The Community Health Worker in HIV Care Curriculum

PURPOSE OF THE CURRICULUM

The Community Health Worker in HIV Care curriculum is a free, accessible training resource to support the integration of the Community Health Worker (CHW) workforce into HIV and other primary care teams. The curriculum addresses topics related to core competencies of CHWs as well as topics about HIV.

Community Health Workers can play an important role in increasing access to healthcare and improving health outcomes, especially for racial and ethnic minority people with HIV. CHWs help increase the accessibility of healthcare for marginalized communities by targeting the social determinants of health that cause barriers to health, and they can improve retention in care and care outcomes by providing education, coaching, and support to individuals, as well as bringing important knowledge to other members of the care team. The curriculum provides training in a variety of topics related to the role and skills of CHWs as described by the CHW Core Competency (C3) Project.[1] The curriculum is focused on HIV care teams, however many of the modules can be applied to CHWs working in health care teams in general and in a variety of settings, including community health centers.

HOW THE CURRICULUM WAS DEVELOPED

The curriculum was developed through a national needs assessment conducted across Ryan White funded participating sites, which helped inform the topics of the modules. It was developed by the Boston University School of Social Work's Center for Innovation in Social Work & Health, and a team of trainers including CHWs and CHW supervisors with expertise in HIV and CHW training. The modules cover HIV and core competencies in accordance with the CHW Core Consensus Project (C3) for CHW programs to be effective in working with people living with HIV engage in care and treatment.[2] The curriculum was developed as part of a three-year cooperative agreement: Improving Access to Care: Using Community Health Workers to Improve Linkage and Retention in HIV Care. The initiative was funded by the Minority HIV/AIDS Fund, and administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB), in the Division of Community HIV/AIDS Programs (DCHAP).

WHERE THE CURRICULUM HAS BEEN USED

The curriculum was delivered to a cohort of CHWs participating in the initiative at ten Ryan White HIV/AIDS Program provider sites across the United States over a period of two years (2017-2019), with the purpose of integrating CHWs as part of the HIV care team to promote linkage and retention to HIV primary care. The ten sites were varied geographically and in terms of urbanicity. Seven out of ten were located in the Southeastern U.S. and three sites were in primarily rural areas. The multi-site project emphasized working with racial/ethnic minority communities where the HIV epidemic is most prevalent. The curriculum provides all of the needed materials, including lesson plans, handouts, and lecture slides used for trainings. More information about the CHW Project can be found at https://ciswh.org/project/chw.

WHO SHOULD USE THE CURRICULUM?

The curriculum is for any healthcare organization who has or is interested in having CHWs on their care teams. Nonprofit and other community based organizations, state and local health departments addressing chronic diseases, and any organization that would like to provide training in HIV for its CHWs may also find the content helpful.

1. See https://www.c3project.org/
2. Ibid.

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WHO ARE COMMUNITY HEALTH WORKERS?

> "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. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."[3]

CHWs are health professionals who are able to link patients to healthcare systems, especially patients from marginalized communities. CHWs are often either members of the communities that they work with or have a close relationship with the people from these communities. CHWs work in multiple settings such as Ryan White HIV/AIDS program clinics, hospitals, substance use treatment centers, nonprofit organizations, and community health centers. They address a variety of health issues such as intimate partner violence and chronic disease. Due to their presence in diverse settings, CHWs are often known by job titles including peers, navigators, promotores, and linkage coordinators. Regardless of job title, CHWs are linked as a workforce by their ability to increase access to healthcare and address barriers that might otherwise interfere with access to care and services for people with HIV. Through their life experience, knowledge of the community, and understanding of healthcare systems, CHWs are able to break down barriers to ensure that healthcare is accessible to everyone.

HOW THE CURRICULUM IS ORGANIZED

This is an 80-hour curriculum organized by the CHW Core Competencies:

- Communication Skills
- Interpersonal and Relationship Building Skills
- Service Coordination and Navigation Skills
- Capacity Building Skills
- Advocacy Skills
- Education and Facilitation Skills
- Individual and Community Assessment Skills
- Outreach Skills
- Professional Skills and Conduct
- Evaluation and Research Skills
- Knowledge Base

The HIV modules fall under the CHW Core Skill of Knowledge Base. The HIV modules provide 16 hours of training on topics including the HIV viral life cycle, how antiretroviral medications work, understand laboratory values, promoting and addressing treatment adherence, managing stigma and disclosure, U=U, treatment as prevention (TasP), pre-exposure (PreP), and post exposure prophylaxis (PeP). The remaining training consists of 64 hours of training modules on the other Core Competencies.

We recommend that the training be delivered by experienced trainers in the field of HIV or chronic disease, and that trainers have experience working with diverse socio-demographic communities. Lesson plans note where additional subject matter expertise is recommended for delivery of the training module.

3. https://www.apha.org/apha-communities/member-sections/community-health-workers

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ASPECTS OF THE CURRICULUM

Dinámicas

Rooted in popular education methods, dinámicas are group activities that recognize the role of feelings and emotions in education. They can be a fun way for groups to meet and become more comfortable with each other, re-energize the group between training modules, and help build community amongst the participants. Training facilitators can utilize their own dinámicas, or find ones that are available via the internet. One potential resource is a Popular Education Manual published by the Community Capacitation Center.

In-Person Trainings

During the initiative in which the curriculum was developed, in-person trainings ranged from 1 to 5 days. We strongly encourage that an initial training of 40 hours in HIV and CHW core competencies take place if your state does not have an existing CHW certification and training program for you to attend. We recommend alternating facilitators and incorporating dinámicas between modules to keep engagement of the group. If possible, participating CHWs can also help facilitate the dinámicas between these training modules.

Virtual Trainings

Some of the training modules can be conducted virtually, and were during the initiative. Virtual trainings are flexible, less costly, and can make trainings more accessible for CHWs. The virtual trainings used in the curriculum range from 1-2 hours. Some of these trainings include pre-work in their lesson plans, which CHWs should complete before the date of the training.

Tips for Virtual Trainings

- Hold at least one practice run before the training to test sound, visuals, and connection.
- Encourage the use of participant's web cameras during virtual trainings to help increase engagement.
- Provide a brief training to participants on how to use the online platform features, such as chat box, screen share, and muting/unmuting.
- Include a slide/reminder at the beginning of the presentation for participants to mute themselves if they are not speaking to reduce background noise.

Self-Paced Modules

The curriculum includes three self-paced modules that CHWs can take at their own discretion. The self-paced modules can be accessed at the New England Public Health Training Center.

CONTINUING EDUCATION

The curriculum covers 80 hours of training to meet the suggested necessary competencies for all CHWs, including training in a knowledge base about HIV. We recommend continued education for CHWs for their professional development, to ensure that they remain informed on changes in healthcare systems, to have up-to-date clinical information related to the health topics and populations with which they work, and to understand ongoing issues affecting their communities.

Acknowlegements

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (https://ciswh.org/resources/HIV-peer-training-toolkit) and the Community Capacitation Center, Multnomah County Health Department (https://multco.us/health/community-health/community-capacitation-center)

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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30462 "Improving Access to Care: Using Community Health Workers to Improve Linkage and Retention in HIV Care" ($2,000,000 for federal funding). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Suggested Citation:

Boston University Center for Innovation in Social Work & Health. (2019). A Training Curriculum for Using Community Health Workers to Improve Linkage and Retention in HIV Care. Retrieved from: https://ciswh.org/chw-curriculum

BOSTON UNIVERSITY

Boston University School of Social Work
Center for Innovation in Social Work & Health

Communicating as Part of a Team

OBJECTIVES

At the end of this unit, participants will be able to:

- Recognize effective ways of communicating that lead to understanding and build trust
- Identify common barriers and facilitators to communication within the team
- Develop a plan to strengthen the team at your agency

INSTRUCTIONS

Facilitator's note: The first exercise requires a very experienced facilitator. Participants may be reluctant to discuss contentious issues in a group, or they may be fearful of retaliation from others for raising subjects that could be seen as "off limits." The facilitator will need to reassure participants that they can express themselves so in a safe, trusting environment.

1. Session preparation

- Before the session begins, write the agenda and objectives for the session on a flip chart sheet, if you are not using the PowerPoint slides. Post for viewing by participants.
- Also write on a flip chart sheet: C-control, I-influence and A- Accept. Bold the "C", "I" and "A."
- On the large sticky notes or note cards, draw pictures of elephants, or find and print photos of elephants for the first activity.
- On another flip chart sheet, write these questions and post for easy viewing. Bold the words, Why, What, Who and When
    - Why are we doing this, or why is this happening?
    - What are we doing about it?
    - Who can resolve this issue?
    - When can we resolve this?

2. Welcome participants and review agenda and objectives.
3. Elephant in the room activity (60 minutes)

- Explain that for this session, we will be focusing on strategies that support effective communication with members of a team and practice a process for identifying and addressing team challenges. We will discuss "the elephants in the room."

(continued)

Related C3 Roles

Care coordination, case management, system navigation

Related C3 Skills

Communication skills, interpersonal and relationship-building skills, capacity building skills, professional skills and conduct, service coordination and navigation skills

Method(s) of Instruction

Individual writing, group activity

Estimated time

90 minutes

Key Concepts

Communication skills, conflict resolution, team building, problem solving skills

Materials

- Computer with internet access and projector (optional)
- Sticky notes or note cards
- Tape (if elephant note cards do not have self-stick adhesive)
- Drawings or photos of elephants
- Flip chart
- Markers
- 4 tennis balls
- Timer (can use a watch or smartphone)

Handouts

- Ten Ways to Communicate Effectively as a Team

Communicating as Part of a Team

INSTRUCTIONS (continued)

- We want to begin this section with thinking about how we communicate as a team when the team must address an obstacle (the elephant in the room).
- Refer to the flipchart and explain that you will address each elephant using the principles of Control-Influence-Accept (CIA). This means deciding whether they are issues that the participants have Control over, that they can Influence, or that they need to Accept.
- Hand out the sticky notes or elephant sheets and give participants five minutes to write down one elephant related to their work.
- They should also write whether their elephant is C, I or A. (Putting their names on the sheet or sticky note is optional.)
- Collect the elephants, read them aloud one by one, then record them on the relevant flip charts (marked C, I or A). **NOTE: If you have a large number of elephants or are limited by time, you may need to vote on which ones to address.**
- Decide as a group whether the A elephants really are issues that just have to be accepted and agree on whether any of the C or I elephants are actually A elephants. Then, let the A-list elephants go. Basically, just accept them.
- Tackle C and I elephants in open conversations and try to come up with solutions or action items. Look and review at each elephant through the "4 Ws."
    - Why are we doing this, or why is this happening?
    - What are we doing about it?
    - Who can resolve this issue?
    - When can we resolve this?
    - End the activity with a short debrief of the process. Ask participants to share one thing about how this process will be helpful in their relationship with their co-workers.

4. Tennis ball activity (30 minutes)

- Say "We are going to create a process aimed at having everyone touch the ball." If you have a group with more than 12 participants, break into two groups.
- Toss the ball to someone on the opposite side of the circle from where you are standing.

(continued)

Resources

Team Building Exercises—Communication:
https://www.mindtools.com/pages/article/team-building-communication.htm
(activity source)

The Tennis Ball Game:
https://www.leadersinstitute.com/resources-tennis-ball-game/

Questions for review from
http://www.ventureteambuilding.co.uk/move-tennis-balls/

Communicating as Part of a Team

INSTRUCTIONS (continued)

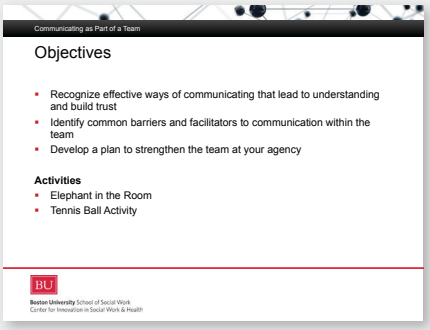
- Tell that person to pass the ball to someone, and to remember who touches the ball after them.
- Have the next person pass the ball to someone new, and so on until everyone has had a turn.
- Say, "Let's see if we can remember the sequence that the ball traveled in," and ask them to do this one more time.
- Then, complicate the process:
- Say "We never do one thing at a time—we're always multitasking." Add in another ball for them to pass around in the same sequence following the first ball.
- Once they have the process down, hand the three balls to the first person. Remind them of the rule that everyone must touch each ball once and in the same established sequence. Then step out of the circle.
- Say, "We don't just multitask—we are usually also working under time pressure. So now we will time you." Use the timer to find a baseline time for the process. Call "Start" when the first ball leaves the hand of the first person, and "Stop" when the third ball touches the hand of the last person.
- Time them, call out the time, and record it as the baseline on the flip chart.
- Incremental improvement:
    - Ask: "Do you think you can do it faster?" Let the group repeat a few times or until they are happy with the progress they have made (and until they are doing it without dropping the balls).
    - Repeat the rule after every round: that everyone must touch each ball once and in the same established sequence.
    - Call out and record their times for each iteration of the process.
- Challenge:
    - Say "You should be proud of getting your speed down to X seconds. However, every group that has done this exercise has been able to bring it down to less than 3 seconds."
    - Most groups figure out how to change their positions and routine so they can get the time down to 2–3 seconds.
    - Don't give any hints!
    - If they are not coming up with any new ideas, Ask: "Should you rethink what you're doing?"
    - Continue to record their time. If they beat 3 seconds and you still have time, tell them that some groups have done it in less than 1 second!

5. Tennis ball activity debrief

- Ask the group what this activity showed them?
- Why was it important to plan before attempting the challenge?
- How did you discuss different ideas? Did everyone have an opportunity to share their ideas?
- Did you support each other during the challenge?
- How well do you feel you worked as a team? What could you improve?
- Did you designate a leader for the challenge? What determines a good leader?
- Did your plan work? If not, why not? How did you respond to this?
- How do you ensure that everyone understands the team strategy?
- What would you do differently next time?
- Looking back on the challenge, what is the one thing you can take away from it?

6. Wrap up
Share and review the communications tip sheet. Thank participants for their engagement with the activity.

SLIDE 1



SLIDE 2

Review agenda and objectives. Explain that for this session, we will be focusing on strategies that support effective communication with members of a team and practice a process for identifying and addressing team challenges.

Ten Ways to Communicate Effectively as a Team

1. **Speak to others directly in one-on-one interactions**

   Don't gossip about team members or speak behind their backs. If you have something to say to your colleague, speak to them directly.

2. **Give clear and concise directions**

   If team members do not receive clear and concise directions for tasks, it can cause chaos.

3. **Encourage two-way feedback**

   It's important for supervisors to be open to feedback, as well as for CHWs to be open to giving and receiving feedback. This keeps the lines of communication open and encourages mutual understanding.

4. **Always show appreciation—that goes both ways!**

   It feels good to be appreciated for the work that both CHWs and supervisors are doing. Appreciation can be shown through a team lunch, being recognized in staff meetings, etc.

5. **Hold weekly team meetings**

6. **Promote collaboration**

7. **Make team members feel they are part of the team; there aren't any big I's or little I's**

8. **Keep personal bias in check**

9. **Keep an open door policy**

10. **Use time wisely—morning check ins over coffee**

Resources

7 Essential Tips for Effective Team Communication
https://www.proofhub.com/articles/effective-team-communication

8 Simple and Effective Ways to Improve Team Communication
https://blog.azendoo.com/8-ways-to-improve-team-communication/

Introduction to Communication Skills

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain effective communication and how it is affected by various factors including culture

INSTRUCTIONS

1. Before the session begins review the PowerPoint slides and talking points. Prepare flip charts with discussion questions if desired.
2. Review talking points and facilitate discussion about factors that influence effective communication (see slide 2 notes).
3. Facilitate the sociodrama activity
   - Ask for two volunteers to act out a scenario between a CHW and client in front of the group.
   - Privately brief the volunteers on their roles (see slide 2 notes).
   - Have volunteers act out the scenario.
   - Facilitate a conversation reflecting on the sociodrama (slide 3).
4. The communicator's context
   - Review slide and notes about the role of context in communication.
   - Facilitate brief discussion using the questions in the slide notes.
5. Wrap-up. Summarize and close.

Related C3 Roles

Cultural mediation among individuals, communities, and health and social service systems; providing culturally appropriate health education and information; providing coaching and social support

Related C3 Skills

Communication skills, capacity building skills, interpersonal and relationship building skills

Method(s) of Instruction

Lecture, sociodrama, reflection

Estimated time

30 minutes

Key Concepts

Communication

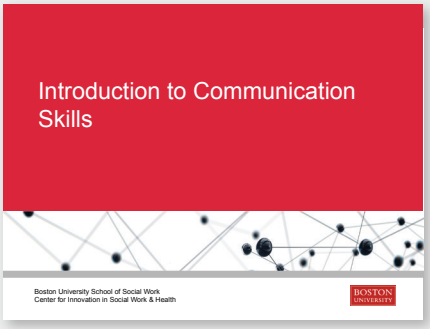
Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Resources

The Communication Process:
http://open.lib.umn.edu/communication/chapter/1-2-the-communication-process/

What is Interpersonal Communication?
https://www.skillsyouneed.com/ips/interpersonal-communication.html



SLIDE 1

SLIDE 2

Introduce session and share objectives

Communication is defined as the imparting or exchanging of information or news. This definition is accurate and simplistic; however, the process of communicating is far more dynamic and complex.

Ask, "What factors affect our ability to communicate effectively?" Write a list of the potential factors, such as identity, power, race/ethnicity, etc. Affirm participants' responses.

Summarize participants' responses and conclude that communication is a multifaceted and complex process. Communication involves a process where communicators convert their thoughts into messages that are conveyed through content and symbols (e.g. verbal messages, emails, emojis, sign language, etc.) Processing the sent messages includes decoding and interpreting them through the receiving communicator's values, attitudes, beliefs and life's experience. Effective communication is essential to the work of CHWs and is worthy of exploration. To demonstrate this complexity, we will now enact a sociodrama.

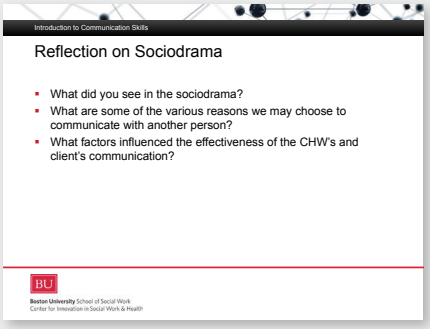
Invite two volunteers to enact a sociodrama in which a CHW and a client of different positionality in terms of social identity, power, race/ethnicity, age, socio-economic status, and/or other factors have a conversation (volunteers can choose the characteristics of their social identities from the generated list). One person will portray a CHW and the other the client.

Speak privately with the volunteers and share the following information prior to their enactment:

At the beginning of their interaction, there should be no conflict, but because of different communication styles, the messages that are being sent are not the messages that are being received. In the sociodrama, the CHW will demonstrate different ways of addressing the issue. For example: Aggression-standing over the client or speaking loudly with terse language.

Review the sociodrama scenario below with the volunteers. They will have 3–5 minutes to enact the scenario in front of the larger group.

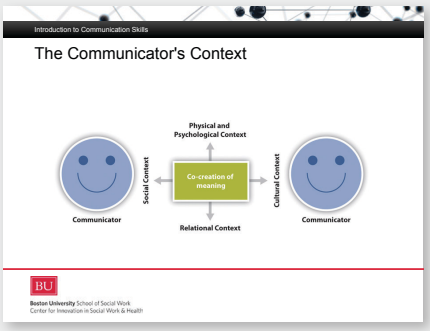
Sociodrama Scenario:
The CHW is meeting with a client for a regularly scheduled appointment. They have been working together for one year. The CHW inquires about the client's adherence. The client is hesitant to respond, but says they have been taking their medications as prescribed. The CHW is aware that the client's lab results reflect differently. The lab results suggest that the client has not been taking their medications as prescribed.



SLIDE 3

Upon completion of the scene, ask participants the questions on the slide (10 minutes).

Facilitator's note: It may be helpful to remind participants that a person's intention does not override the impact of their communication. Sometimes it's helpful to reflect on the question, "Is my intent to be right, or to build and maintain relationship?"



SLIDE 4

Communication is essentially about the sending and receiving of messages. The communicators, often referred to as the sender and listener, use verbal (words), vocal (tone, intonation, volume, etc.) and visual (body language) cues to both send and receive messages. In addition, the speaker and listener come to the conversation with their own personal background, culture, values, positionality and other factors we call context. Context impacts how messages are sent and received.

Context—The transactional model of communication views communication as inclusive of all of the previous elements and adds a layer of context. As we just stated, each communicator has their own sphere of context through which they interpret and evaluate exchanged messages. The inclusion of a communicator's context is an important distinction for this model of communication. A person's context is made up of several factors:

- **Physical context** includes the environmental factors in a communication encounter. The size, layout, temperature, and lighting of a space influence our communication. Ask participants for examples from their experience of a "good physical context" for communication. Ask for examples of where the physical context could be challenging and what makes it challenging.
- **Psychological context** includes the mental and emotional factors in a communication encounter. Stress, anxiety, and emotions are just some examples of psychological influences that can affect our communication.
- **Social context** refers to the stated rules or unstated norms that guide communication. As we are socialized into our various communities, we learn rules and implicitly pick up on norms for communicating.
- **Relational context** includes the previous interpersonal history and type of relationship we have with a person. We communicate differently with someone we just met versus someone we've known for a long time.
- **Cultural context** includes various aspects of identities such as race, gender, nationality, ethnicity, sexual orientation, class, and ability.

Ask:

- What value does this information provide for the CHW?
- How will you use this information in your role as a CHW?

Summarize and close. The co-creative process of developing understanding between communicators is influenced by the amount of commonalities and differences between their two spheres of context. For example, If communicators share similar cultural contexts (e.g. race, sexuality), the shared experiences can help facilitate more effective communication. In contrast, the fewer commonalities in context communicators share, the more challenging it will be to facilitate shared understanding. The CHW should be aware of the many facets that impact effective communication. This understanding will help CHWs employ effective communication skills to facilitate a shared understanding with others.

