support	Advocacy, organizing & cultural mediation	Education	Assessment, evaluation, & research
Community health worker	• Coordinate with involved systems of care • Assist with referrals • Contribute to team care plans and planning • Assist with transitions between providers and phases of care • Connect people to community and/or social service resources • Facilitate community members' attendance at medical and other appointments	• Conduct case-finding, recruitment and enrollment • Engage individuals and communities in the field • Provide follow-up with individuals, families and groups • Make presentations at agencies and community events • Provide basic services and screening tests • Help individuals meet basic needs	• Provide social support and build social networks • Conduct home visiting • Motivate and encourage individuals to obtain care and services • Plan and facilitate support groups	• Advocate for the needs and perspectives of individuals and communities • Advocate for health-promoting policies • Organize communities to identify and address pressing health issues • Conduct two-way education about community and systems needs and norms	• Share culturally appropriate and accessible health education and information • Support chronic disease self-management • Build individual and community capacity and empowerment • Increase health literacy • Support stress management • Train new CHWs	• Participate in individual-level and community-level assessments • Participate in evaluating CHW services and programs • Identify and engage research partners and participate in research • Document and track individual and population-level data
Doula	• Coordinate with involved systems of care • Assist with referrals • Assist with the creation of birth plans • Connect people to health and/or social service resources	• Provide anticipatory guidance before, during and after birth • Support client-informed decision making • Outreach • Physical support and comfort measures during childbirth	• Referrals to social service and/or community resources • Assess social networks and support	• Serve as a cultural liaison • Mediate for client's needs before, during and after birth • Advocate for health promoting policies and practices	• Increase perinatal health literacy • Support stress management • Share culturally appropriate and accessible health education and information	• Participate in individual and community-level assessments • Participate in evaluating Doula services and programs • Document and track individual data • Participate in research

THW types	Care coordination system	Outreach & direct service	Coaching & social support	Advocacy, organizing & cultural mediation	Education	Assessment, evaluation, & research
Peer support specialist	• Coordinate with implementation of involved systems of care • Assist with information, appointments and referrals • Contribute to Plan of Care, ensuring goals, needs and strength of peer's voice • Provide support during transitions and assist with natural supports and formal services • Connect individuals to community and formal service resources	• Conduct community-based engagement and empowerment activities regarding behavioral health and wellness • Enhance individual and family engagement • Provide continuity of communication between peers, natural supports and providers • Make presentations at agencies and community events • Assist individuals to meet their own basic physical and emotional crisis and long-term needs	• Provide mutual support and build natural and services networks • Provide support and services at times and locations needed by peers • Inform, motivate and assist individuals to receive effective and culturally appropriate needed services • Plan and facilitate support groups • Enhance peer inclusion in service and program planning, policy development, and education at local and state level	• Advocate for the needs and perspectives of individuals in services and communities • Advocate for wellness, recovery and behavioral health promotion across the lifespan • Organize communities to identify and address individuals planning and directing their own behavioral health care, education and other needed services • Conduct two-way education about community and system needs	• Share culturally appropriate and accessible emotional health education and information • Support emotional health, wellness and self-management of social and health challenges • Promote leadership development and client-directed behavioral health systems education • Increase resilience, developmental assets • Support client-directed services and program management • Supervise and train other PSS	• Participate in individual- and family-level assessments and planning • Participate in service system and community-level policymaking • Participate in evaluating programs and service systems • Identify and engage policymakers and participate in publications and research • Document and track individual, program, population and service system-level data
Peer wellness specialist	• Coordinate with implementation of involved systems of care • Assist with referrals and appointments (as requested) • Contribute to Plan of Care, ensuring needs and strength of peer's voice • Assist with transitions between natural supports, providers and phases of care • Connect people to community and service resources • Serve as cultural liaison between peer and provider	• Conduct community-based engagement and empowerment activities regarding behavioral health and holistic wellness • Enhance individual and family engagement • Provide continuity of communication between peers, natural supports and providers • Make presentations at agencies and community events • Assist individual peers to meet their own basic physical and emotional needs • Develop needed community resources	• Provide mutual support and build natural and services networks • Provide support and services at times and locations needed by peers • Motivate and assist individuals to clearly receive effective and culturally appropriate needed services • Plan and facilitate support groups • Enhance peer inclusion in service and program planning, policy development, evaluation at local and state level	• Advocate for the needs and perspectives of individuals and communities • Advocate for wellness, recovery, disease prevention and health promotion • Organize communities to identify and address individuals planning and directing their own health care, education and other needed services • Conduct two-way education about community and system needs and norms	• Share culturally appropriate and accessible health education and information • Support chronic disease and holistic wellness self-management • Serve on integrated care teams in behavioral, primary and specialty care • Increase resilience, holistic wellness and health literacy • Support client directed services and program management • Train and supervise PWS	• Participate in individual- and family-level assessments • Participate in service-system and community-level assessments • Participate in evaluating programs and service systems • Identify and engage research partners and participate in publications and research • Document and track individual, program and service system-level data

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Personal health navigator	• Coordinate with involved systems of care and community resources • Assist with referrals and appointments • Coordinate care with other health care coordinators in the community • Contribute to care team planning • Promote person-centered care • Assist with transitions and phases of care	• Conduct outreach to clients to engage and maintain them in care • Connect clients to the appropriate level of care • Assist with enrollment in insurance, specialty care and social service programs • Provide social service and/or community resource connections	• Assist clients with setting goals for care • Promote social support and/or relationship building	• Advocate for the clients with the health system • Connect clients to culturally appropriate health resources • Promote effective communication between clients and health care providers	• Educate clients about the health care system • 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 PHN • Educate other health professionals about role and value of PHN	• 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 resources and health outcome data