Introduction to Motivational Interviewing and the Stages of Change

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand the key components of the Stages of Change model
- Define Motivational Interviewing
- Identify and make distinctions between positive and negative examples of Motivational Interviewing skills in practice
- Analyze elements of Motivational Interviewing
- Practice Motivational Interviewing skills, including simple, complex, and double-sided reflections and active listening

INSTRUCTIONS

1. Before the session begins, review the PowerPoint slides and notes. Test videos to confirm that links and audio work. Prepare 5 index cards with a Stage of Change on each card. Review the resources and decide if there are any specific items you want to share with participants. All are valuable for CHW work.
2. Welcome participants and review objectives for the session (slide 2).
3. Stages of change (15 minutes)

- Review slide 3
- Pass out cards to five volunteers. Ask volunteers to read their card, then stick it on the wall.
- Show video, Improve Your Life Using the Stages of Change: *https://youtu.be/Twlow2pXsv0*
- Review slides 4 and 5 on stages of change.

4. Introduction to Motivational Interviewing (60 minutes)

- Review slide 6 on Introduction to Motivational Interviewing.
- Show videos of bad and good examples of motivational interviewing:
- How NOT to do Motivational Interviewing (bad example): *https://youtu.be/kN7T-cmb_I0*
- Motivational Interviewing A conversation with "Sal" about managing his asthma (good example): *https://youtu.be/-RXy8Li3ZaE*
- Review slides 7–13, including reflection questions and practice in pairs.

5. Facilitate Motivational Interviewing and active listening

(continued)

Related C3 Roles

Providing coaching and social support, building individual and community capacity, implementing individual and community assessments

Related C3 Skills

Communication skills, interpersonal and relationship-building skills, capacity building skills, individual and community assessment skills

Method(s) of Instruction

Participatory drawing, lecture, large group discussion, dyads, role play

Estimated time

135 minutes

Key Concepts

Stages of Change, Motivational Interviewing, active listening skills, reflecting skills, OARS

Materials

- Computer with internet access and projector
- PowerPoint slides
- Cards: Stages of change

Videos

- Improve Your Life Using the Stages of Change: *https://youtu.be/Twlow2pXsv0*
- How NOT to do Motivational Interviewing (bad example): *https://youtu.be/kN7T-cmb_I0*
- Motivational Interviewing A conversation with "Sal" about managing his asthma (good example): *https://youtu.be/-RXy8Li3ZaE*

Handouts

- Stages of Change Model
- Motivational Interviewing: Case Scenarios
- Introduction to Motivational Interviewing
- Strategies of Motivational Interviewing: OARS

Introduction to Motivational Interviewing and the Stages of Change

INSTRUCTIONS (continued)

practice activity (60 minutes) Facilitator's note: Time allotted is generous and can be modified to suit a shorter time frame.

- Distribute handouts: Motivational Interviewing: Case Scenarios, and Strategies of Motivational Interviewing: OARS.
- Divide participants into groups of three. Ask group members to choose one of three roles: CHW, client or observer. Each participant will have an opportunity to experience each role.
- The observer's role is to make note of MI and active listening skills noticed during the role play.
- Display the O.A.R.S. Reference slide (slide 15) as a visual aide.
- Set a timer for 10 minutes for each role play. At the end of 10 minutes, allow role play participants and the observers to share feedback regarding the MI and active listening skills they observed. (Allow 5 minutes for feedback.)
- Ask participants to switch roles and proceed to the next scenario.
- Repeat the process for the final scenario.
- Reconvene the group for a large group debrief.
- Facilitate dialogue with the following questions: (Allow up to 15 minutes)
- From the standpoint of a client, what was your experience like? Did you feel like the CHW understood where you were stuck? As the client, did you have an "ah ha" moment?
- From the standpoint of the CHW, what was this experience like for you? Where did you feel challenged? What was it about the interaction that made you feel like you hit your stride/felt connected to the community member? What MI skills were most useful during your interaction?

6. Wrap up
Thank the group for their participation. Close the session by stating that Motivational Interviewing skills take practice. As a CHW it is a core skill for our work with clients to promote healthy behavior changes.

Resources

Motivational Interviewing Pocket Guide. 2019. MidAtlantic AIDS Education and Training Center Program. *https://aidsetc.org/resource/motivational-interviewing-pocket-guide*

SAMSHA/CSAT Treatment Improvement Protocols. 2019. Enhancing Motivation for Change in Substance Use Disorder Treatment. Chapter 3. *https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003*

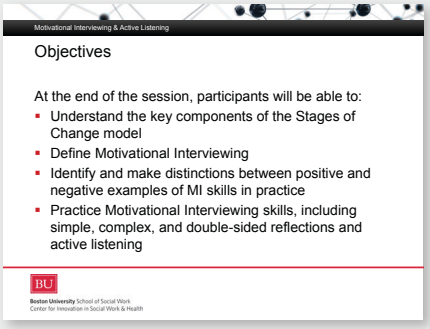
See slide 16 with additional resources

Introduction to Motivational Interviewing and the Stages of Change

SLIDE 1

This session will cover the Stages of Change and Motivational Interviewing (MI) models in order to support our work as CHWs.

Many of you have already experienced, or perhaps have used, elements of Motivational Interviewing. We invite everyone to share their knowledge and experience.



SLIDE 2

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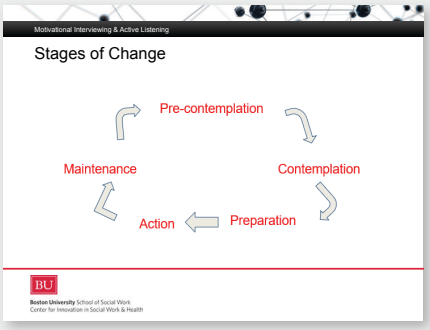


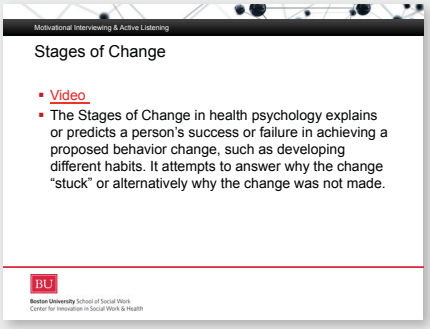
SLIDE 3

To build upon your experience, we would like to first present the Stages of Change model.

Pass out index cards to five volunteers with each stage of change on the card.

Ask volunteers to come up to the front, read their card, and stick it on the wall.

Provide a brief explanation of the different stages.



SLIDE 4

Show video: https://youtu.be/Twlow2pXsv0

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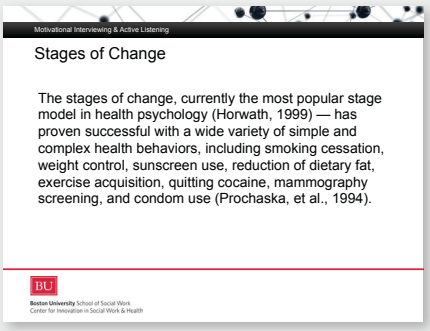
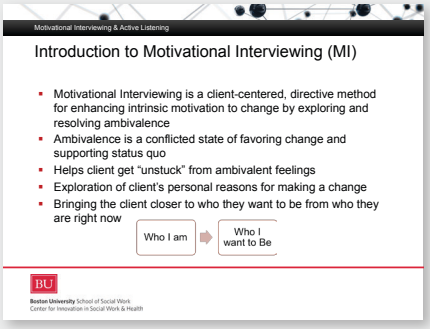


SLIDE 5

Ask for a volunteer to read the slide.



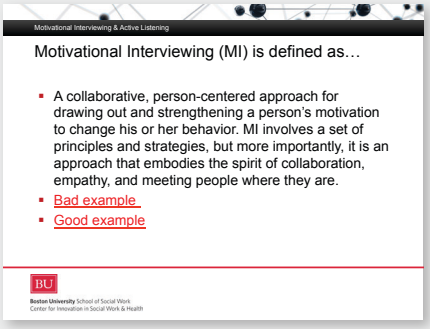
SLIDE 6

Define the following terms:

- **Client-centered approach:** A client-centered approach places emphasis on a client's autonomy and right to choose goals and/or interventions based on his or her identified needs for services.
- **Intrinsic motivation:** Intrinsic motivation can be described as doing something that is motivated from our own passions without the incentive of reward or fear of a negative consequence. Doing the behavior is often its own reward.
- **Ambivalence:** Ambivalence is often described as a state of being "wishy-washy." It is the gap between who I am and who I want to be.
- In many cases, people hold expectations for themselves that favor change while simultaneously supporting the status quo. That inner struggle (ambivalence) often drives indecision and a sense of feeling stuck that is common in all people. Motivational Interviewing is a client-centered, skillful practice that aids people in moving beyond ambivalence to get closer to who they want to be.

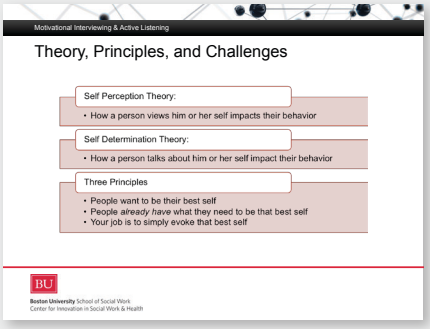
Facilitator's Resource:

Motivational Interviewing Definition, Principles and Approach document
https://www.umass.edu/studentlife/sites/default/files/documents/pdf/Motivational_Interviewing_Definition_Principles_Approach.pdf



SLIDE 7

- Video: We will view two videos. One video will demonstrate effective MI skills and the other, ineffective MI skills. Participants should take note when they see effective and ineffective MI skills employed.
  - Bad example: https://youtu.be/kN7T-cmb_l0
  - Good example: https://youtu.be/-RXy8Li3ZaE
- Video Debrief:
  - What did you observe?
  - What didn't work well?
  - What worked well?
  - When did you see examples of compassion, client-centered care, acceptance, and collaboration?



SLIDE 8

Review the slide.

We understand that Motivational Interviewing is a way of working collaboratively with people to support their motivation for and commitment to change. The following 2 theories and 3 principles serve as important anchors to ground the CHW's disposition and perspective when working in partnership with clients.

2 Major Theories:

- Self-Perception Theory: A key idea in Self-Perception Theory is how people view themselves impacts their behavior. If a person feels negatively about themselves, they are less likely to take positive action. Consider the influence of your own self-perception and the impact when making changes in your life.
- Self-Determination Theory: Self-Determination Theory can be considered generally as the way a person talks impacts their behavior. For example, If they speak negatively, they perform negatively.

These two theories underscore the work of the CHW who uses Motivational Interviewing techniques because they help us see why it is important to support people in talking and feeling more positively about themselves and their challenges when they want to make and sustain changes in their lives.

Read the 3 Principles on the slide.

CHWs work with people whose lives and experiences can be very complicated. It can be easy to propose solutions or prioritize the client's circumstances according to our own values. These three principles help to ground the CHW in a client-centered approach by honoring the virtue in each statement and being willing to prioritize viewing the client's concerns through the eyes of the client and not our own. Strong alignment with these principles can have transformative effects in the CHW/client relationship.

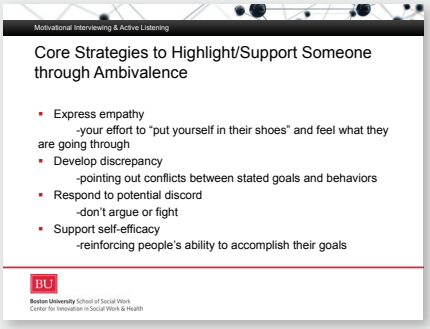
SLIDE 9

When using Motivational Interviewing skills, the following four qualities should undergird your approach with people. Define each characteristic and briefly explore the questions on the slide with participants.

1. Acceptance: Embody a disposition of acceptance by recognizing that people have the right to make their own choices free of judgment from others.
2. Compassion: Employ compassion by extending empathic care without judgment.
3. Evocation: Be intentional to ask the right questions to help people resolve ambivalence.
4. Collaboration: Work in partnership with people to examine their situations and ways to respond.

Reflection Questions

- What are some actions we do that stifle acceptance?
- How do you find a balance between your own self-interest and the client's?
- What can we do to learn about our client's strengths?
- What do we do to contribute to conflict and discord?



SLIDE 10

Express empathy (your effort to "put yourself in their shoes" and feel what they are going through)

Empathy helps to build trusting and supportive relationships that aide in the CHW/ client collaboration.

Develop discrepancy (pointing out conflicts between stated goals and behaviors)

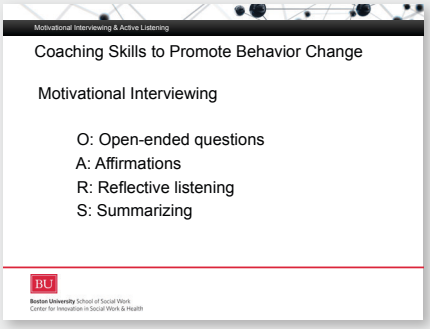
Example: You want to be healthier, but you do not show up for your medical appointments.

Respond to potential discord (don't argue or fight)

Developing discrepancy or responding to potential discord isn't synonymous with confronting or wrestling with a client about their behavior. The goal is to empathetically shine light on a situations in such a way that the client can view their own behavior.

Support self-efficacy (reinforcing people's ability to accomplish their goals)

We understand from the self-perception theory that how we view ourselves can impact our behavior; thus, reinforcing a client's belief in their ability can have a positive impact and aide change.



SLIDE 11

O.A.R.S. is a set of skills that help to create an open, affirming, accepting environment where the client can explore their feelings, behaviors and beliefs. O.A.R.S. skills help to move MI conversations forward and allow clients to freely express content that can position them to hear and make progress toward change.

Review O.A.R.S. skills and provide examples. (If time permits, invite participants to reflect and share the value of using O.A.R.S. skills.)

Open-ended questions

Use open-ended questions that invite elaboration or descriptive information. Open questions usually require more than a yes or no response and encourages the client to talk more. Examples: What helps you stay on track with your medications? Tell me more about…

Affirmations

Using affirmations helps to reinforce the client's strengths. Affirmations can be used to validate the client's experience or feelings.

Examples: You've accomplished a lot in a short time. I appreciate your honesty.

Reflective listening

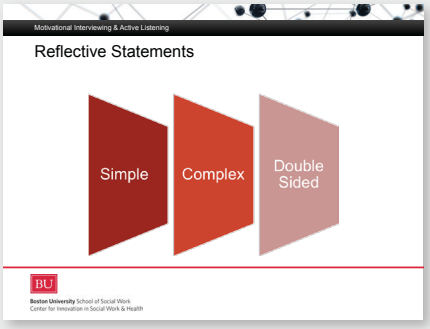
Reflective listening is a way to clarify statements and demonstrate that you heard and understood your client.

Examples: It sounds like you… You're wondering if…

Summarizing

Summarizing statements link material that has been discussed to reinforce what has been said and demonstrates that you have been listening carefully.

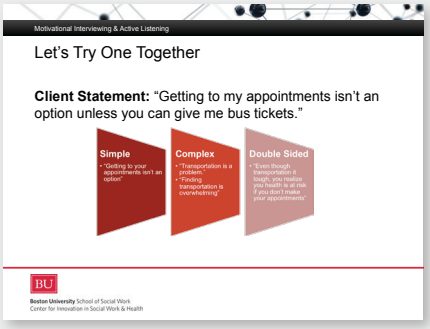
Examples: Here's what I've heard… Let me see if I got this right…



SLIDE 12

Define the difference between simple, complex, and double-sided reflections.

- Simple: A simple reflection is a basic restatement of the client's own words, being careful to use the client's language.
- Complex: Complex reflections add meaning, value, or emotion to the client's words. In essence, you are reflecting a deeper layer of the simple reflection that helps to open new perspective.
- Double-sided: The aim of double-sided reflections is to highlight the discrepancy between the client's words/values and their actions.



SLIDE 13

Review examples on slide.

Activity: Ask participants to get into pairs. Read a simple reflection below. Ask participants to take turns making complex and double-sided reflections.

"I don't see how this program is going to help me."

"I just don't like wearing a condom."

"I am not going to take my meds. My meds make me sick."

"Keeping my appointments is hard for me."

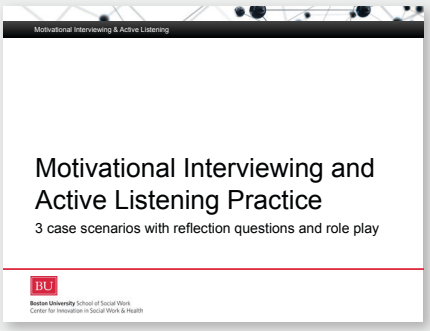
"I can't quit smoking."

"I just can't commit to exercise."

"Going to AA is sometimes a hassle."

"No one understands what it's like to not be able to pay my bills."

Summarize and close.



SLIDE 14

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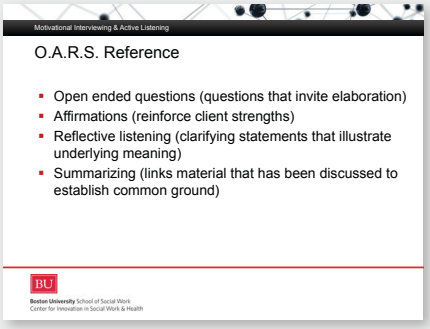


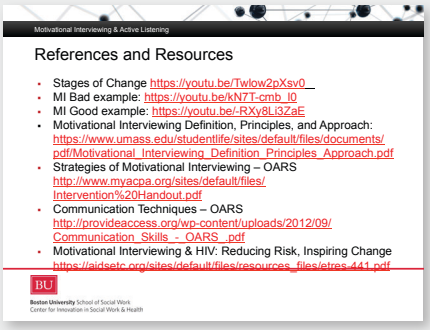
SLIDE 15

The next activity will allow more time to practice Motivational Interviewing (MI) and active listening skills.

Distribute handouts: Case Scenarios and Strategies of Motivational Interviewing: OARS.

See lesson plan for activity details.

Display this slide as a reference.



SLIDE 16

Share the series of resources and videos for the participants.

Stages of Change Model

According to the Stages of Change Model, behavior change is a process that involves moving through a series of five major stages: precontemplation, contemplation, preparation, action, and maintenance.

Stage 1. **Precontemplation** *(Not Ready)*

In this stage, people do not intend to take action in the near future, and can be unaware that their behavior is problematic.

Working with someone in precontemplation stage: Encourage them to think about the pros of changing their behavior, and to feel emotions about the effects of their negative behavior on others. Help them become more mindful of their decision-making and more conscious of the multiple benefits of changing an unhealthy behavior.

Stage 2. **Contemplation** *(Getting Ready)*

In this stage, people are beginning to recognize that their behavior is problematic, and start to look at the pros and cons of their continued actions. People in this stage intend to start the healthy behavior within the next six months.

Working with someone in contemplation stage: While they are usually aware of the pros of changing, their cons are about equal to their pros. This ambivalence about changing can cause them to keep putting off taking action. Encourage them to work to reduce the cons of changing their behavior.

Stage 3. **Preparation** *(Ready)*

People at this stage are ready to start taking action within the next 30 days. They take small steps that they believe can help them make the healthy behavior a part of their lives. For example, they tell their friends and family that they want to change their behavior.

Working with someone in preparation stage: Encourage them to seek support from friends they trust, tell people about their plan to change, and think about how they would feel if they behaved in a healthier way. Their number one concern is: when they act, will they fail? They learn that the better prepared they are, the more likely they are to keep progressing.

Stage 4. Action

In this stage, people make specific adjustments in changing their problem behavior or in acquiring new healthy behaviors.

Working with someone in action stage: You can teach people techniques for keeping up their commitments, such as substituting activities related to the unhealthy behavior with positive ones, rewarding themselves for taking steps toward changing, and avoiding people and situations that tempt them to behave in unhealthy ways.

Stage 5. Maintenance

People at this stage changed their behavior more than 6 months ago. People sustain action and work to prevent returning to their problematic behavior. It is important for people in this stage to be aware of situations that may tempt them to slip back into doing the unhealthy behavior—particularly stressful situations.

Working with someone in maintenance stage: It is recommended that people in this stage seek support from and talk with people whom they trust, spend time with people who behave in healthy ways, and remember to engage in healthy activities to cope with stress instead of relying on unhealthy behavior.

Adapted from: Prochaska, JO; Velicer, WF. The transtheoretical model of health behavior change. *Am J Health Promotion*, 1997. Sep–Oct; 12(1):38–48.

Motivational Interviewing: Case Scenarios

Scenario 1

Bolivia is a 34-year-old, single woman who has been living with HIV for one year. Bolivia learned of her diagnosis when she was hospitalized for a hip injury from playing softball. Since her diagnosis, she has experienced several major life changes. She was laid off from her job due to downsizing last month, her rent will increase by $100 due to property improvements next month, and her mobility is poor due to her hip injury. It has been very difficult for Bolivia to get around because she cannot drive until her hip has healed completely (about another 10 months). Bolivia is feeling increasing amounts of stress as financial issues loom and her urgent need to find employment is hindered by her mobility. On her last day of employment, she was instructed that her health insurance would end after three months, compounding her issues. She has been taking her medications inconsistently because she forgets and feels overwhelmed. Bolivia's provider encouraged her to talk with a CHW on staff to learn about her options.

Scenario 2

Mario is an 18-year-old, African American MSM who was diagnosed with HIV one month ago. Mario lives at home with his parents and is scheduled to start classes at the local community college in the fall. He has not told his parents about his sexual orientation or his diagnosis with HIV. Mario is deeply grieved and concerned because his father is a pastor at a large church where Mario serves in a leadership role as the minister of music. Mario's fears escalate as his appointment with the doctor inches closer. In a panic, Mario tells a friend he is considering skipping the appointment and leaving the state to avoid the rejection and shame he believes awaits him if people find out. Mario's friend suggests that he talk with the CHW at the agency he works for to learn about options.

Scenario 3

Jimmy is a 62-year-old man who has been living with HIV for 28 years. Jimmy has been an HIV activist, peer educator, outreach worker, and served as president for several LGBTQIA organizations over the past 30 years. Jimmy recently buried his long-time friend and roommate about six months ago. Since his friend's passing, Jimmy has stopped taking his medications, missed several doctor appointments, and has been missing in action in his community engagement activities. Jimmy has been referred to the CHW by his provider for re-engagement.

Introduction to Motivational Interviewing

O.A.R.S.: 4 Strategies of Motivational Interviewing in the Early Stages of Treatment

Open-Ended Questions

- Open questions gather broad descriptive information
- Facilitate dialogue
- Require more of a response than a simple yes or no
- Often start with words like “how” or “what” or “tell me about” or “describe”
- Usually go from general to specific
- Convey that our agenda is about the client

Affirm

- Must be done sincerely
- Support and promotes self-efficacy
- Acknowledges the difficulties the client has experienced
- Validates the client’s experience and feelings
- Emphasizes past experiences that demonstrate strength and success to prevent discouragement

Reflective Listening

- Reflective listening begins with a way of thinking
- It includes an interest in what the person has to say and a desire to truly understand how the person sees things
- It is essentially hypothesis testing
- What you think a person means may not be what they mean
- Repeating – simplest
- Rephrasing – substitutes synonyms
- Paraphrasing – major restatement
- Reflection of feeling – deepest

Summarize

- Summaries reinforce what has been said, show that you have been listening carefully, and prepare the client to move on
- Summaries can link together client’s feelings of ambivalence and promote perception of discrepancy

4 Principles for Motivational Interviewing

Express Empathy

- Acceptance facilitates change
- Skillful reflective listening is fundamental to expressing empathy
- Ambivalence is normal

Develop Discrepancy

This is accomplished by thorough goal and value exploration

- Help the client identify their own goals/values
- Identify small steps toward goals
- Focus on those that are feasible and healthy
- When substance use comes up, explore the impact of substance use on reaching goals/consistency with values
- List pros and cons of using/quitting (decisional balance/payoff matrix)
- Allow client to make own argument for change

Roll with Resistance

- Avoid arguments
- Human beings have a built-in desire to set things right (righting reflex)
- When the righting reflex collides with ambivalence, the client begins defending the status quo
- If a person argues on behalf of one position, he/she becomes more committed to it
- Resistance is a signal to change strategies

Support Self-Efficacy

- Express optimism that change is possible
- Review examples of past successes to stop using
- Use reflective listening, summaries, affirmations
- Validate frustrations while remaining optimistic about the prospect of change

Miller and Rollinick, Motivational Interviewing: Preparing People for Change Guilford Press. 2002

Strategies of Motivational Interviewing: OARS

Strategies	Description	Examples
Open-Ended Questions	• Elicits descriptive information • Requires more of a response than a simple yes or no • Encourages client to do most of the talking • Helps us avoid premature judgments • Keeps communication moving forward	• Often start with words like “how” or “what” or “tell me about” or “describe.” • What are you enjoying about the services you receive? • Tell me about the last appointment you attended. • What challenges you as a client? • How would you like things to be different?
Affirmations	• Must be done sincerely • Supports and promote self-efficacy • Acknowledges the difficulties the client has experienced • Validates the client’s experience and feelings • Emphasizes past experiences that demonstrate strength and success to prevent discouragement	• I appreciate how hard it must have been for you to decide to come here. You took a big step. • I’ve enjoyed talking with you today, and getting to know you a bit. • I appreciate your honesty. • You handled yourself really well in that situation. • That’s a good suggestion. • You are very courageous to be so revealing about this. • You’ve accomplished a lot in a short time.
Reflective Listening	• A way of checking rather than assuming that you know what is meant • Shows that you have an interest in and respect for what the client has to say • Demonstrates that you have accurately heard and understood the client • Encourages further exploration of problems and feelings	• It sounds like you… • You’re wondering if… • So you feel… • Please say more… • Reflections are statements. Statements ending with downward inflection (as opposed to questions) tend to work better because clients find it helpful to have some words to start a response. Statements are less likely than questions to evoke resistance. • Avoid “Do you mean…” and “What I hear you saying is that you….” (can appear patronizing).
Summarize	• Reinforces what has been said • Shows that you have been listening carefully • Prepares the client for transition • Allows you to be strategic in what to include to reinforce talk that is in the direction of change • Can underscore feelings of ambivalence and promote perception of discrepancy	• So, let me see if I got this right… • So, you’ve been saying… is that correct? • Let me see if I understand so far… • Here’s what I’ve heard. Tell me if I’ve missed anything. • Let me make sure I understand exactly what you’ve been trying to tell me… • What you said is important. I value what you say. Here are the salient points. • We covered that well. Let’s talk about…

(Miller & Rollinick, 2002)

Communicating with Providers

OBJECTIVES

At the end of this unit, participants will be able to:

- Identify professionals on your healthcare team
- Understand the role of each healthcare team member
- Discuss how to get the most from a healthcare visit
- Define self-advocacy
- Define self-advocacy in healthcare

INSTRUCTIONS

1. Before the session begins, prepare flip chart sheets for the Know Your Role activity by writing the job titles Case Manager, HIV Doctor, Primary Care Doctor, Nurse, Therapist, and CHW or Peer Educator on separate sheets. Prepare index cards with roles and tasks applicable to your agency. For example:
   - Doctor/ID Specialist:
     - Order lab tests
     - Prescribe medication
     - Review lab work
     - Address side effects
     - Monitor your health & HIV infection
     - Provide referrals
     - Evaluate symptoms
   - Nurses
     - Schedule appointments
     - Check vitals
     - Explain lab results
     - Relay concerns to doctor
     - Monitor your health & HIV infection
     - Calling in medication prescriptions
     - Giving vaccines
     - Coordinate care with other healthcare providers
   - CHWs
     - Disclosure and stigma
     - Adherence resistance
     - Outreach to lost-to-care individuals
     - HIV-101 basics
     - Viral life cycle
     - HAART medications
     - Assistance selecting ID providers

(continued)

Related C3 Roles

Providing coaching and social support, providing culturally appropriate health education and information, advocating for individuals and communities

Related C3 Skills

Interpersonal and relationship-building skills, communication skills, advocacy skills, education and facilitation skills

Method(s) of Instruction

Group activity, role-play, case scenarios, lecture

Estimated time

75 minutes

Key Concepts

Self-advocacy, multidisciplinary team, HIPAA, advance healthcare directives, PrEP, U=U

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart sheets
- Markers
- Pre-printed index cards listing tasks that health care team members perform. Sample tasks could be for nurses, case manager services, HIV provider services, and CHW HIV services. Cards/tasks will vary depending on the agency.

Handouts

- Communicating with Providers (Helpful Tips)
- Communicating with Providers (What Do All Those Letters Mean, Anyway?)
- Communicating with Providers: Advocating for Your Needs

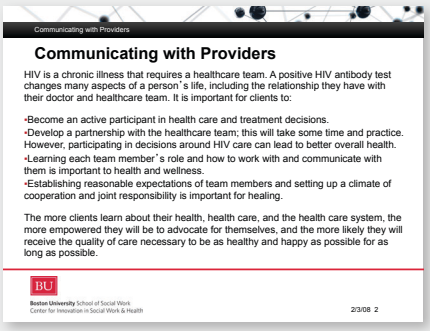
Communicating with Providers

INSTRUCTIONS (continued)

- CHWs (*continued*)
  - Emotional support
  - Social support
  - Lab tests
  - Attend HIV medical appointment
- Case management
  - Linkage to care coordinators
  - Medical case management
  - Youth case management
  - Family case management
  - Retention in care case management
  - Insurance enrollment/maintenance
  - Service/goal planning
  - Assistance selecting ID providers
  - HIV education/ HIV case management
  - Recertification (I.E. 6 month and annual updates
  - Bio-psych-social assessment
  - Social support-HIV case management

2. Welcome participants and review agenda and objectives.
3. Review slides on Understanding the Health Care Team.
4. Facilitate the Know Your Role activity.
   - Each participant will receive index cards with roles that define tasks that multidisciplinary team members perform.
   - Participants will need to match the correct task with the correct health care team member.
   - Participants will be given 8 minutes to complete the tasks.
   - Ask participants to share information about the matching of the tasks. What was easy? Did they find that some tasks overlapped? How as community health workers might they direct a client to different members of the care team?
5. Ask participants to name some essential things patients should do before, during and after the medical appointment. Write responses on the flipchart.
6. Review slides on Coaching Clients on Communicating with Providers.
7. Ask participants:
   - Has anyone had to advocate for themselves recently?
   - Has anyone ever had to advocate for themselves or a family member in terms of a health care situation?
8. Review slides on Self-Advocacy.
9. Facilitate role-play activity.
   - Ask participants to divide into groups of three.
   - Each group will have two people to role-play and one observer.
   - Distribute the handout Communicating with Providers: Advocating for Your Needs.
   - Groups will have one member read the scenario, then decide who will role-play each part.
   - The observer will listen for the following:
     - What was the problem/issue?
     - Did the client advocate for themselves?
     - Were active listening skills used?
     - Was the communication effective and was there a solution?
     - Role play as many scenarios as time allows.
10. Wrap Up.
    - Summarize key points and thank participants. Emphasize that their role as a CHW is to encourage clients to foster a good relationship with their medical provider. This is a powerful tool in their tool belt for living well with HIV.

SLIDE 1

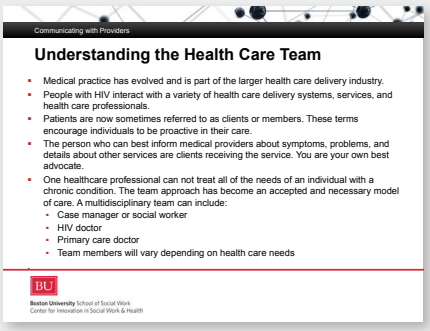


SLIDE 2

Review the slide.

Some additional talking points:

- Many people develop a more assertive attitude about their health and well-being when they find out they have HIV. Because HIV and its treatment is complicated, making decisions about when, how and whether to start therapy isn't always easy.
- One great step to take is to become an active participant in your health care and treatment decisions. This means that both you and your doctor need to learn how to work and communicate with each other.
- Just as there isn't a "one size fits all" approach to HIV care, there's no one doctor-patient relationship that suits everyone.

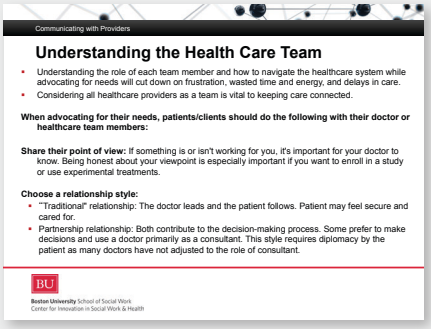


SLIDE 3

Review the slide.

Additional talking point:

- Each healthcare professional on a team must focus on a particular part of care. There has to be someone who understands how all parts of your care fit together in keeping you whole. That person is usually your primary care provider (PCP). But the most important member of your healthcare team is the consumer, client, member, and patient.



SLIDE 4

Review the slide.

Some additional talking points:

- The more each provider on the team knows about where else a client goes for care and the kinds of services they receive, the better it is when it comes to prioritizing aspects of health and care.
- Clients can explain why they are considering a particular decision and listen to what their doctor has to say.
- Whether or not agreement is reached on particular treatments, proper monitoring through exams and lab tests should be routine.
- Choose a relationship style and discuss it with your doctor. People have different styles of relating to doctors.
- None of these styles is right or wrong, but they all make different demands upon the relationship. It's important that clients communicate with their provider about which style they prefer. As clients become more familiar with HIV and experience different health challenges, the relationship style that works best might change.

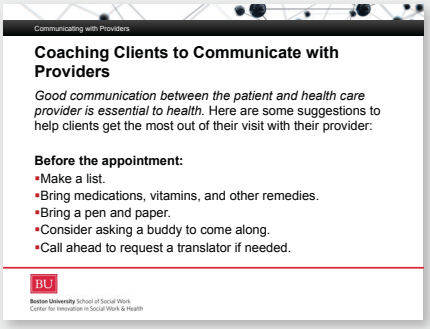
SLIDE 5

Each participant will receive index cards with roles that define tasks that multidisciplinary team members perform.

Participants will need to match the correct task with the correct health care team member (written on flip chart sheets).

Participants will be given 8 minutes to complete the tasks.

Ask participants to share information about the matching of the tasks. What was easy? Did they find that some tasks overlapped? How as community health workers might they direct a client to different members of the care team?

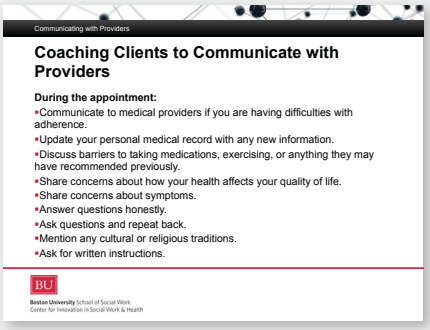


SLIDE 6

Review the slide.

Some additional talking points:

- Make a list. Clients can write down a list of questions and things they want to talk about with their provider. As a CHW, you can help clients prepare the list before an appointment.
- Bring medications, vitamins, and other remedies. Before taking additional medications it's a good idea for clients to talk to their provider. Clients can share what they are taking with their provider so they will know. It is important because some drugs, herbs, and supplements can interact with medications the provider might prescribe.
- Bring a pen and paper. Clients can bring paper or a notebook to an appointment so they can write down what the provider says. This can be a helpful strategy to support memory and understanding. As a CHW, you might support a client by reviewing their notes and talking about them with a client.
- Have someone go with you to the appointment. Clients can ask a family member or close friend to go with them to an appointment in order to help provide information that the client might forget or overlook. As a CHW, you might be in the position to accompany a client to a provider appointment.
- Clients can call ahead to request a translator, especially if English is not the client's first language.

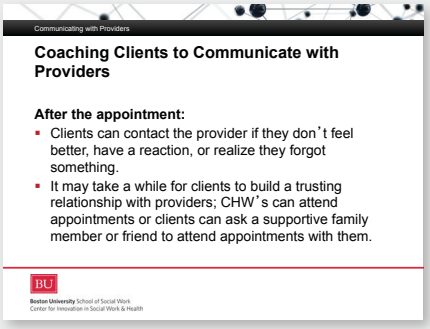


SLIDE 7

Review the slide.

Some additional talking points:

- Answer questions honestly. CHWs can encourage clients to answer all of the questions their provider asks them, even if the questions are about sensitive or uncomfortable topics. CHWs can educate clients on why providers ask certain questions and support them in talking with their provider. CHWs can also share information with a provider directly with a client's permission.
- Ask questions and repeat back. Clients can make sure they understand what their healthcare provider says during the appointment. Clients have the right to understand what their provider says. It's important that clients understand treatments their provider recommends, risks associated with treatments, and treatment choices. As a CHW, you may provide education and information to clients that help them understand their treatment, and treatment options.
- Mention any cultural or religious traditions. Clients can tell their provider about any cultural or religious traditions that might affect their care. For example, if a client engages in fasting at certain times of the year, it is important information for the provider.
- Ask for written instructions. Clients can ask their provider to put advice in writing so they can refer to the written instructions at any time.

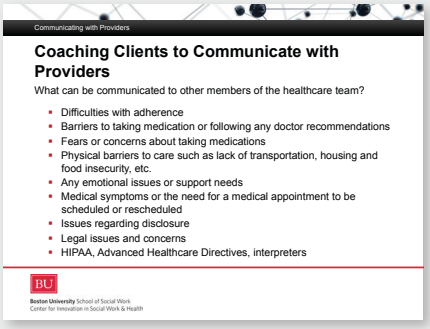


SLIDE 8

Review the slide.

Some additional talking points:

- Review any instructions or advice from the provider. As a CHW, you may be involved in reviewing information with a client.
- Contact the provider if:
  - You have questions or don't understand the instructions you were given
  - You don't feel better after your visit
  - You seem to be having a bad reaction to a new medication



SLIDE 9

Ask, "What can be communicated to other members of the healthcare team?"

Ask for volunteers to read each bullet point and give an example of what a client and CHW might share.

For the last bullet—ask, "What is HIPAA? What is a Advanced Health Directive? Why it is important as a CHW to help clients understand these terms?"

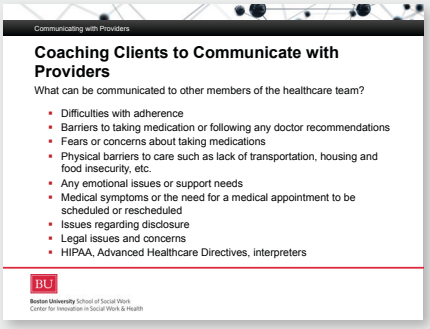
Emphasize how as CHWs they may need to advocate for clients to ask for interpreters.

Describe HPIAA, Advance Healthcare Directives, and interpreters according to the information below.

HIPAA: The Health Insurance Portability and Accountability Act
You may have heard about HIPAA restrictions. HIPAA rules impact the sharing of information about patients in medical care. Although when the act was first initiated there was some confusion about how much information families and caregivers could receive about a patient's medical situation, it is now clear that information must be shared. The US Department of Health and Human Services says: If the patient is present and has the capacity to make health care decisions, a health care provider may discuss the patient's health information with a family member, friend, or other person if the patient agrees or, when given the opportunity, does not object. A health care provider also may share information with these people if, using professional judgment, he or she decides that the patient does not object. In either case, the health care provider may share or discuss only the information that the person involved needs to know about the patient's care or payment for care. Particularly when you are named in an Advance Directive, there should be no problem with your being able to receive information about, and speak for, your loved one. Check to be sure that a current copy of the Advance Directive is in the patient file.

Advance Healthcare Directives:
These documents clarify who will speak for patients if they cannot speak for themselves. They include instructions on the type of care individuals desire if they

(*continued*)

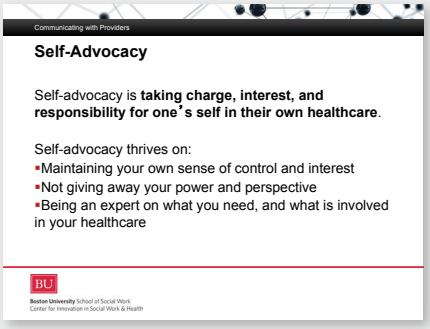


SLIDE 9 (*continued*)

are very ill or dying. (The documents may be referred to as living wills, healthcare proxies or Durable Powers of Attorney for Healthcare.) These documents can only be completed when a person is competent to do so (i.e., does not have dementia). Many doctors' offices and hospitals have forms available.

The right to have an interpreter present:
More than 200 different languages are spoken in the U.S., with approximately 25 million people speaking English at a level below "very well." We know that it's difficult enough to understand complex medical information if your first language is English. For those who primarily speak a different language (if the doctor does not speak that language), comprehension is difficult if not impossible, and the results of misinformation can be life-threatening. Fortunately, based on the Civil Rights Act of 1964, patients have the right to the services of an interpreter—including sign language interpreters—in healthcare settings.

Although there are now national certification programs to ensure that interpreters are competent to translate medical/healthcare language, there is still wide variation from state to state in the availability of such interpreters. Some families simply use a relative to provide translation, but unless they are familiar with medical terminology, that may not be the best choice when complicated information is delivered or treatment decisions must be made. Be sure to request an interpreter if you will need one.

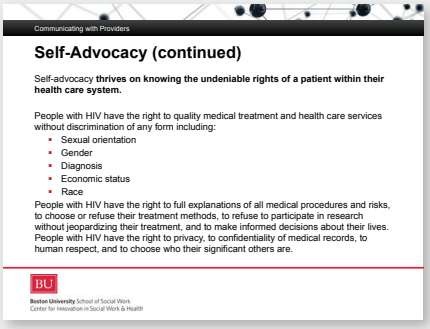


SLIDE 10

Review the information on the slides after covering the following:

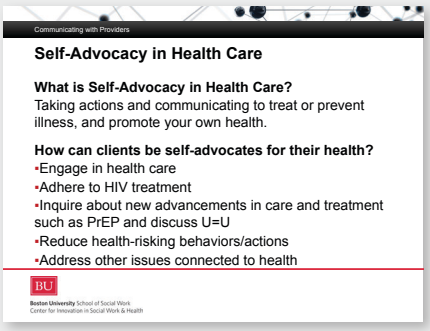
What is an advocate? By definition, an advocate is a person who publicly supports or recommends a particular cause or policy. However, if the thought of being an HIV advocate in public makes you nervous, there are other types of advocacy that might be a first step. You may know that you want to do something, but you may not know what to do or where to start. This is why learning more about different forms of advocacy can help you realize that you are already an advocate almost every day.

Much of your advocacy as a person with HIV probably revolves around your health and the health care you receive. To get the best care possible, it is important to speak up for and support yourself.



SLIDE 11

Review the slide.



SLIDE 12

Review the slide.

SLIDE 13

Ask participants to divide into groups of three.

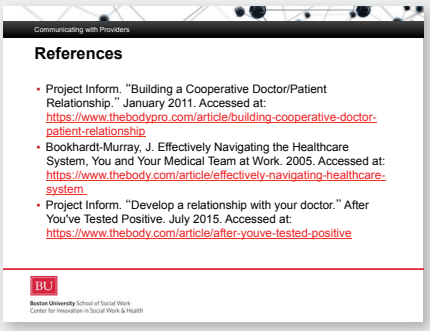
Each group will have two people to role-play and one observer.

Distribute the handout Communicating with Providers: Advocating for Your Needs.

Groups will have one member read the scenario, then decide who will role-play each part.

The observer will listen for the following:

- What was the problem/issue?
- Did the client advocate for themselves?
- Were active listening skills used?
- Was the communication effective and was there a solution?
- Role play as many scenarios as time allows.



SLIDE 14

Summarize and thank participants.

Emphasize that their role as a CHW is to encourage clients to foster a good relationship with their medical provider. This is a powerful tool in their tool belt for living well with HIV.

Communicating with Providers

Helpful Tips

The following tips may help you navigate and negotiate your way through health care systems, your appointments, and your relationships with health care professionals:

- ***Prepare for your visit***. Write down your questions ahead of time. List your symptoms and concerns so you don't forget them. Your health care provider has a limited amount of time to spend with you, so make every minute count.

- ***Know the names and doses of your medications***. Write the names and doses of your medications on a piece of paper and tuck it into your wallet or purse. Or take all of your medication bottles to your appointments. If another provider prescribes medications for you, be sure to inform the other health care professionals on your team. Inform your PCP if you use over-the-counter medications or natural remedies such as herbs and supplements.

- ***Read all medication labels and instructions***. Ask your PCP or pharmacist about potential side effects or possible drug interactions of the medications you are taking. Let them know if you have side effects. Some side effects are serious, while others are not serious and are manageable.

- ***Know how to contact your PCP if you have an emergency when the office is closed***. Most PCPs have systems in place to handle off-hours emergency calls. Know whom to contact if your PCP is away and the hospital affiliation of your PCP in case you need emergency care.

- ***Know when you need refills on your medications***. Contact your PCP's office about a week ahead of time to allow time for the prescriptions to be processed.

- ***Leave clear messages when you call your PCP's office***. Chances are that if you leave a message for your PCP without stating the reason, the response will be delayed. PCPs must prioritize calls and respond accordingly. Tell the receptionist why you are calling. The receptionist is an important part of your health care team.

- ***Update your address and phone number.*** Your PCP's office should have your current contact information in case there is a need to contact you about test results, scheduling changes, and so on.

- ***Know the reason you were referred to a medical consultant or for a special test.*** That will help you stay focused on the reason for the appointment and provide accurate information to the consultant.

- ***Carry your PCP's contact information with you at all times***. Whenever you see a specialist, go to the emergency department, or have at tests performed, insist that the results be sent to your PCP. Ask whether there are any special forms you need to sign to make sure the information can be sent. Be sure to have your PCP's contact information with you when you travel.

- ***Provide your PCP with names, addresses, and dates of specialists you have seen and tests that have been performed.*** Your PCP may refer you but may not necessarily know the date of your test or where you were sent. Keep notes about who you saw, why you saw them, and what was recommended so that you can report that information back to your PCP so that he or she can follow up effectively.

- ***Remind medical consultants to either call your PCP or send a report***. Take a note of referral from your PCP to the consultant. That will help make it clear as to exactly why you are there. The note also provides the consultant with your PCP's name, address, and phone number.

- ***Know how to use your health insurance plan***. Understand your health plan. Your PCP may not know the details of patients' plans. For example, some plans require written referrals from your PCP to a specialist. Preapproval for equipment of special medications may be required. Each plan has its own formulary of medications that it covers.

- ***Keep a notebook with dates and results of your test results***. Reviewing your results in private may allow you to learn more about what's happening with your health.

- **Call to cancel appointments you cannot keep**. Try not to miss appointments. It may be difficult to get another one in the near future depending on the availability of services in your community. Also, missed appointments send the message that you aren't interested or invested in your health. That may not be true, but that is the impression that is made.

- ***Continue to educate yourself about HIV and other conditions that you may have.*** Members of your health care team will be able to direct you to information sources that are accurate and credible. Ask questions and for explanations until you understand the answers. Inquire about options, expected results, and outcomes. If you don't ask questions, the members of your team may assume you know everything about what is going on.

- ***Understand that waiting is an unfortunate norm in the world of health care***. Most health care professionals have very little control over their schedules. Because of the large numbers of people who need care, schedules are usually tightly packed. This can lead to backups and crowded waiting rooms. Computer problems, staff illnesses, staff turnover, misplaced medical records, or very complicated patients on any given day may result in even further delays and increased waiting time. Many of these problems are beyond the control of the health care professional and are just as frustrating for the provider as they are for you. A crowded waiting room creates anxiety among the staff. The tension can lead to unproductive and dissatisfying visits, medical errors, and staff resignations. This is ultimately detrimental to all involved.

- ***Complain in an effective manner.*** Emotional outbursts in waiting areas make staff and other patients nervous and create even further delays. It is more effective to lodge a formal complaint. Look for someone to whom you can voice your complaints. Most administrators take complaints seriously and use them to figure out how to improve systems so that problems can be fixed over time.

Communicating with Providers

What do all those letters mean, anyway?

Healthcare professionals and researchers often have many letters following their names. These titles indicate, to some degree, their training, experience, and qualifications. The following list isn't exhaustive, but explains what some of the abbreviations following professionals' names refer to.

AAHIVS — American Academy of HIV Medicine (AAHIVM) HIV Specialist

An MD, DO, PA, or NP who has completed 30 hours of continuing medical education (CME) credit in two years, has seen 20 or more patients with HIV within two years, and has passed a qualifications exam on HIV care. Two thousand providers are registered by the AAHIVM as HIV specialists. When choosing a healthcare provider, be aware that many providers may have equivalent experience in HIV care, but aren't certified by the AAHIVM. Visit www.aahivm.org for a referral.

ACRN — HIV/AIDS Certified Registered Nurse

A registered nurse who has completed 70 hours of CME credits, has at least two years of experience in HIV/AIDS care, and has passed a certification exam for HIV/AIDS care.

DO — Doctor of Osteopathic Medicine

A Doctor of Osteopathy has the same rights and privileges as a Medical Doctor (MD). They can prescribe medications and practice medicine in all fifty states. The training that a DO receives is comparable and, in some cases, identical to that of an MD but may have more of a "whole person/whole body" approach. DOs tend to consider the psychosocial as well as the physical well-being of a person, as well as how individual symptoms of certain parts of the body may affect others. DOs also receive additional training on the musculoskeletal system and Osteopathic Manipulative Treatment.

FAAN — Fellow of the American Academy of Nursing

A distinction given to nurses in recognition of their accomplishments in nursing. Many fellows have high levels of training (82% hold a doctorate in nursing), and most have leadership positions in academic, research, government, or community settings.

GI — Gastroenterologist

An MD or DO who specializes in the care of the stomach, intestines and liver.

ID — Infectious Disease Specialist

An MD or DO who specializes in treating a range of infectious diseases, including HIV.

LPN — Licensed Practical Nurse

A nurse who has completed certification to administer certain treatments. Works under the supervision of a Registered Nurse (RN).

MSW — Masters in Social Work

Social work is a profession committed to helping individuals, families, and communities at multiple levels. Some social workers continue their training to become licensed or certified psychotherapists.

MD — Medical Doctor

A physician who holds a medical degree and is licensed to practice medicine and surgery as well as prescribe medications and other treatments.

NP — Nurse Practitioner

A registered nurse with advanced clinical and academic experience, including a master's degree. A Nurse Practitioner's abilities vary depending upon each state's regulations. In many states, a Nurse Practitioner can prescribe medications.

ANP — Nurse Practitioner (adult care)
FNP — Nurse Practitioner (family care)
GNP — Nurse Practitioner (geriatric care)
PNP — Nurse Practitioner (pediatric care)

PA — Physician's Assistant

Clinicians who provide healthcare to individuals under the supervision of physicians (MDs or DOs). Their training is not as long as that of MDs and DOs, but their responsibilities are quite similar. They routinely take medical histories, examine and treat, order and interpret laboratory tests and X-rays, make diagnoses, and prescribe medications. They also treat minor injuries by suturing, splinting, and casting. PAs also record progress notes, instruct and counsel patients, and order or carry out therapy. In rural and inner-city areas, PAs may be the principal care providers when a physician is present only one or two days a week. They are able to practice in 47 states, all of which require PAs to pass a certification exam and are then designated as a PA-C (Certified Physician Assistant).

Ph.D. — Doctor of Philosophy

A doctorate (advanced) degree in any subject matter (not necessarily philosophy or medicine). Nurses, pharmacists, nutritionists, and social workers, among others, may continue their education to receive this doctorate degree.

Pharm.D. — Doctor of Pharmacy

In addition to two years of pre-pharmacy study, a Pharm.D. has completed at least four years of graduate studies to earn a doctorate degree in pharmacy.

Psy.D. — Doctor of Clinical Psychology

Psychologist with specialization in clinical psychology, including deep understanding of severe psychological disorders and psychotherapy.

RD — Registered Dietician

Many nutritionists are also registered dietitians. RDs are trained in the science of nutrition as well as dietetics, a discipline focused on relationships between dietary patterns and health, both in normal nutrition and in disease states.

RN — Registered Nurse

A nurse who has completed a Bachelor of Nursing program.

R.Ph. — Registered Pharmacist

A Registered Pharmacist must be licensed in the state in which they practice and hold at least a bachelor’s degree in pharmacy.

Adapted from ACRIA Update Winter 2004/05 -- Vol. 14 No. 1 (www.acria.org).

Communicating with Providers: Advocating for Your Needs

Scenario One

A patient needs information and advice about her medication. The medicine does not seem to be working and it makes her sick. She decides to ask her doctor about the pills she is taking.

Patient: Hello, Dr. Roe. I need to talk with you about my medication. These pills are upsetting my stomach and they don't seem to be working.

Doctor: I'm sorry to hear that the pills are upsetting your stomach. When are you taking your pills?

Patient: Well, I usually take them sometime in the afternoon and right before I go to bed. If I forget about them, I just take them whenever.

Doctor: You should take the blue and orange pills together after breakfast or lunch but not in the evening. In the evening or at bedtime you only need to take the orange pill; and make sure your doses are 12 hours apart. For example: if you take your first dose at 8:00am, then take your last dose at 8:00 p.m. Eating when you take the first pill dose (2 pill regimen) will keep you from feeling sick to your stomach. Plus, the pills will not suppress the virus nor be effective if you do not take them as instructed. (Hands her a pamphlet)

Patient: Oh, I get it. I take the blue and orange pills together after breakfast or lunch. And I need to take them with food. I shouldn't take both pills at night; I only need to take the orange pill. Oh, and everything needs to be spaced 12 hours apart like 8 AM to 8 PM. Thank you, Dr. Roe. I really appreciate your help with this information. I now see that I was not taking the medicine correctly.

Doctor: You're welcome. Please call me or the nurse if you keep feeling nauseated or if you have any other questions. We'd be glad to answer them. I'll see you in a couple months. Okay?

Patient: Okay. I will check back if I need to. Thanks again.

Scenario Two

An elderly client (woman) recently moved to the area, returning to her hometown after many years. She needs to go grocery shopping but does not have any transportation. She has not shopped in about a month—since her children left, returning to their homes about 12 hours away. She met members of her health care team a week ago and the CHW seemed nice and relatable. She decides to call the CHW and ask her to help by taking her to the store to shop.

Woman: Hello there, Ms. Wright. I was wondering if I could ask you for a ride to the grocery store today. My groceries are beginning to run low. I haven't been since my children left. You know this is really home for me and that's why I moved back, but my friends don't drive and I don't know my way around anymore.

CHW: Thank you for calling, Ms. Wright. I'm sorry to hear that you're low on groceries. Unfortunately, at my organization we're not allowed to transport our clients however, we have a few options/resources I can recommend. How does that sound?

Woman: Well, I don't like a lot of strange folks at my house knowing that I live alone; but I trust you because I saw your badge and I know where you work. What resources are you talking about**?**

CHW: Well, we have several options and you can tell me what will work best for you. I certainly want you to be able to take care of your health and feel good about navigating the area until you get more familiar with the neighborhood. Our first option—the options are not in any particular order, I'm just advising you of choices—I can help you sign up for Meals on Wheels, which will deliver a daily meal to your home; there is a sliding small fee according to your income. For our second option, we have a volunteer who works for us and she transports patients wherever they need to go Monday through Thursday during the hours of 9:00 AM-5:00 PM. Our third option is to take the bus and I'll be glad to arrange a time for the two of us to meet at your home and review the bus route. We can ride the bus together and I can show you a few stores that are really close to your home. How do those options sound to you?

Woman: Well, to be honest I'm disappointed that you can't take me but I'm glad you could recommend some good options I am okay with. I like options two and three. However, it's Monday and I'd like to go to the grocery store by this Friday; no later than Monday, next week.

CHW: I understand, how about tomorrow?

Woman: That works for me! Thank you, Ma'am.

CHW: No, thank you. I'm just glad I could offer some options for you, I'll see you tomorrow.

Scenario Three

A woman attends her doctor appointment. The doctor can tell that she is feeling down. This is not normal for her. She is usually jubilant; she has been undetectable for a while. She's at her annual 6-month checkup.

Woman: Hello Dr. Sharon (looking gloomy).

Doctor: Hello! You don't look like yourself today. I'm used to your smile and your jokes that keep me laughing. It's your 6-month visit but I sense that there are other things on your mind?

Woman: You're right. I am kind of down. I've been dating and I really like this guy; no serious intimacy yet. But, I don't want to be holding on to this secret about my status. I know he wants children and I do too. It's early in the relationship. I don't want him to walk away. I just have too much on my mind right now and my stomach is in knots.

Doctor: Well, one thing at a time. You have a lot to think about and I can empathize with you about wanting to tell him and being afraid of what he might say or do with regard to the relationship.

Woman: I know I need to talk things out with someone. I was wondering who you could recommend that I could speak with today?

Doctor: Have you talked with a CHW before? CHWs are member of your healthcare team.

Woman: Who is that? I remember a lady showed up at my medical visit one time when I had an increase in my A1C and said she could talk to me about diet and nutrition. That was last year and I've got things under control now.

Doctor: Yes, and I'm happy about your progress with modifying your diet and your numbers are under control. However, the CHW also works with people with HIV. She educates and supports people who sometimes hit bumps in the road even though medically they may be doing well. I believe she would be a good listener and we have new options like PrEP and U=U that she can explain in detail to you. Are you open to seeing her again?

Woman: If you recommend her Dr. Sharon, I know she's ok. Besides she's another resource on my team.

Doctor: Alright, she just happens to be in clinic today so I'll call her after we review your labs. Sound like a plan?

Woman: Yes Dr. Sharon, sounds like a plan. I'm so glad I kept my appointment today—I was depressed;

I almost stayed at home. But I feel better already. Thanks so much!

Doctor: Ok, let's review those labs and I'll call the CHW for you.

Cross-Cultural Skills

OBJECTIVES

At the end of this unit, participants will be able to:

- Provide and use a broad-based definition of culture that goes beyond race/ethnicity
- Identify various cultural groups of which they are members
- Explain how power and privilege influence interactions among and between cultural groups in the U.S.
- Practice cultural self-awareness and cultural humility in their work as CHWs

INSTRUCTIONS

1. Prior to the session review all PowerPoint slides, resources, and handouts. Test video clips to ensure that they work. Prepare a Mkeka (see slide 8).
2. Welcome participants and review objectives and agenda (slides 2–3).
3. Defining culture
   - Brainstorm/hot potato: Have the group form a circle and toss the ball around. When the music stops, whomever is holding the ball will be asked this question: "What comes to your mind when you hear the word, 'Culture'"?
   - See slide 4 for facilitation details.
   - Review and discuss definition of culture (slide 5).
4. Exploring our identities
   - Discuss awareness of identity, intersectionality (slides 6–7).
   - Mkeka activity: Distribute sheets of colored paper, markers, and tape or glue. Participants will create a Mkeka, or woven mat, to illustrate their own intersectional identities. See slide 8 for detailed instructions.
5. Check in with participants and provide a break if necessary.
6. Introduction to Power, Privilege and Oppression in U.S. Society
   - Review and discuss elements of dominate U.S. culture (slide 10).
   - Distribute One Up-One Down Model handout.
   - Image theater activity to explore power imbalances: Break participants into groups of three, follow facilitation details on slide 11.

(continued)

Related C3 Roles

All

Related C3 Skills

All

Method(s) of Instruction

Brief presentation, brainstorming, individual work, gallery walk, large group discussion, small group discussion, image theater, video.

Facilitator's note: This session should be conducted by a trainer experienced in cultural humility and/or a similar approach.

Estimated time

120 minutes

Key Concepts

Cultural humility

Materials

- Computer with internet connection and projector
- PowerPoint slides
- Flip chart
- Markers
- Ball
- Music player
- Colored construction paper cut into strips
- Glue sticks and/or tape
- Video: Cultural Humility: People, Principles and Practices *https://www.youtube.com/watch?v=_Mbu8bvKb_U*
- Video: Kimberle Williams Crenshaw: Intersectionality *https://www.youtube.com/watch?v=9yKX_MH2bHs*

Handouts

- Shared Language
- One Up—One Down
- Building Cross-Cultural Skills Awareness

Cross-Cultural Skills

INSTRUCTIONS (continued)

7. Cultural Humility
- Introduce the concept of cultural humility (slide 12).
- Watch video, Cultural Humility: People, Principles and Practices: *https://www.youtube.com/watch?v=_Mbu8bvKb_U* (7 minutes, slide 14)
- Review aspects of Cultural Humility (slide 14).
- Break participants into small groups and distribute flip chart sheets and markers for a brainstorm session. See slide 15 for details.

8. Wrap up. Summarize by asking a volunteer to read slides 16 and 17. Show video on intersectionality (slide 18) if time allows. Share resources, encouraging participants to explore these topics in greater depth. Emphasize that this journey with cross cultural skills and cultural humility is a life-long process. Ask participants to share one message that they learned today and can take back to their work.

Resources

Cultural Humility vs. Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education: *https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf*

Race: The Power of an Illusion *http://www.pbs.org/race/000_General/000_00-Home.htm*

The Business Case for Racial Equity, a report by Ani Turner and Altarum Institute; funded by WK Kellogg Foundation (2013): *https://www.wkkf.org/resource-directory/resource/2013/10/the-business-case-for-racial-equity*

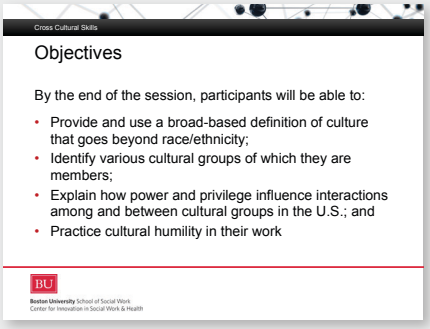
Coalition of Communities of Color. Community-based participatory research project into the lived realities of communities of color in Multnomah County. *http://www.coalitioncommunitiescolor.org/research-and-publications*

Racial Equity Tools *http://www.racialequitytools.org/home*

Racial and Social Justice Initiative: *http://www.seattle.gov/rsji/*

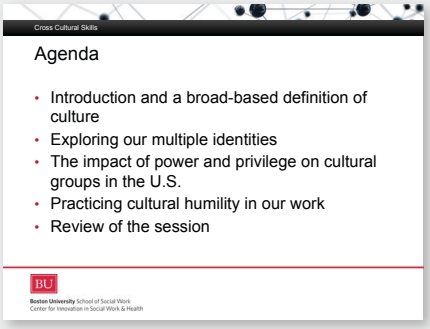
SLIDE 1

Welcome participants.



SLIDE 2

Review the slide.

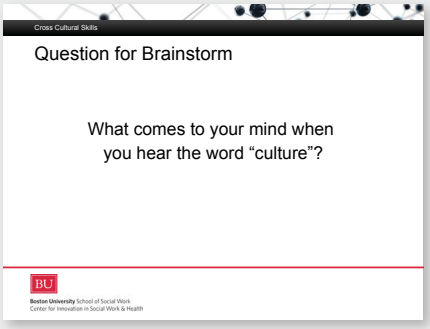


SLIDE 3

Review the slide.

Mention that the ability to work effectively cross-culturally is a very important skill for CHWs. This skill can be applied in all settings (with communities, our co-workers, and our institutions).

Ask, "Does anyone have questions before we proceed?"



SLIDE 4

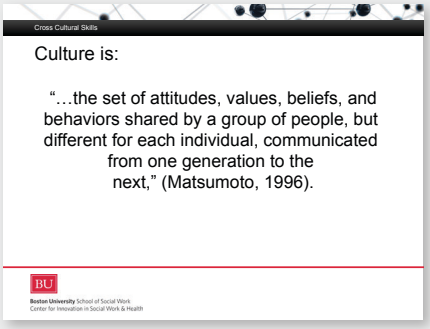
Explain that in order to talk about working cross-culturally, it is important that we have a shared definition of culture.

Play the hot potato game. Ask participants to toss a ball around the circle. When the music stops, whomever is holding the ball will be asked this question: What comes to your mind when you hear the word "culture"?

Write responses on the flip chart page. Play the game long enough so that most of the participants get a chance to participate.

After finishing the game, review what was written and ask participants if anyone would like to add anything else.

Reflect as a large group: What catches your attention about the words we associate with the word "culture"?

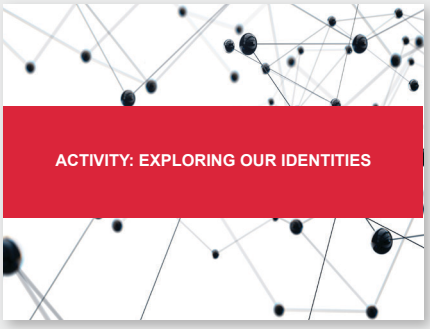


SLIDE 5

Ask for a volunteer to read the definition.

Ask, "What catches your attention about this definition? Is it consistent with the words that come to our mind when we think about culture? If it is different, how is it different?"

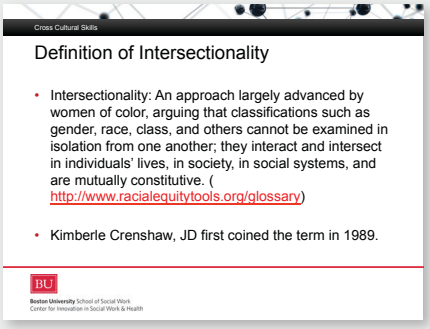
When we think about cultures, we often think about racial/ethnic culture. However, it's important to recognize that, as the definition states, any social group in society can and does have a culture. So there are class cultures, religious cultures, sexual orientation cultures, etc.



SLIDE 6

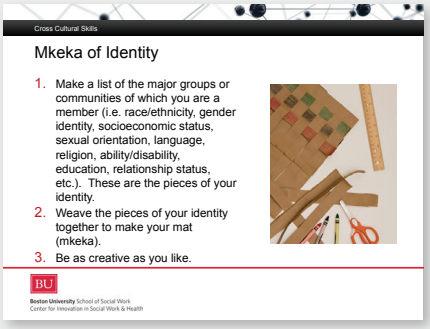
Explain that in order to be able to work cross-culturally, we first need to develop an awareness of our own cultures and how they affect us. The next activity will help us become more aware of the cultures of which we are all members.

Sometimes we think of ourselves in terms of one part of our identity. For example, on one day, I might be really aware that I am _____ (insert examples of your identity). In reality, all of us have multiple identities that make us who we are. This is called intersectionality.



SLIDE 7

Ask for a volunteer to read the slide.



SLIDE 8

To demonstrate our multiple identities, we can use the woven mat or "mkeka" in Swahili. Here is my mkeka (facilitator shows their example).

Facilitator discusses the strands that make up their mkeka, and how they are woven together.

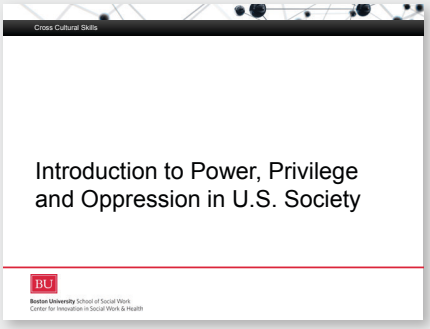
These strands intersect and cross each other in order to form our identity. This is a concept known as intersectionality.

Explain that participants will now have about 10 minutes to make their own mkeka. Distribute strips of colored paper, tape or glue, and markers.

Say, "Here's how to do it." (read instructions on PowerPoint).

After everyone has finished, ask that participants attach their mats to the wall, do a silent "gallery walk" and note to themselves anything that catches their attention or raises questions.

Reflect by asking: What caught your attention about our mats of intersectionality? Did anything surprise you?

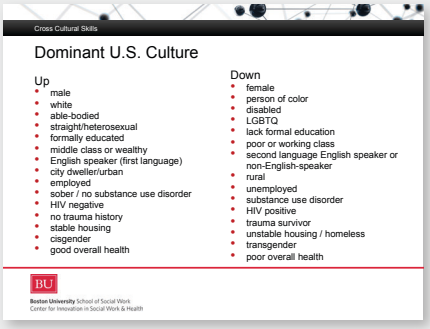


SLIDE 9

In order to work effectively across cultures, it is also necessary to understand how power and privilege influence interactions among and between cultural groups in the U.S.

Think for a moment about how you interact with your supervisor at the clinic. Now think for a minute about how you interact with children in your life. Do you relate the same way to both of these people?

Power relations strongly affect how we interact with the people around us in society.



SLIDE 10

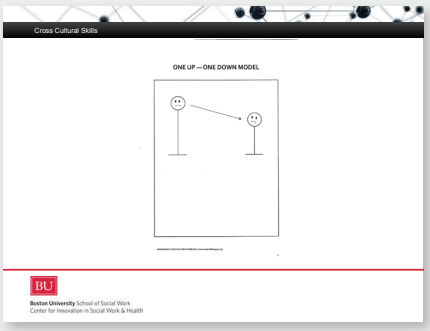
To explore this idea, we are going to use the "One Up-One Down Model." We borrowed this model from Guadalupe Guajardo at the Non-Profit Association of Oregon.

In dominant U.S. society, some characteristics tend to give us power or put us "up." These include being: male, white, able-bodied, straight/heterosexual, formally educated, middle class or wealthy, first language English speaker, city dweller, employed, sober/no substance abuse, HIV negative, no trauma history, stable housing, cisgender, and having good overall health.

Some characteristics tend to deprive us of power or put us "down" in dominant culture in the U.S. These include being: female, person of color, disabled, LGBTQ, lacking in formal education, poor or working class, second language English or non-English-speaker, rural, unemployed, having substance use issues, HIV positive, trauma survivor, unstable housing/homeless, transgender, or having poor overall health.

Let's brainstorm on the flip chart: What are some other things that put us up that we have not listed yet? What are some things that put us in the down position?

Write responses on corresponding columns on the flipchart.



SLIDE 11

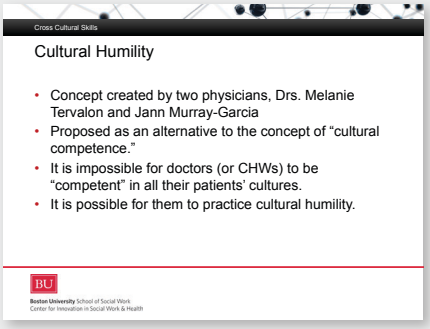
Pass out copies of the "One Up-One Down Model." Ask participants to take a moment to write which characteristics give them power and which take away their power within the context of dominant U.S. culture.

Explain that now we will use a technique called Image Theater to explore power differences. In a moment, I will break you into groups of three. Two people will be the "clay" and will be sculpted by the third person into a still image that represents how the power imbalances might look or feel like. Each person will get a chance to be the sculptor and the clay. After each round, ask the group to stop and look at the other images.

Break participants into groups of 3 and ask them to create their images.

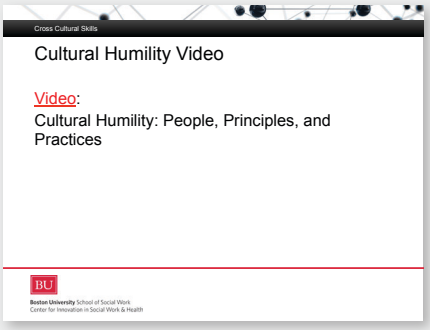
Ask: "What did you notice or feel during that exercise?"

Our place in society is sometimes referred to as our "positionality." Just as we all have multiple identities, our positionality changes depending on who we are with. Sometimes we are up, sometimes we are down, and sometimes we are both at the same time. Keep this in mind as we view the video in the next segment.



SLIDE 12

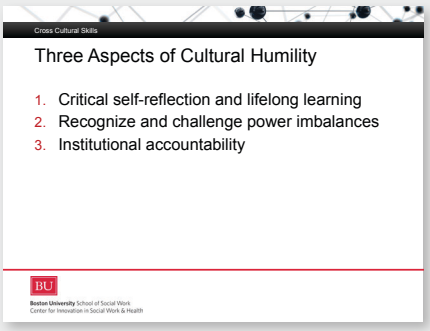
In our work as CHWs, we encounter people from a variety of class, racial/ethnic, and other types of cultures. It is impossible for us to be "competent" in all the cultures we encounter. But it is possible to practice **cultural humility** in all our interactions.



SLIDE 13

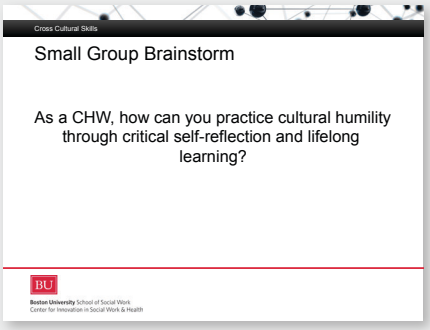
Watch the video.

Cultural Humility: People, Principles and Practices:
https://www.youtube.com/watch?v=_Mbu8bvKb_U



SLIDE 14

The authors identified 3 aspects of cultural humility. Read the slide.



SLIDE 15

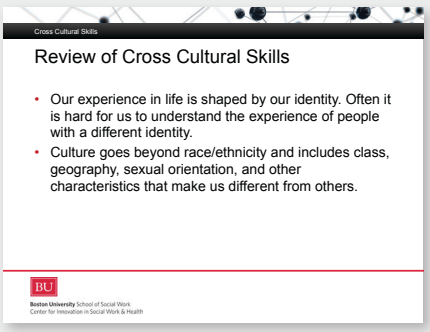
Explain that in a moment we will break into small groups so that you can reflect together on how you can practice cultural humility through critical self-reflection and lifelong learning in your work as a CHW.

Each group will be given a flip chart sheet with the words "cultural humility" in a mindmap format.

Please use the flipchart page to capture your thoughts. For the brainstorm, please draw from your experiences, the CHW roles, and the handout on Building Cross-Cultural Skills Awareness.

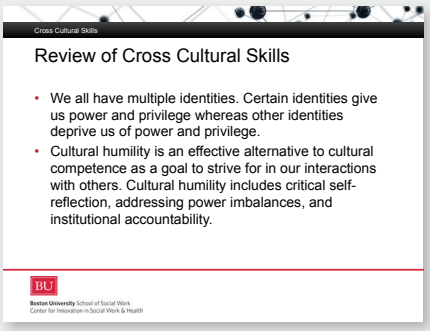
Ask each group to share back 3 ideas from their discussion. Post flipchart pages around the room for participants to look at throughout the day.

Summarize: No matter our background or our position in society, there are ways we can interact with others from different backgrounds that increase the effectiveness of the interaction. Remind people that we also have further resources if anyone wants to dig into these topics more deeply.



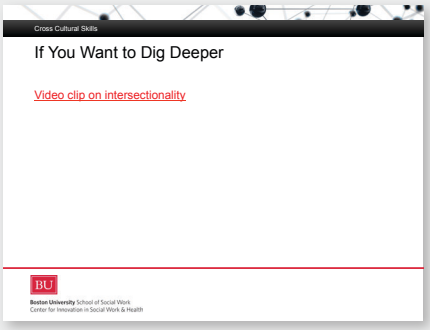
SLIDE 16

Ask for a volunteer to read the slide.



SLIDE 17

Ask for a volunteer to read the slide.



SLIDE 18

If time permits, show the video Kimberle Williams Crenshaw: Intersectionality: https://www.youtube.com/watch?v=9yKX_MH2bHs

Shared Language

Dominant and non-dominant culture: Through economic or political power, one culture imposes its values, language, and ways of behaving on subordinate cultures. This can manifest in the form of legal or political suppression of other sets of values and patterns of behavior, or by monopolizing the media of communication. (Dictionary of Sociology. 1998)

Inclusion: Authentically bringing traditionally excluded individuals and/or groups into processes, activities, and decision making in a way that shares power.

Intersectionality: An approach largely advanced by women of color, arguing that classifications such as gender, race, class, and others cannot be examined in isolation from one another; they interact and intersect in individuals' lives, in society, in social systems, and are mutually constitutive. (http://www.racialequitytools.org/glossary)

Oppression: Prejudice + power. The systematic marginalization of one social group by a more powerful social group for the social, economic, and political benefit of the more powerful social group. Oppression can manifest through racism, classism, sexism, heterosexism, and other isms. Only the dominant group can be oppressive because of their power.

Prejudice: A conscious or unconscious negative belief about a whole group of people and its individual members. When the person holding the prejudice also has and uses the power to deny opportunities, resources, or access to a person because of their group membership, there is discrimination. (Sheri Schmidt, 1994)

Positionality: People are defined not in terms of fixed identities, but by their location within shifting networks of relationships, which can be analyzed and changed. Understand where you stand in relation to power within those shifting networks and relationships. (Maher and Tetreault, 2001)

Power: Access to resources and to decision makers. Power is the ability to get what you want done, the ability to influence others, the ability to define reality for yourself and potentially for others. Power can be visible, hidden, or invisible. Power can show up as power over others, power with others, and/or power within.

Racialization: Racial identities are not fixed categories. This term makes explicit that this is not about inherent characteristics but about the ways in which we are socialized to differentiate groups of people on the basis of physical characteristics. It emphasizes the active process of categorizing people while at the same time rejecting "race" as a scientific category.

Social constructs: A social mechanism, phenomenon, or category created and developed by society; a perception of an individual, group, or idea that is "constructed" through cultural or social practice.

Bias: A particular tendency, trend, inclination, feeling, or opinion, especially one that is preconceived or unreasoned.

Class: A relative status according to income, wealth, power and/or position. (www.classmatters.org)

Classism, Sexism, Racism, Heterosexism, Ableism, Ageism, and other 'isms': The systematic oppression of members of a targeted group (lower/working class, women, people of color, members of gender and sexual minorities, disabled people, children and the elderly, etc.) by members of the dominant group (upper class, men, white, straight, able bodied, and younger adults, etc). This oppression is supported by the actions of individuals, cultural norms and values, and the institutional structures and practices of society. (Adams, Bell & Griffin. Teaching for Diversity & Social Justice, A Source Book. 2007.)

Cultural Competency: An ability to interact effectively with people of different cultures. Cultural competency comprises four components: a) awareness of one's own cultural worldview, b) Attitude towards cultural differences, c) knowledge of different cultures and worldviews, and d) cross-cultural skills. (Wikipedia, 2011.)

Discrimination: Unjustifiable negative behavior towards a group and its members. Usually this involves behaving differently, usually unfairly, towards members of a group. (Adams, Bell & Griffin. Teaching for Diversity & Social Justice, A Source Book. 2007.)

Equity: Equity is an ideal and a goal, not a process. It ensures that everyone has the resources to succeed. (Multnomah County Equity & Empowerment Lens. 2012.)

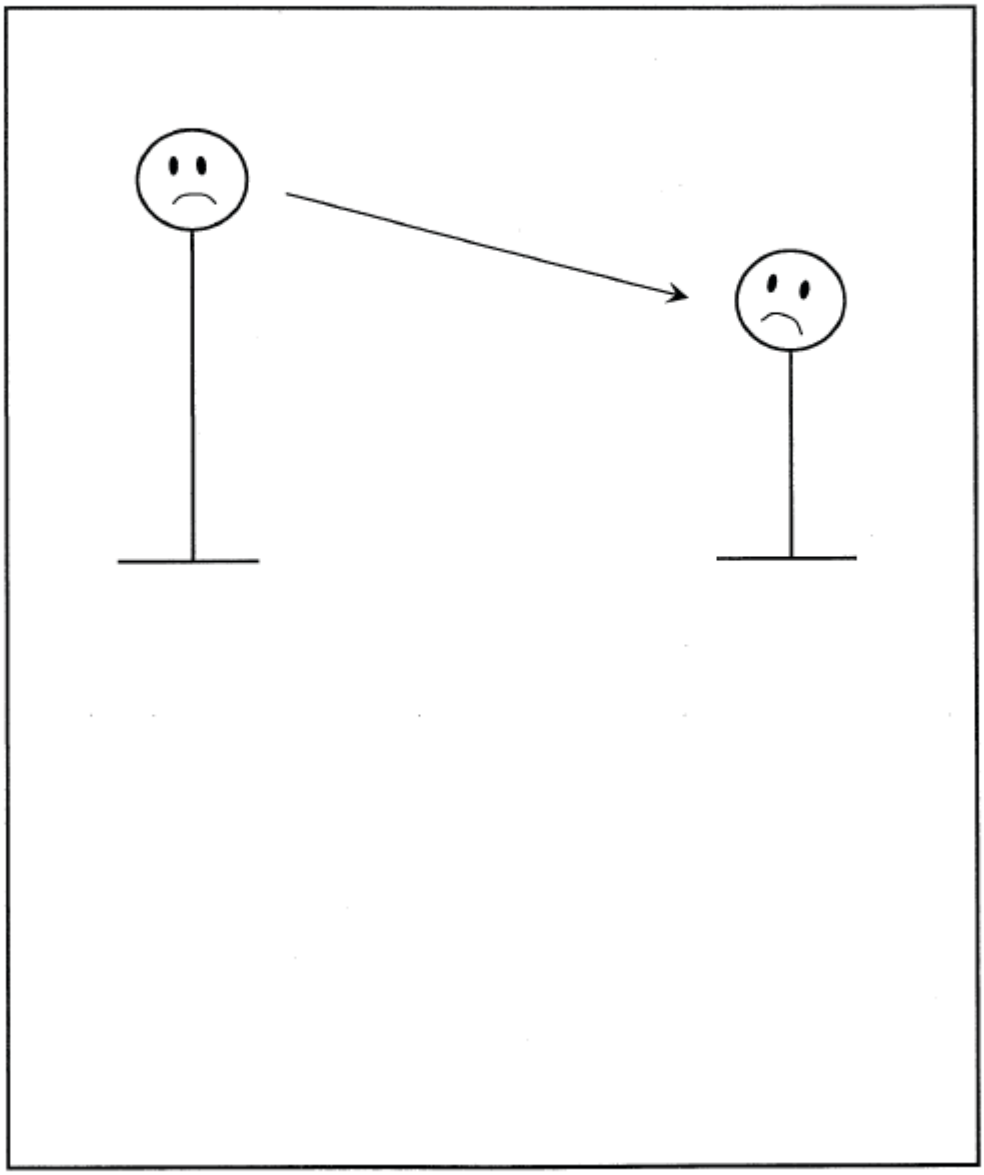
Oppression: When stereotypes and prejudice are so woven into our way of life, discrimination is put into structures of society through policies, laws, etc. The system then grants advantages/disadvantages differently to different groups. This creates the agent group, who has privilege, and the target group, who is disadvantaged. (UCSB English Department, 2007.)

> **Horizontal oppression**: The result of people of target groups believing, enforcing, and acting on the agent system of discrimination. This can occur between members of the same group (e.g., a Chicano telling another Chicano to stop speaking Spanish), or between members of different target groups (e.g., Asian Americans fearing Blacks as criminals). (UCSB English Department, 2007.)

> **Internalized Oppression:** The "buying into" the elements of oppression by the target group. When target group members believe the stereotypes they are taught about themselves, they tend to act out and thus perpetuate the stereotypes which reinforces the prejudice and keeps the cycle going. (Sheri Schmidt, 1994.)

One Up—One Down

ONE UP — ONE DOWN MODEL



Building Cross-Cultural Skills Awareness

Instructions: Read the information below with your partner. What catches your attention? What additional ideas do you have about how to strengthen your skills to work cross-culturally?

Cultural humility: Cultural humility acknowledges that it is impossible for someone to be "competent" in the cultures of those that they work with. It is a process that includes three core practices:

- Critical self-reflection and lifelong learning
- Recognizing and challenging power imbalances
- Institutional accountability through mutually beneficial and respectful relationships between the community and agencies

*(*Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, *9*(2), 117-125.*)*

"It is very difficult to separate ourselves from our own "cultural baggage." Becoming aware of it and keeping this awareness in the forefront of our consciousness makes it more likely that we will limit its impact on our work."

*(*Dean, R. G. (2001). The Myth of Cross-Cultural Competence. *Families in Society*, *82*(6), 623–630.*)*.

Ideas for Moving Forward:

- Learn everything you can about oppression and privilege – it's your job to educate yourself.
- Practice cultural humility and not knowing.
- Work with and build a relationship with someone from a different cultural identity.
- Invite feedback from community members.
- Remember that it's not a question of "if" but "when" you will make a mistake.

(Adapted from the collective work of Ann Curry-Stevens)

Am I willing to do the following?

- Remember that others speak about more than the conditions of their own group.
- Take responsibility to learn about the history, culture, and struggles of other groups as told by them.
- Notice what I expect from and assume about others, and note what experiences formed my ideas.
- Address accessibility, include such things as money, space, transportation, child-care and language.
- Make sure the context welcomes everyone's voice and listen.
- Regard people as whole human beings with families, interests, and ideas.
- Name unacknowledged realities to include everyone's experience.
- Expect discomfort when relating to people different from myself.
- Take responsibility for equalizing power.
- Name dominating behavior when I see it.
- Understand individuals in the context of their social history.
- Ask questions and respect disagreements.
- Struggle over matters of principle and politics.
- Make all information accessible so others can decide if they are interested.
- Appreciate efforts that point out my mistakes or lack of awareness.
- Appreciate the risk a person takes in sharing their experience with me.
- Take risks, trust others.

(Tools for Change)

Cultural Humility: A Pathway to Empathy

OBJECTIVES

At the end of this unit, participants will be able to:

- Identify and define the four pillars of cultural humility
- Describe how a cultural value/belief related to their identity can impact their work with a client
- Describe how cultural humility is a pathway to employing empathy in their interpersonal relationships

INSTRUCTIONS

1. Prior to the session, review slides, handouts and test video to be sure it plays.
2. Set the tone for the session by reviewing the group agreements and expectations (slides 2–4).
3. Lead the group in a mindfulness activity (slide 5).
4. Discuss the history of cultural humility, definitions of culture, and cultural humility (slides 5–9).
5. Show cultural humility video (6 minutes): *https://www.youtube.com/watch?v=16dSeyLSOKw*
6. Review the four pillars of cultural humility and the difference between cultural competence and cultural humility (slides 11–13).
7. Personal reflection activity. Ask participants to consider how they bring their identity, power, and privilege to their work. Distribute personal reflection handout. Allow time for participants to complete the handout individually, then ask them to form pairs to share insights with their partner. Reconvene the group to discuss (slides 13–15).
8. Explain the connection between empathy and cultural humility and facilitate discussion (slide 16).
9. Wrap up: Review the four pillars of cultural humility. Ask participants to share a lesson learned from today's session that they will use in their work (slide 17).

Related C3 Roles

Cultural mediation among individuals, communities, and health and social systems

Related C3 Skills

Communication skills, ability to communicate with empathy, interpersonal and relationship-building skills, ability to practice cultural humility

Method(s) of Instruction

Lecture, dyads, dialogue

Facilitator's note: This session should be conducted by a trainer experienced in cultural humility and/or a similar approach.

Estimated time

60 minutes

Key Concepts

Cultural humility, empathy

Materials

- Computer with internet access and projector
- PowerPoint slides
- Video: Cultural Humility *https://www.youtube.com/watch?v=16dSeyLSOKw*

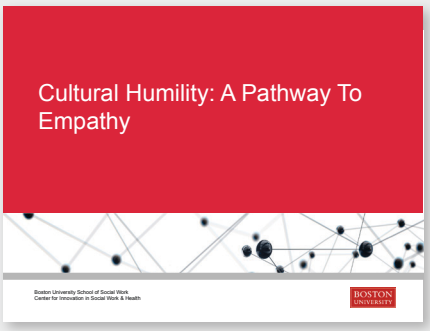
Handouts

- Personal Reflection Activity

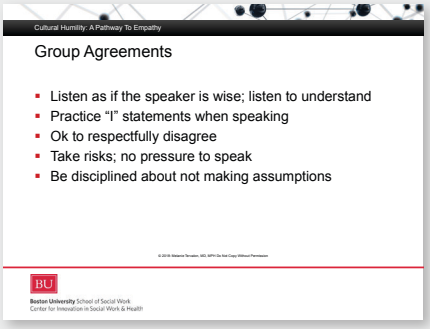
Resources

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf



SLIDE 1

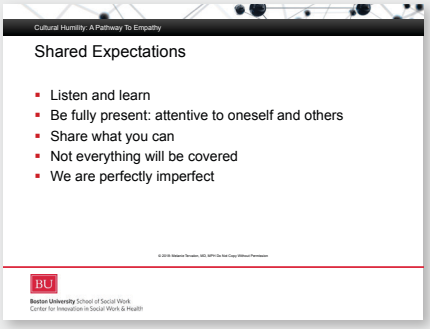


SLIDE 2

Set the tone for the session by reviewing the group agreements. This is an important step for establishing a context for safe exploration and dialogue. Take a few minutes to review and encourage feedback from participants. Probe for meaning and clarify statements. Invite participants to agree to uphold the group agreements to establish and maintain a learning environment that is respectful and safe for everyone.

SLIDE 3

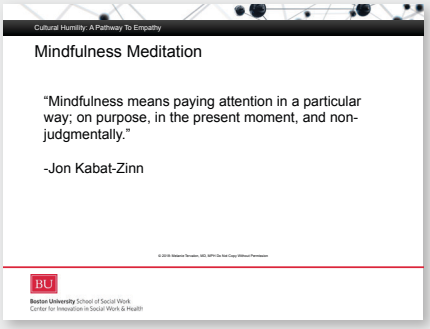
After reviewing, ask participants to raise their hands to demonstrate their commitment to the group agreements.



SLIDE 4

Review the slide.

In addition to the group agreements, aligning ourselves with these shared expectations will help us explore the content together and invite us to be conscious and courageous.



SLIDE 5

Lead the group in a mindfulness activity. This can be a simple exercise of deep breathing to center participants in the present moment (approximate time: 5 minutes).

Mindfulness is how we ground ourselves for the work of cultural humility. It is the desired disposition for creating an environment within oneself that is patient, present, and accepting of things as they are without judgment.

Example of a guided meditation: (Read the meditation at a comfortable, unrushed pace. Allow space between statements to aid the experience.)

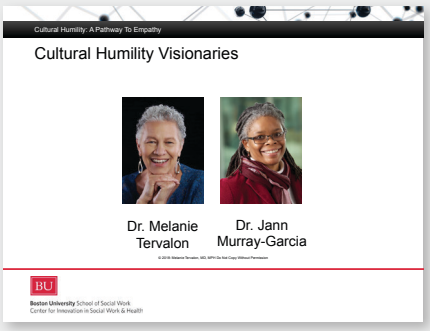
- Make yourself comfortable and take a few deep breaths. Close your eyes if you'd like or fix them on a object of your choosing.
- With the ease of each breath, inhale peace, compassion, and acceptance and exhale tension, worry or concerns. Rest in the calm of the present moment.
- Continue to breath deeply as peace comforts you.
- Now, imagine your heart is the sun. It shines brightly within you. Its warmth and light radiates throughout your being and into the world around you. Imagine each beam of light extends acceptance, forgiveness, patience and love to all of humanity including yourself. Acceptance, forgiveness, patience, and love fills you and extends to those you love and to those you find difficult. You allow this light of love to evoke peace—peace for all people and all situations. You simply flow in the energy of this moment. You trust that life supports all beings. You rest in your wholeness and offer wholeness for all others.
- Take a few more deep breaths. When you are ready we can move forward together.

Debrief:

Ask participants to briefly share any reflections or comments.

Summarize

Thank participants for individually committing to co-create quality in our learning environment. As we move forward, we will come to understand the work of cultural humility is anchored in many of the practices we've just completed. It is an ongoing practice of curious inquiry by interrupting our tendencies make assumptions.



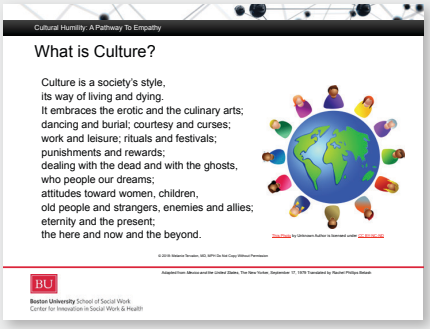
SLIDE 6

Before we define cultural humility, let's become acquainted with the two women who founded this framework—Dr. Melanie Tervalon and Dr. Jann Murray-Garcia.

In 1992, while working at Children's Hospital Oakland, Dr. Tervalon and Dr. Murray-Garcia were providing services to a community that was reeling from rioting and racial divisions resulting from the acquittal of four Los Angeles, police officers who were charged with brutally beating Rodney King after a high-speed chase.

The Rodney King verdict and riots fueled racial tensions and fostered divisions that impacted the quality of care patients received and relationships among the ethnically diverse hospital staff. In response, hospital staff and community members engaged in ongoing dialogues and processes to address the issues, ultimately leading to the formation of The Children's Hospital Multicultural Curriculum Program between 1992 and 1997.

As a result of those efforts, the Cultural Humility framework was formed and the journal article "Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes multicultural education" written by Dr. Tervalon and Dr. Murray-Garcia was published in 1998.



SLIDE 7

Let's take a moment to reflect on the meaning of culture.

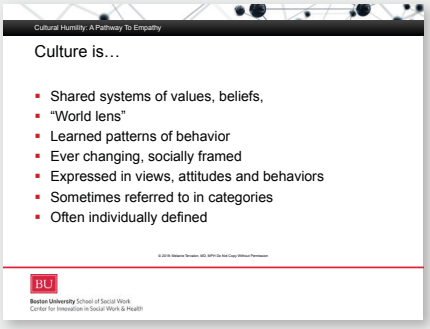
Ask a participant to read the excerpt on the slide that describes culture.

Invite participants to share their thoughts about this passage and how it relates to their understanding of culture.

_____

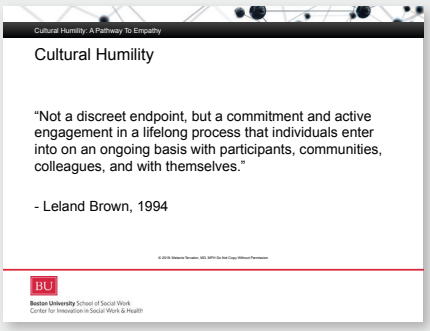
Facilitator's Note: Octavio Paz wrote the original quote in Spanish. This translation may not fully capture the original meaning. Octavio Paz was referring to civilization, though we believe this is applicable to what we mean and how we talk about culture certainly in the United States.

Reference:Adapted from *Mexico and the United States,* The *New Yorker,* September 17, 1979 Translated by Rachel Phillips Belash



SLIDE 8

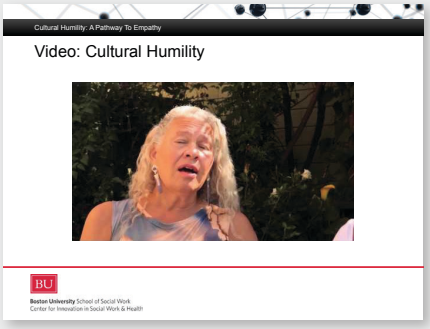
Share these defining points for culture.



SLIDE 9

Share information on the slide.

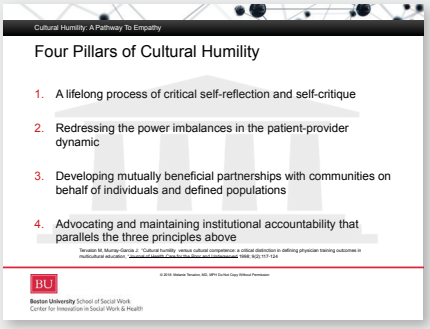
The important point to make about this statement is that cultural humility is an ongoing, lifelong commitment and process.



SLIDE 10

Video: Cultural Humility Edited https://www.youtube.com/watch?v=16dSeyLSOKw (Time: 6 minutes)

This video provides a brief introduction of Cultural Humility and makes distinctions between cultural humility and cultural competence. It features the founders Dr. Melanie Tervalon and Dr. Murray-Garcia.



SLIDE 11

Let's briefly review what we heard in the video and add more dimension.

Pillar 1

A lifelong process of critical self-reflection and self-critique.

The idea behind this pillar is that individuals will gain ongoing awareness of and critique their own cultural lens, biases, power, privileges, and identities. This insight is to be used on an ongoing basis to ensure that service delivery is respectful and equitable; thereby avoiding stereotyping, erroneous assumptions, and biased behaviors.

Pillar 2

Redressing the power imbalances in the patient-provider dynamic

This pillar recognizes that people are experts of their own lives. In the CHW context, this pillar acknowledges that a client-centered approach is best as clients set their own priorities. The voice of the patient is centered in the client/provider dynamic; thus, stripping away power differentials and creating equitable exchanges. Humility is evidenced in the CHWs intention to listen and learn.

Pillar 3

Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations

This pillar recognizes the provider/client relationship occurs within the community's context, which includes it's history, politics, economics etc. Mindful consideration and critique of those contextual elements is important in forming meaningful and equitable partnerships. Additionally, organizations develop policies and ways to center community voices and work in partnership to provide quality services.

Pillar 4

Advocating and maintaining institutional accountability that parallels the three principles above

The fourth and final pillar of cultural humility recognizes that individual work is important, AND institutions must engage in the same work of critical self-reflection and self-critique, mitigating power imbalances and developing mutually beneficial partnerships to transform inequity, discrimination and biased organizational policies and cultures. Organizations are encouraged to face the mirror, look at their own reflections and respond with curious inquiry to develop fair, accessible, respectful, inclusive policies and workplace environments.

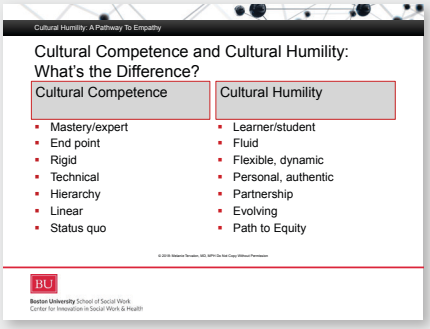
Facilitator's note: This is intended to be an introduction/overview of cultural humility. Cultural humility is a multilayered and nuanced framework where ongoing learning and development is encouraged.

Read more about cultural humility

Resources:

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117–125.

https://melanietervalon.com/wp-content/uploads/2013/08/CulturalHumility_Tervalon-and-Murray-Garcia-Article.pdf



SLIDE 12

People often use cultural competence and cultural humility interchangeably, but there are distinctions that make them different.

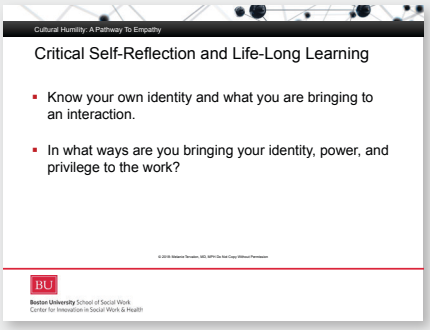
Ask participants share their ideas on the differences between the two frameworks as they view the bulleted lists.

Share key distinctions:

Cultural competency is defined as having an ability to interact effectively with people of different cultures. Cultural competency comprises four components: a) awareness of one's own cultural worldview, b) Attitude towards cultural differences, c) knowledge of different cultures and worldviews, and d) cross-cultural skills. (Wikipedia, 2011.)

Cultural competence implies that people can gain mastery or become experts on a community or cultural group. The implication of gaining mastery is that people assume they know all there is to know about a group and they stop noticing distinctions and learning. This disposition can lead them to approach interactions with cultural arrogance and separatism; thereby, invoking a position of privilege. Essentially, practicing cultural competence can place emphasis on gaining knowledge about a cultural group and applying that information to all members who belong to that group. In this way, that knowledge becomes the status quo and there is no recognition of the impact of one's own biases, values, power and privilege. Invite participants to recall the example regarding the Latino patient from the video.

In contrast, cultural humility recognizes the importance of being a lifelong learner who is ever curious about cultural groups and the unique experiences of individuals who are members of those groups. According to Dr. Teravalon and Dr. Murray-Garcia, "The cultural humility framework deliberately focuses learning on interactions between people within their context, recognition of power imbalances between those interacting, and the realization that individual experience and expression, for institution, provider, and client redefine what culture means in each interaction." There is no end point. Thus, a culturally humble practice is fluid, flexible, dynamic, and an evolving path to equity.

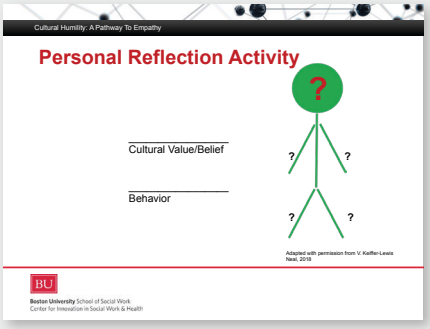


SLIDE 13

As we discussed, a key distinction for cultural humility is having knowledge of your own identity and what you are bringing to an interaction.

Ask participants, "In what ways are your bringing your identity, power, and privilege to the work?"

Invite responses and explain that the next activity will help us gain further insight on how our identities, cultural values, and beliefs impact our behaviors.



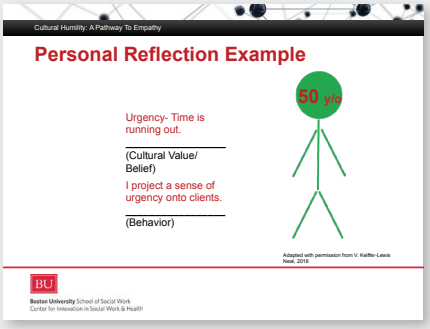
SLIDE 14

Explain that for our next activity, we will spend time considering our own identities.

We all have multiple identities that include our gender, race, ethnicity, sexual orientation, socioeconomic status, and religious/spiritual affiliation. Some additional examples of identities are parent, education level, disability, care-giver, and others. Our identities are always evolving and they shape how we view and interpret the world around us. They inform how we show up and interact in spaces and with people because of our associated values and beliefs. Many of us are not aware of these values and beliefs and how they influence our perceptions, judgments, and interactions. This activity will help illuminate a personal example as we practice the first pillar of cultural humility by engaging in a moment of critical self-reflection.

- Draw participants' attention to the handout "Personal Reflection." Give instructions for completing the handout and provide an example (an example is provided on the next slide.)
- Ask, "What are some examples of your identities?" Tell participants to list four examples, one next to each arm and each leg of the stick figure on the handout.
- Next, choose an identity that is most prominent or pressing for you at the moment. It can be one of the identities you've just written or a different one. Write that identity in the head of the stick figure.
- Now consider, "What is a cultural value or belief associated with that identity?" Write the value or belief in the space provided on the handout.
- Then, identify how that cultural value or belief impacts your work/behavior with your clients.
- Proceed to the next slide to illustrate an example.

Facilitator's note: Complete the handout "Personal Reflection" prior to this session to use as an example in addition to the one provided on the next slide.



SLIDE 15

Example:

4 identities (not shown on slide, but should be written to the arms and legs of the stick figure.)

- Woman
- Married
- Christian
- College educated

Prominent identity is 50 year-old person (written in the head of the stick figure)

The cultural value or belief that is significant to this identity is urgency and the belief that time is running out to get things accomplished. The sense of urgency is very pressing for this person who realizes at the age of 50 they may have lived more life than they have left ahead of them.

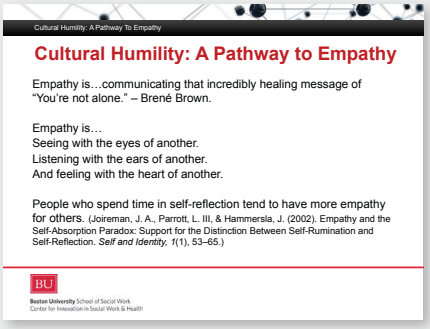
This cultural value/belief in urgency shows up in this person's work as a CHW through projecting a sense of urgency onto their clients.

For example, a client might be contemplating quitting smoking. The client is undecided and has not determined for themselves the benefits of stopping smoking. Instead of helping the client weigh the pros and cons of quitting smoking, the CHW's belief in urgency hijacks the interaction. The CHW (unconsciously) places pressure on the client to make the decision to stop smoking NOW and pushes the client to make an action plan. Since the client has not decided that they are ready to quit, the efforts by the CHW to push forward will likely fail. In this example, we can see how our own cultural values/beliefs inform how we view and interpret the world around us. Many times, we are unaware of these cultural and value based lenses, but they impact how we behave.

Allow time for participants to complete their handout individually. Then ask participants to form pairs to share their insights with their partner. (Approximately 10 minutes)

After sharing, reconvene the group and ask:

- What insight(s) did you gain as a result of this activity?
- What value does critical self-reflection and self-examination bring to the work of a CHW?



SLIDE 16

How is empathy connected to cultural humility?

Before we explore that question, let's define empathy.

According to social scientist, Brené Brown, empathy is communicating that incredibly healing message of "You're not alone."

Empathy is…

- Seeing with the eyes of another.
- Listening with the ears of another.
- And feeling with the heart of another.

Empathy is the capacity to understand or feel what another person is experiencing from within their frame of reference, that is, the capacity to place oneself in another's position. (Wikipedia, 2019)

These definitions of empathy coupled with what we understand about cultural humility allow us to make the assertion that cultural humility is a pathway to empathy. Empathy is a necessary skill for CHWs working with clients and within institutions because it encourages us to see and feel from another's perspective. Information derived from empathic connection can help to broaden our perspectives and gain insight necessary for mitigating power imbalances, working in partnership with others, and holding institutions accountable to the work of cultural humility.

In fact, the first pillar of cultural humility, engaging in a lifelong process of critical self-reflection and self-critique, is particularly useful in developing empathy skills.

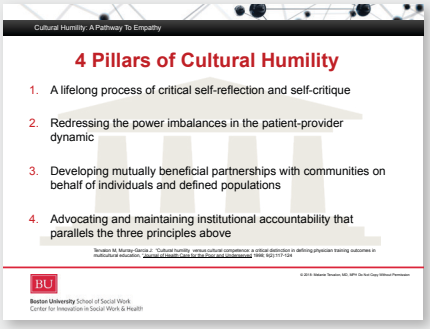
Invite participants to work with their partner from the Personal Reflection activity and dialogue about the following question: List at least two reasons why engaging in a lifelong process of critical self-reflection and self-critique is particularly useful in developing empathy skills (approximately 3–5 minutes).

Reconvene the group and invite participants to share their responses with the large group.

Summarize the group's responses and share the final point on the slide: "People who spend time in self-reflection tend to have more empathy for others."

The work of cultural humility is an invitation to gain awareness of and be accountable for our own culturally-informed lenses and what we bring to the relationship dynamic. A robust practice in self-awareness can foster the mindfulness and humility needed to extend empathy to individuals, circumstances, events, and institutions. We can engage in the work responsibly, with authenticity and respect for differing views.

Facilitator's note: If time allows, explore the value of having empathy when mitigating power imbalances, working in partnership with others, and holding institutions accountable to the work of cultural humility.



SLIDE 17

Summarize:

Ask participants to share a meaningful insight from this session. Encourage participants to note the relevance of cultural humility in their work as CHWs.

Summarize and close with the following points. Add other insights that are worth revisiting from today's session.

The four pillars of cultural humility are:

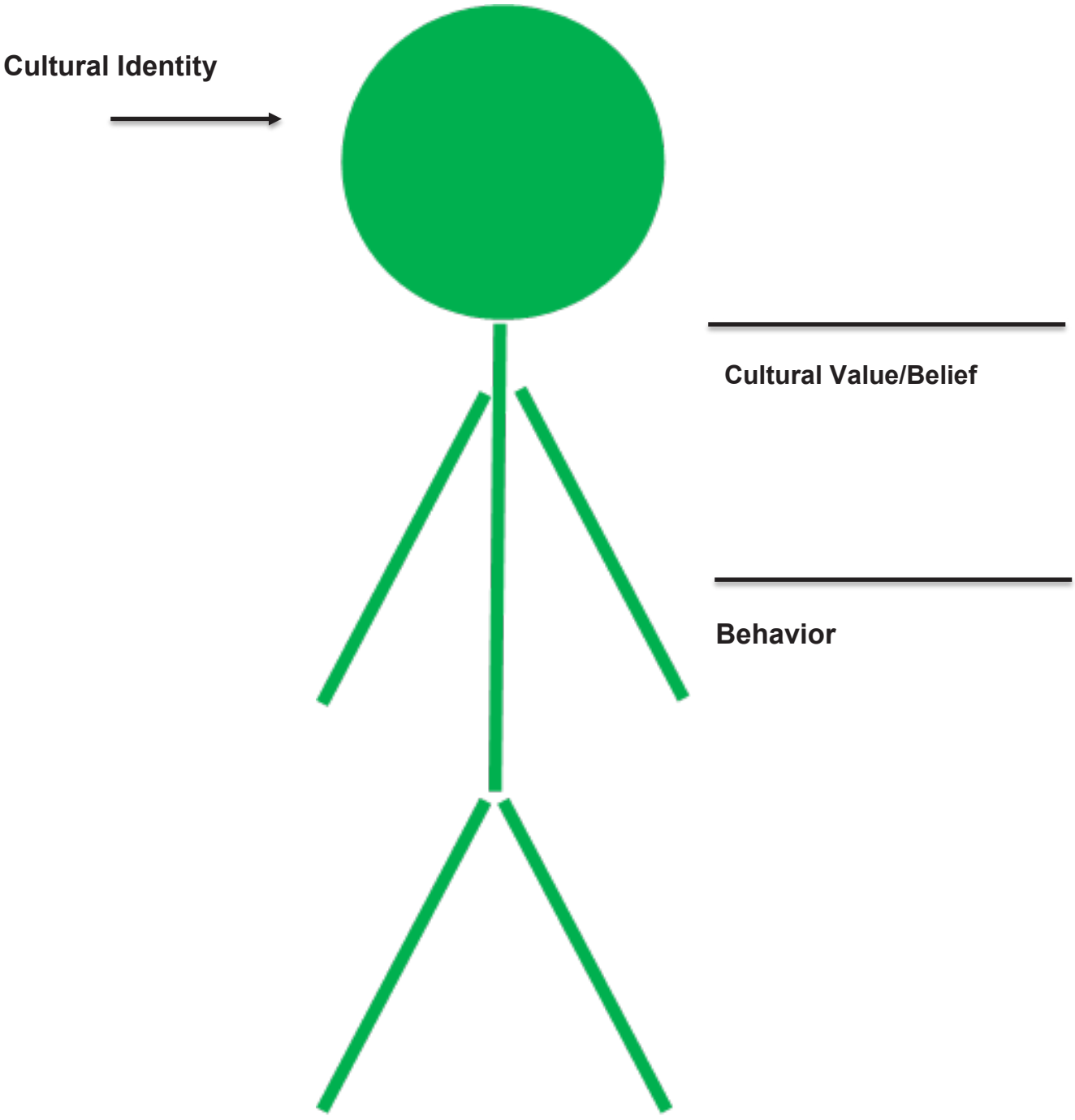
1. A lifelong process of critical self-reflection and self-critique.
2. Redressing the power imbalances in the patient-provider dynamic.
3. Developing mutually beneficial partnerships with communities on behalf of individuals and defined populations.
4. Advocating and maintaining institutional accountability that parallels the three principles above.

Cultural humility is different from cultural competency.

Cultural humility is a lifelong process and is a pathway to developing empathy skills.

Cultural humility is a conscious lifelong transformative practice.

Personal Reflection Activity



Adapted with permission from V. Keiffer-Lewis Neal's "An Introduction to Cultural Humility" (2018)

Team Building Skills to Support Integration

OBJECTIVES

At the end of this unit, participants will be able to:

- Identify how they and their team members can build trust
- Name the skills and experience of their team members
- Understand the different contributions of team members

INSTRUCTIONS

1. Before the session, review slides and organize chairs for small group activity.
2. Welcome participants and review the objectives (slide 2).
3. Review examples of how to build and earn trust (slide 3). Ask participants if they can think of other examples of how to build trust among colleagues and clients.
4. Activity: Building Trust with Your Team (20 minutes)
   - Ask participants to get into small groups with their organization's team.
   - Distribute Building and Earning Trust handout.
   - Display activity instructions (slide 4).
5. Wrap up. Ask, "What have you learned that will be helpful as you work together as a team?"

Related C3 Roles

Care coordination, case management, and system navigation

Related C3 Skills

Communication Skills, Interpersonal and Relationship-Building Skills, Capacity Building Skills, Professional Skills and Conduct, Service Coordination and Navigation Skills

Method(s) of Instruction

Individual writing, small group activity

Estimated time

30 minutes

Key Concepts

Trust, team integration

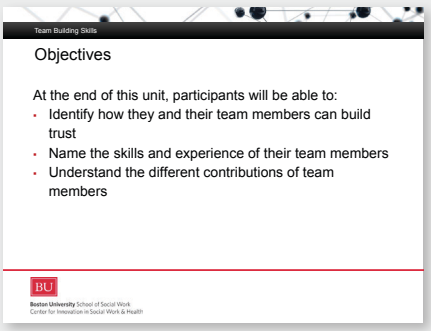
Materials

- Computer with internet access and
- projector
- PowerPoint slides

Handout

- Building and Earning Trust

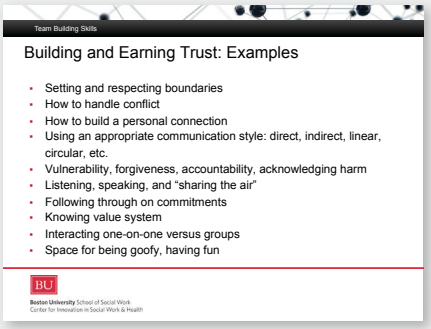
SLIDE 1



SLIDE 2

Review the slide.

Explain that for this session, we will be focusing on how we can create more trust with our team members and appreciation for their roles.



SLIDE 3

Review the slide.

Invite participants to share other examples of how to build trust among colleagues and clients.

SLIDE 4

We will now do an activity where you will have a chance to think on your own about how you build and earn trust, and then you will learn from your teammates how they build and earn trust.

Distribute Building and Earning Trust handout.

Ask each participant to take 10 minutes to fill out the handout on their own.

Then, ask participants to form small groups with their team members and share with each other what they wrote. Participants should write down their team member's responses on their own handout (10 minutes).

To close, bring the group back together. Ask, "What have you learned that will be helpful as you work together as a team?"

Building and Earning Trust

Person's Name	How do you build trust with others?	How do others earn your trust?	What does it feel like to be in a trusting relationship?	How do you like to be addressed, contacted, touched, and greeted? What are your pronouns?
Me				

Person's Name	How do you build trust with others?	How do others earn your trust?	What does it feel like to be in a trusting relationship?	How do you like to be addressed, contacted, touched, and greeted? What are your pronouns?

Trust Building

OBJECTIVES

At the end of this unit, participants will be able to:

- Begin to build trust and relationships with each other.

INSTRUCTIONS

1. Before the session, prepare a flip chart sheet with a header that says "Hopes for Training."
2. Welcome participants. Explain that we will be using a philosophy and methodology for education and organizing called popular education (people's education), which has been identified as a best practice in training CHWs all over the world.
3. Dinámica/Movement activity
   - A principle of popular education is to create an atmosphere of trust so that people can share their ideas and experiences.
   - Distribute the handout. Explain that to create an atmosphere of trust and sharing, we will use a Dinámica called "The Reporters."
   - In English, we call these activities "movement-building activities" intentionally. We are using both meanings of the word "movement." These are social learning games that often include physical movement of some kind, and that also build relationships and social movements.
   - When we say go, please move away from where you are sitting and find the person in the room whom you know the least. When you find your partner, interview that person like a reporter, using the questions on the handout.
   - After all pairs have interviewed each other, we will come back together and each person will introduce their partner.
   - Give participants 15–20 minutes to meet and ask questions.
   - Have the group reconvene and introduce their partners.
   - Record notes on the flip chart only for the hopes for the training.
4. Wrap up. Ask participants what catches their attention about this Dinámica. Share the PowerPoint slide on why we use Dinámicas.

Related C3 Roles

Providing culturally appropriate health education and information, providing coaching and social support

Related C3 Skills

Interpersonal and relationship-building skills, communication skills

Method(s) of Instruction

Think, pair, and share

Estimated time

30 minutes

Key Concepts

Trust, communication

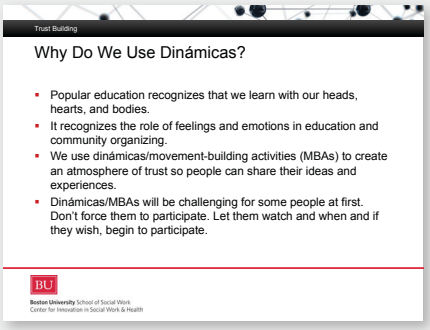
Materials

- Computer with projector
- PowerPoint slides
- Flip chart
- Markers
- PowerPoint

Handouts

- The Reporters

SLIDE 1



SLIDE 2

Review the slide.

"The Reporters"

Instructions: Please find a person in the room who you know the least. When you find your partner, interview that person like a reporter. You will ask the other person:

1. What is your name?

2. Where do you work and/or what community do you represent?

3. What is your hope for this training?

After all of the pairs have interviewed each other, we will come back together and each person will introduce their partner.

Building a Network of Community Partners

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand strategic partnerships
- Learn how to develop and maintain partnerships
- Know the various types of partnerships
- Identify the types of resources that people with HIV might want and need

INSTRUCTIONS

1. Prior to the session, review PowerPoint slides and handouts. Prepare two flip chart sheets: 1. Successful partnerships and 2. Challenges with partnerships. Place sticky notes in two colors on the tables along with markers.
2. Welcome participants and review objectives (slide 2).
3. Review how to implement partnerships and types of partnerships, and ask participants for examples from their work (slides 3–8).
4. Facilitate brainstorming activity about how to build partnerships (slide 9).
5. Discuss building a resource toolkit (slide 10) and complete handout.
6. Wrap up. Ask if participants have any final questions or comments. Reference the handout on building community resources and a network plan. Ask volunteers to share something they learned that they would use in their work with partners.

Resources

Boston University School of Social Work. Center for Innovation in Social Work and Health. 2019. *A Guide to Implementing a Community Health Worker (CHW) Program in the Context of HIV Care.* Boston, MA, ***https://ciswh.org/chw-impact-materials/***

Related C3 Roles

Building individual and community capacity, care coordination; case management and system navigation; cultural mediation among individuals, communities, and health and social service systems; advocating for individuals and communities; conducting outreach

Related C3 Skills

Capacity building, service coordination and navigation skills, advocacy skills, outreach skills, professional skills and conduct

Method(s) of Instruction

Lecture, small group activity, brainstorm

Facilitator's note: This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

60 minutes

Key Concepts

Community partners, community network, outreach, resources

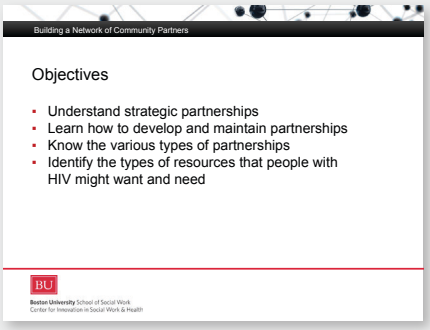
Materials

- Computer with internet connection and projector
- PowerPoint slides
- Sticky notes, preferably in different colors (blue and yellow)
- Flip chart
- Markers

Handouts

- Building a Network of Community Resources and Partners

SLIDE 1



SLIDE 2

Read the objectives.

SLIDE 3

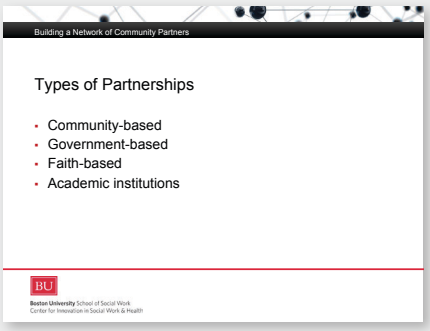
Ask for a volunteer to read the slide.

SLIDE 4

Read the steps to implementing partnerships.

Ask participants, "Would you add additional steps based on you experience?"

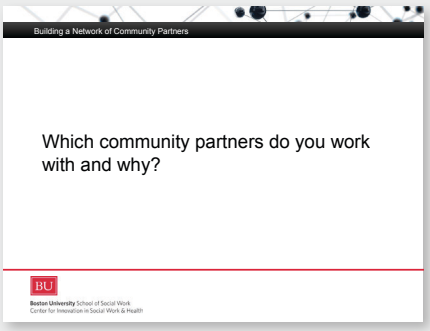
Write comments on the flip chart.



SLIDE 5

Read the slide.

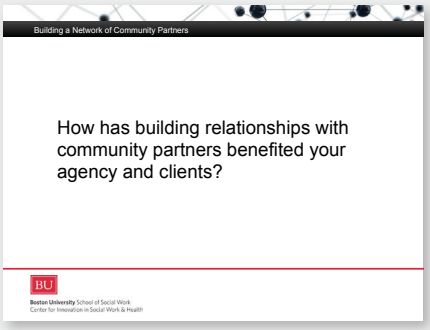
Ask participants if they have any examples to share from their work.



SLIDE 6

Ask participants the question on the slide.

Facilitate a brief discussion around the responses.



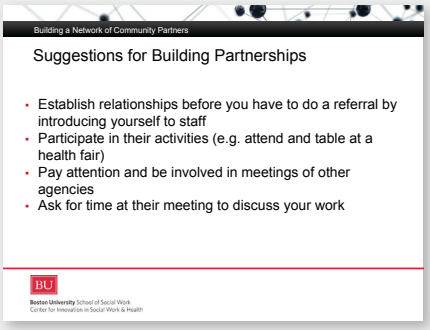
SLIDE 7

Ask participants the question on the slide.

Facilitate a brief discussion around the responses.

Share examples as needed:

- Applying for a grant together instead of competing as individual organizations.
- Strengthening communication between staff about client needs.



SLIDE 8

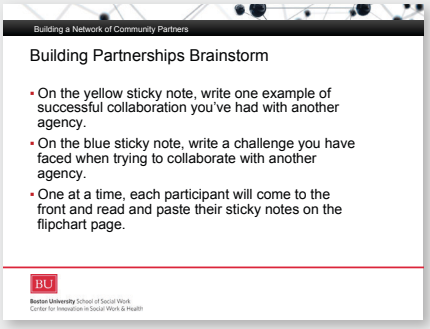
Talking points for this slide:

Be strategic: for example, different organizations can work together instead of competing for the same money.

Join forces with a community-based organization that may provide housing or medical care, that serves the same demographics and works towards same goals.

Form a contract of partnership—which organization will do what? For example, one organization provides housing and the partnering organization provide medical care (refer clients to one another).

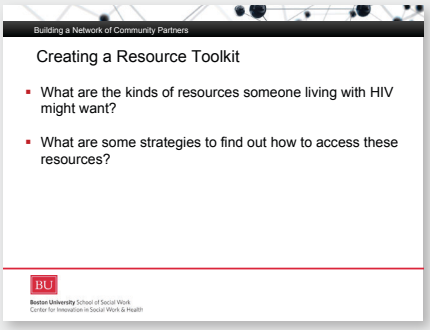
How do you bring your supervisors into these discussions? It is the supervisor's and director's job to form relationships. CHWs make it happen, they are the feet on the ground. CHWs may start to do some of these things as their experience grows but not at the beginning. You will learn more as you go along.



SLIDE 9

Ask participants:

- Who took the lead in this relationship and what part did they play?
- Are there new relationships for your agencies because of your work?
- Are there CHWs or navigators in your agencies who you've built relationships or collaborated with?



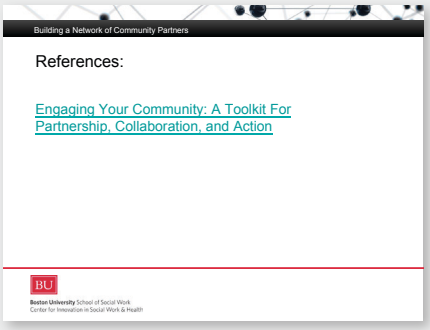
SLIDE 10

Ask the participants the questions on the slide.

Facilitate a brief discussion around the responses.

Distribute the handout: Building My Community Resources and Network Plan. Give participants 10 minutes to complete the form. Ask for volunteers to share their responses with the group. Review each question.

Invite participants to review the form with their supervisor at another time. Also, encourage them to use the community needs assessment in the implementation guide resource as a reference when assessing their community's strengths, needs, and resources.



SLIDE 11

Share the toolkit reference.

https://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14333&lid=3

Building a Network of Community Resources and Partners

Participant name: _____

What resources in my community are important for my clients to access? Which organizations provide those resources? List resources and agencies:

What might be some barriers to helping clients access those resources?

How can I help clients address those barriers?

Which organizations do I already have relationships with?

Which organizations do I need to build relationships with? How will I reach out to them? Is there someone who can connect me with their staff?

What types of support do I need from my agency in order to build relationships with these community partners?

Acknowlegements

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (https://ciswh.org/resources/HIV-peer-training-toolkit) and the Community Capacitation Center, Multnomah County Health Department (https://multco.us/health/community-health/community-capacitation-center)

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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30462 "Improving Access to Care: Using Community Health Workers to Improve Linkage and Retention in HIV Care" ($2,000,000 for federal funding). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Suggested Citation:

Boston University Center for Innovation in Social Work & Health. (2019). A Training Curriculum for Using Community Health Workers to Improve Linkage and Retention in HIV Care. Retrieved from: http://ciswh.org/chw-curriculum

BOSTON UNIVERSITY

Boston University School of Social Work
Center for Innovation in Social Work & Health

Case Conferencing

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand the purpose of a case conference
- Describe the difference between case coordination and case conferences
- List some practical things to consider when organizing a case conference
- Be aware of general documentation principles related to case conferences
- Identify what their site does to incorporate CHWs into the case conference process

INSTRUCTIONS

1. Prior to the session, review the PowerPoint slides and handout. Prepare a flip chart sheet with the header: Example of Case Conferences.
2. Welcome participants and review the objectives (slide 2).
3. Review definitions of case conferences vs. case coordination and facilitate brief discussion as indicated in slide notes (slides 3–5).
4. Review slides on options for case conferences, how they are used, why one would be held, and why it would be documented in a client's record. Ask questions and facilitate brief discussion as indicated in slide notes (slides 6-10). Note responses from participants on flip chart. Review slide 8 and ask "Why do we document case conferences?" Distribute Handout "Example Case Conference form."
5. Ask, "How do you prepare for a case conference?" Review slides on how to prepare for a case conference (slides 11–12). Review slide 13 for points to cover during a case conference.
6. Review slide on what to do during and after a case conference (slides 13–14).
7. Wrap up. Ask if there are any final questions. Ask participants to each identify a key message they learned from this unit. Thank participants for their contributions.

Related C3 Roles

Care coordination, case management, and system navigation; providing coaching and social support; advocating for individuals and communities

Related C3 Skills

Communication skills, interpersonal and relationship-building skills, service coordination and navigation skills

Method(s) of Instruction

Lecture, small group and dyad practice, site-specific discussions.

Facilitator's note: Ideally an experienced CHW and supervisor present as a team.

Estimated time

2 hours

Key Concepts

Case conference; service coordinator; patient plan

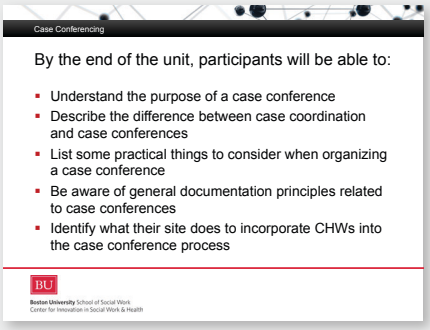
Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Handout

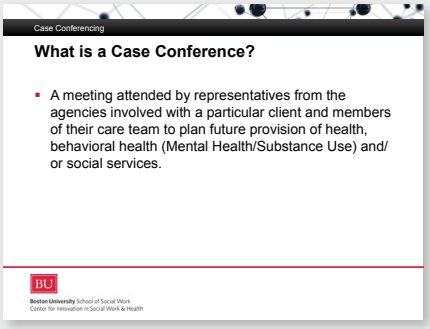
- Example Case Conference Form

SLIDE 1



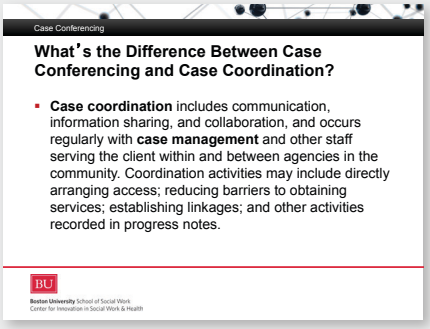
SLIDE 2

Review the slide.



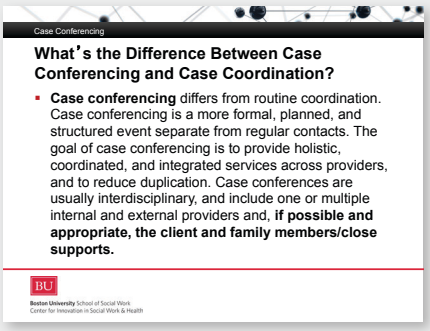
SLIDE 3

Review the slide.



SLIDE 4

Review the slide.

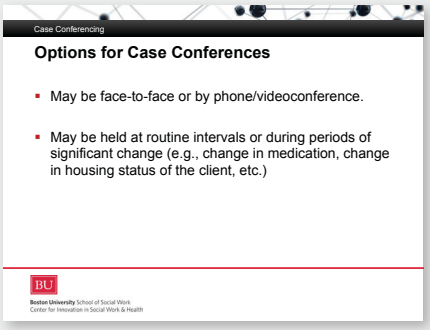


SLIDE 5

Review the slide.

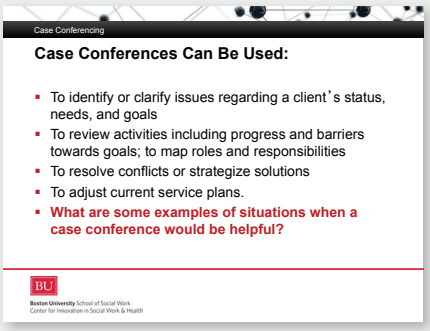
Ask, "What do you notice are differences between the two?" Write responses on flip chart.

Ask, "How many people in your agency participate in case conferences? Case coordination?"



SLIDE 6

Review the slide.

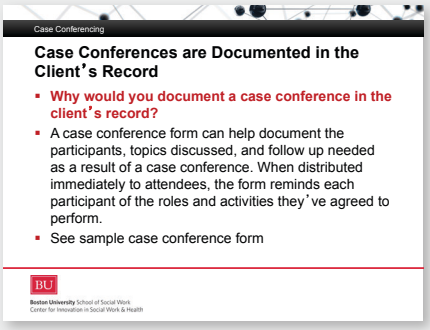


SLIDE 7

Review the slide.

Ask, "What are some examples of situations when a case conference would be helpful?"

Note responses on flip chart.

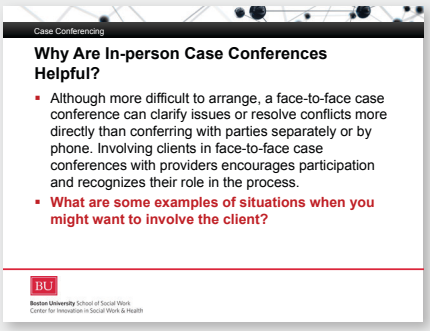


SLIDE 8

Ask, "Why would you document a case conference in the client's record?"

Write responses on flipchart.

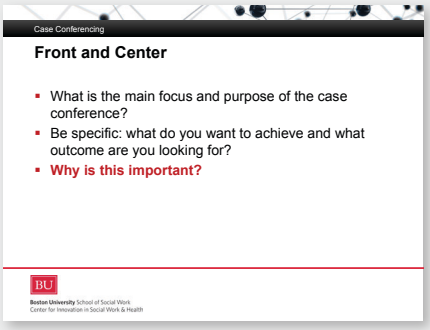
Review the slide.



SLIDE 9

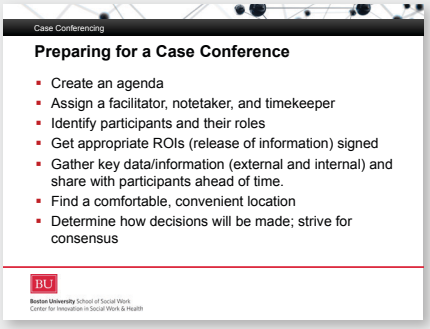
Review the slide and ask, "What are some examples of situations when you might want to involve the client?"

Write responses on flip chart.



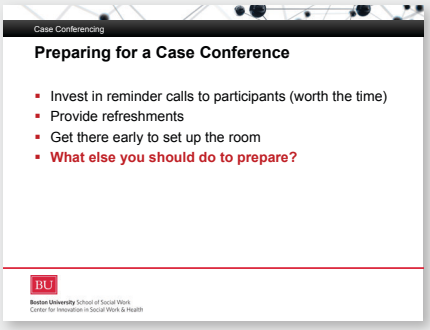
SLIDE 10

Review the slide and facilitate a discussion, writing responses on flipchart.



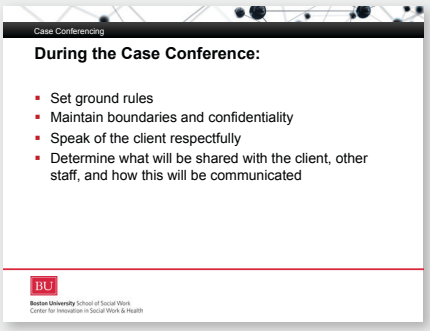
SLIDE 11

Review the slide.



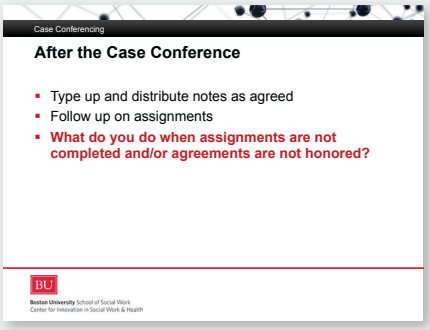
SLIDE 12

Review the slide.



SLIDE 13

Review the slide.



SLIDE 14

Review the slide.

Ask, "What do you do when assignments are not completed and/or agreements are not honored?"

Examples to note:

1. If you can't follow up as the CHW, or if you have trouble with a partner or team member, talk with your supervisor to make a plan.
2. If the client is not following through, ask your supervisor for advice. During your next meeting with the client, bring the case conference agreement and the care plan and discuss openly what next steps would be realistic for the client.

Example Case Conference Form

Client Name:	**Chart #:**
Organizer:	**Case Conference Date:** **Time:**
Client to be present at meeting **Yes ❒ No ❒**	**Meeting Location:**

Case Conference Participants & Title	Agency & Phone	Signed ROI	Phone or In Person
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒
		Yes ❒ No ❒ NA ❒	In Person ❒ Phone ❒

Purpose of case conference:
Brief assessment of client status and unmet needs:
Progress in current service plan and/or other notes:

ACTION PLAN ASSIGNMENTS FOLLOWING CASE CONFERENCE MEETING (Track actions)

Individual/Agency	Action Item	Due Date	Follow Up Notes

Organizer Signature & Date:

_____

Supervisor Signature & Date:

_____

Defining the Multidisciplinary Care Team

OBJECTIVES

At the end of this unit, participants will be able to:

- Describe the characteristics of the multidisciplinary care team
- Compare the traditional approach versus the multidisciplinary approach to health care
- Identify the roles of multidisciplinary care team members

INSTRUCTIONS

1. Before the session, review PowerPoint slides and notes. Print out copies of slide 9—the blank table with multidisciplinary team roles—for small group activity.
2. Welcome participants, review the session's objectives, and ask questions about multidisciplinary teams (slide 2).
3. Review characteristics of a multidisciplinary care team in the clinic setting (slides 3–4).
4. Review the traditional vs. multidisciplinary approach (slides 5–8). Ask questions and write responses on flip chart.
5. Facilitate activity: Role of Multidisciplinary Team Members (slide 9).
6. Wrap Up. Review answers on slide 10, noting the similarities and differences in team member roles when compared to the participants' responses. Ask participants to share what they learned from this session that they could apply to their teams.

Related C3 Roles

Care coordination, case management and system navigation

Related C3 Skills

Communication skills, interpersonal and relationship building skills, service coordination and navigation skills

Method(s) of Instruction

Lecture, group discussion, small group activity

Facilitator's note: This session can be delivered to both CHWs and supervisors together.

Estimated time

30 minutes

Key Concepts

Team, multidisciplinary

Materials

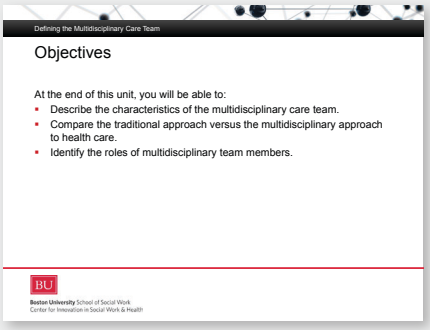
- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Resources

Role of Multidisciplinary Team Tasks ***https://ciswh.org/wp-content/uploads/2016/05/HIV-peer-training-core-peer-role2.pdf***

Allen, C. G., Escoffery, C., Satsangi, A., & Brownstein, J. N. (2015). Strategies to Improve the Integration of Community Health Workers Into Health Care Teams: "A Little Fish in a Big Pond." *Preventing Chronic Disease, 12,* E154. ***http://doi.org/10.5888/pcd12.150199***

SLIDE 1

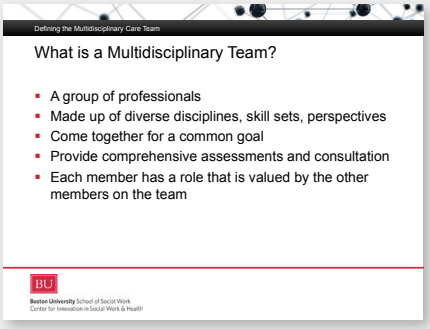


SLIDE 2

Review the objectives.

Ask, "What is your experience with care teams in your organization? What are the characteristics of a multi-disciplinary care team?"

Write answers on flip chart.



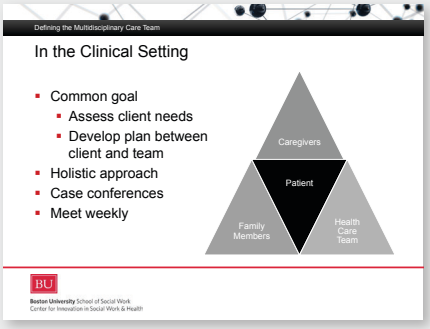
SLIDE 3

Let's review the basic characteristics of a multidisciplinary care team.

Review the slide or ask for volunteer readers.

Share the following observations about multidisciplinary care teams:

- Multidisciplinary teams are groups of professionals from diverse disciplines who come together to provide comprehensive assessments and consultation for a common goal (client/patient).
- Multidisciplinary teams members do not have to be all located at the same agency/clinic, but are connected in the provision of services to the same client/patient.
- Multidisciplinary teams are more prominent in health care: hospitals, clinics, and at social services agencies. They are also present in nonprofit, community-based organizations and state funded agencies.
- Multidisciplinary teams are present in the business field and at schools, but often times the title of the team is different; however they include professionals from diverse disciplines coming together to provide assessments for a common purpose. An example in business would be a proposal to bid on a construction job where the marketing department, sales, mechanical and electrical engineers, and other team members would be involved. Another example is in a school setting, where helping a student excel could include the school counselor, the school nurse, and the home room teacher.



SLIDE 4

Let's focus on multidisciplinary teams in the clinical setting.

- The goal of the team is to assess a client's needs and develop a care plan.
- Teams take into consideration the whole person and all their needs. This requires different perspectives from diverse disciplines. Diverse disciplines include social workers, case managers, physician, nurses, psychiatrist or mental health representatives, peer educators, and others depending on the number of disciplines/services offered at the hospital or clinic.
- Multi-disciplinary team meetings typically occur in HIV clinics.
- Ask, "How many of you typically meet as team with physicians, nurses, case managers, or maybe even behavioral health specialists or nutritionists?"
- Ask, "How often does the multi-disciplinary team meet?"
- Note that many teams meet at least weekly, some monthly, some have daily huddles.

Ask, "Who is invited to team meetings? How do you determine which cases to discuss at team meetings?"

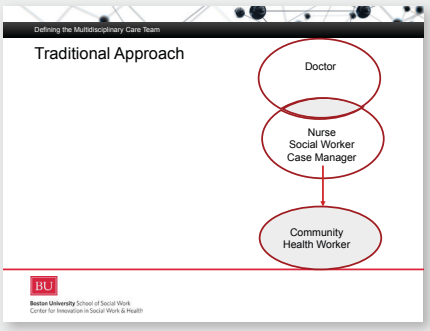
Points to share:

How the team decides which case to conference varies. Some cases maybe chosen because of multiple agencies involved in providing services to the client, the client is at risk of losing housing or insurance, the client has not had a case conference in six months, or the client is coming in for a medical appointment and there is suspicion of substance abuse that is affecting adherence to medications, etc.

Ask, "How can CHWs and supervisors prepare for case conferences and team meetings?"

Points to share:

All disciplines are encouraged to share information they know about the case to support a holistic assessment and explore options for resolution at the client case conference.

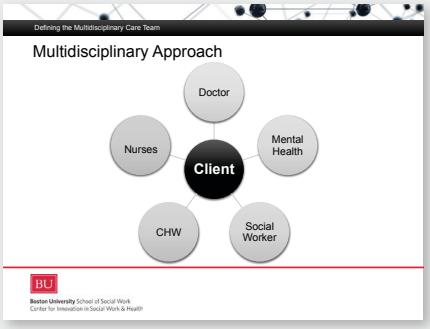


SLIDE 5

Now that we have defined the characteristics of a multi-disciplinary team, let's focus on how working in teams changes our approach when working with clients and other team members. We'll do this by comparing the multidisciplinary approach to a traditional approach to care.

Ask, "What are the characteristics of a traditional approach?"

Points to share: In the traditional approach, usually the team consists of the doctors, nurses, and social workers who give direction to the CHW. Not much information is shared across the team members. The approach to service delivery is not considered to be holistic.



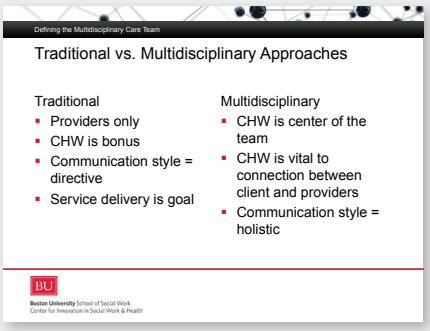
SLIDE 6

Review the slide.

Ask, "How is the multidisciplinary approach different from the traditional approach?"

Points to share:

- In the multidisciplinary approach we see that the client is at the center with all disciplines, including the CHW, sharing information and providing a team approach to delivery of services.
- The CHW is vital to the connections between the client and the multiple service providers.

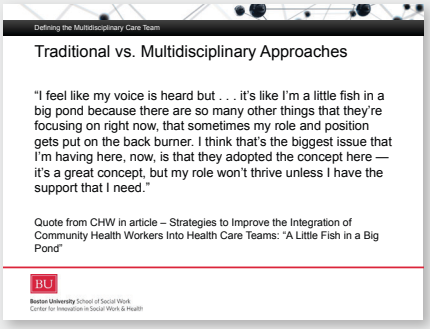


SLIDE 7

Now, let's compare the and contrast the difference between the two approaches.

Ask participants the following questions and facilitate discussion.

- What are the major differences between the traditional approach versus the multi-disciplinary approach of collaborating with clients?
- What are some of the benefits to the multidisciplinary approach?
- What could be some challenges in working as a team?



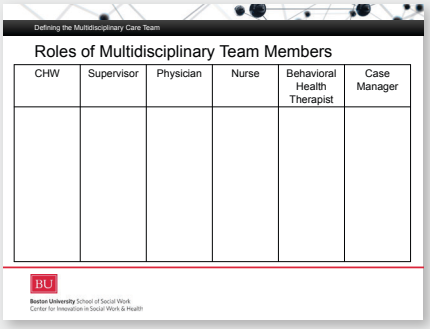
SLIDE 8

Ask a volunteer to read the quote.

Ask, "Is this something a CHW from your organization might say? Why or why not?"

Ask, "How do you ensure that each discipline's role on the multidisciplinary team is valued?"

Write responses on flip chart.



SLIDE 9

Roles of Multidisciplinary Team Members Activity

Say, "We will now do an exercise on defining the roles of multidisciplinary team members. Understanding the roles of co-workers is essential for a multidisciplinary team to work well together."

Break into small groups.

Give each group a flip chart sheet and markers, and a copy of this slide. Ask the group to make a table like the one shown on the slide.

Each group will identify tasks for each team member. Have one person in each group write the tasks on the flip chart sheet. Remind participants that some tasks will be shared and some will be unique to that team member. Groups should put a star next to shared tasks.

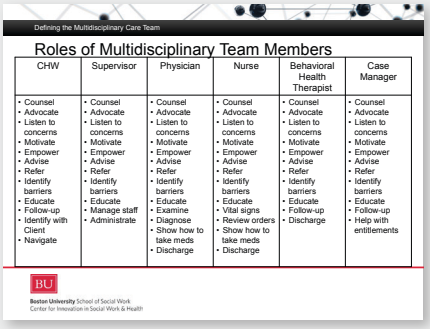
Remind participants that since we have already spent time on the CHW's role, they should do that part quickly and then spend most of their time on the other team member's roles.

Allow 15 minutes for the groups to write down their responses.

Ask the groups to present their lists.

Discuss any differences in the assignment of tasks between the groups.

Ask participants to comment on tasks that are shared by different team members (e.g. "listen to patient concerns") as well as tasks that are unique to CHWs or medical personnel. Mark shared tasks among all job titles with asterisks using colored markers. Then emphasize unique tasks for CHWs.



SLIDE 10

Share the activity answer key. Note similarities and differences between the answer key and the participants' versions of the chart. Note that answers can differ depending on the organization.

Patient Navigation

OBJECTIVES

At the end of this unit, participants will be able to:

- Describe the purpose and elements of patient navigation meetings
- Share how patient navigators can help clients access necessary services
- Know which forms are needed to track patient navigation activities

INSTRUCTIONS

1. Prior to the session, review the slides and resources. Review the resource HRSA HAB Dissemination of Evidence Informed Interventions: Enhanced Patient Navigation for Women of Color with HIV: Modules 1, 2, 4. If desired, print out copies of the handouts: Care Plan and Acuity Tool. Adapt slides that may be relevant for your training programs, such as slides 4–7 in Module 2
2. Welcome participants and review the objectives (slide 2).
3. Review CHW Proactive Roles and Responsive Roles and how they impact the continuum of care. (slide 3).
4. Facilitate a discussion about roles at participants' agencies (slide 4–7).
5. Share samples forms (care plan and acuity tool) that CHWs may use when performing navigation roles. Ask participants to share any forms and describe how they document their work with clients at their agency.
6. Explain that participants do not have to use these specific forms, but they are a tool that is available online to help document work if you do not already have a method in place. They can also inspire you to improve your methods for higher quality outcomes.
7. Wrap up. Navigation is one of the roles of a CHW and affects the continuum of care by helping clients with access and retention in primary care, as well as support in secondary and tertiary care.

Related C3 Roles

Care coordination, case management, and system navigation; providing coaching and social support; providing direct service; implementing individual and community assessments

Related C3 Skills

Interpersonal and relationship skills, communication skills, capacity building skills, education and facilitation skills, documentation skills

Method(s) of Instruction

Lecture, group discussion

Facilitator's note: This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

95 minutes

Key Concepts

Continuum of care, navigation, care delivery

Materials

- Computer with internet access and projector
- PowerPoint slides

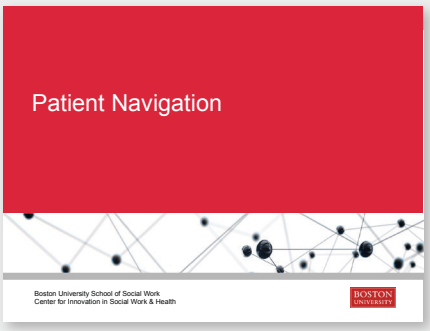
Handouts

- Care plan (optional)
- Acuity tool (optional)

Patient Navigation

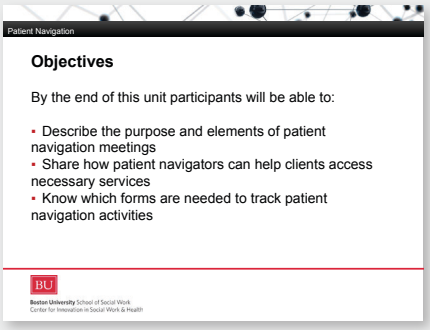
Resources

- Video: HRSA HAB Dissemination of Evidence Informed Interventions/AIDS United Treatment Tips *https://www.youtube.com/playlist?list=PLmeLn9qRyk-hdU_ueS_QQCY8wHkKLqN0g*
- HRSA HAB Dissemination of Evidence Informed Interventions: Enhanced Patient Navigation for Women of Color with HIV: Modules 1, 2, 4 available at: *https://targethiv.org/library/dissemination-evidence-informed-interventions-2017*
- A Guide to Implementing a Community Health Worker (CHW) Program in the Context of HIV Care. Available at: *https://targethiv.org/library/hiv-chw-program-guide*



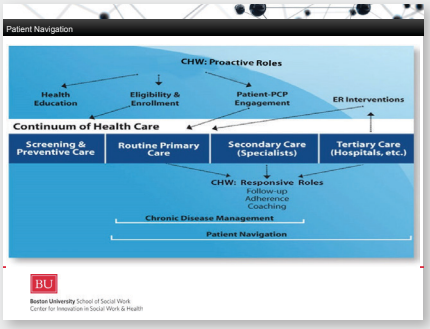
SLIDE 1

Welcome participants.



SLIDE 2

Review the objectives.



SLIDE 3

Let's take a look at the care continuum and what areas patient navigation influences.

This diagram reflects the key components of care: Screening and preventive care, routine primary care, secondary care (specialist), and tertiary care (hospitals). The CHW roles are separated into two categories:

Proactive roles

- Health education
- Eligibility and enrollment
- Patient and PCP engagement
- Emergency room interventions

Responsive roles

Follow-up, Adherence, and Coaching

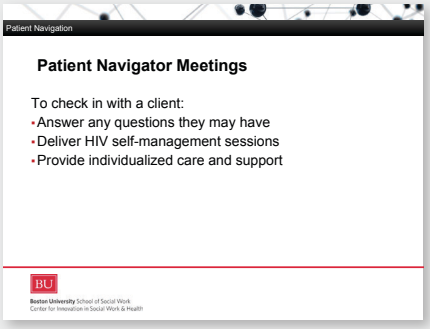
- Routine primary care
- Specialty care
- Tertiary care (e.g., hospitals)

The two areas that chronic disease management falls under are:

- Routine primary care: working with clients on adherence, making appointments, and reaching their health care goals on their care plan.
- Tertiary care: supporting clients in hospice situations, end stage liver disease and hospitalization transitions.

Patient navigation encompasses both of these, plus secondary care which might entail escorting a client to specialty appointments and understanding instructions from the PCP, or helping form questions they can ask the PCP. These roles are responding to the needs and goals of the client. Proactive roles are those supportive roles that help the client gain access to and navigate the health systems.

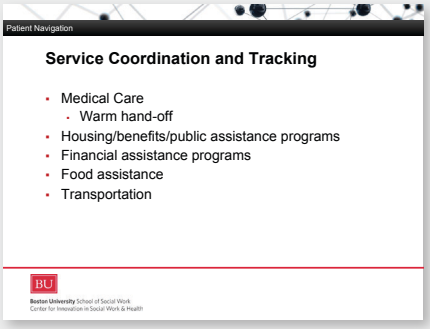
Ask, "Considering this diagram what roles are you playing at your organization?"



SLIDE 4

Tell participants: These meetings are where you bond and gain trust with the client as you support them in identifying and developing health-related goals, as well as answer their questions and clear up myths that they may have using your communication skills such as motivational interviewing.

Ask Participants, "Do you perform these tasks at your organization, or does someone else?" "How do you perform these activities?" "How do you document and track your meetings with a client?"



SLIDE 5

Tell participants: These are some of the services that you as a CHW may perform and help a client navigate the service system in addition to linking and staying in medical care. You may work closely with the care team and other community partners to communicate client needs that may arise out of these meetings in order to support them in reaching their goals and increasing their investment in their health outcomes.

Ask Participants, "Do you perform these tasks at your organization, or does someone else?" "How do you perform these activities?" "Who do you contact?" "How do you document and track your work with clients on obtaining services?"

Write participant responses on a flip chart and note similarities and differences.

SLIDE 6

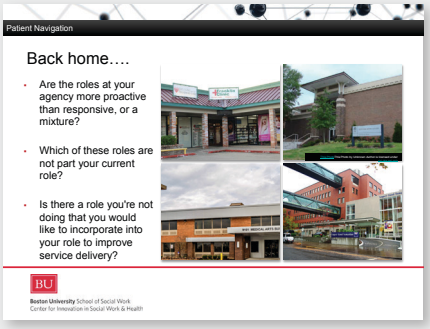
Tell participants: The need for assistance will vary from client to client. Some will require more support than others, especially in the beginning. You may have to physically escort or accompany them to appointments at first; that might be a good opportunity to educate a client about scheduling, identifying types of reminders that work best, and assisting them in setting up appointments. Remember, always make time for documentation as soon as possible after the visit and review the care plan and update what was and wasn't accomplished.

Ask participants, "Do you perform these tasks at your organization, or does someone else?" "How do you perform these activities?" "Who do you contact?" "How do you document and track your work with clients on obtaining services?"

Ask participants, "Do you perform patient education?" If yes how for volunteers to share how they educate materials on what topics and what materials they use.

Share with participants: the video clips from AIDS United HRSA DEII initiative that can be used to educate clients.

Write participant responses on a flip chart and note similarities and differences.

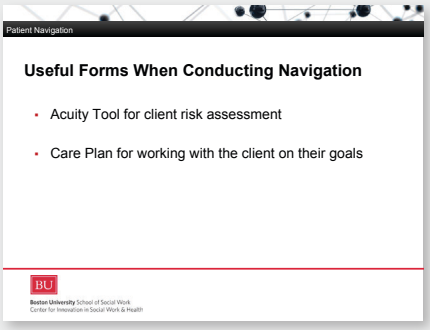


SLIDE 7

Review the slide.

Break participants in to groups of 3–4 persons. Ask them to discuss the 3 questions on the slide for about 15 minutes.

Bring participants back and ask them to share what they learned from each other.

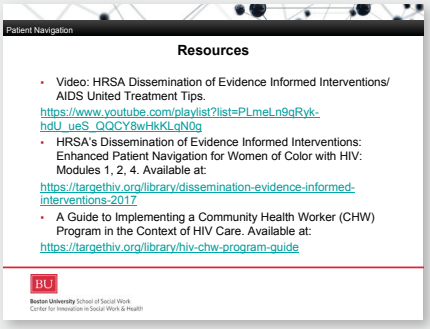


SLIDE 8

In the HRSA Dissemination of Evidence Informed Interventions: Enhanced Patient Navigation for Women of Color with HIV tool kit you will find useful forms to help track client progress and health outcomes.

Ask participants if their agencies has forms they need to complete and how they document their services. Ask if they have access to the patients electronic medical record or paper chart. Note responses on a flip chart.

Tell participants: Whether your work is proactive or responsive, remember to schedule regular meetings with the client, take care to communicate changes and progress to your team, and document all the work you do concerning the client.



SLIDE 9

Share the resources with participants and wrap up the session.

Sample Care Plan I

CHW Care Plan Protocol

Each **care plan** with include a health goal to include the following:

- The team agreed on incorporating a team approach in following each client which will promote a health network with the goal of VLS, RIC and VLS

The following **interventions** will be incorporated to assist that client achieve goals:

- BHC consult (phone visit if necessary)
- PharmD appointment (phone visit if necessary)
- MCV
- Educational module
- Weekly contact via call or text. Efforts to contact the patient will be documented
- Quarterly cross checks and balances from teammate to check in with client to make sure things are going well and to offer assistance if needed.
- Client will receive a thank you card with affirmation if meeting goals

0-6 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA	CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA
INTERVENTION 1. Bi-weekly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Conduct home visit 3. Reassess client for barriers & explore options to overcome the identified barriers 4. Reinforce previous goals 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate

NOTE: The BHC, PharmD and provider visits should occur within 6-8 weeks of the LTCM assessment

The team will celebrate milestones and achievements with the client.

6-9 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Home visit from LTCM and CHW 3. Reassess client for barriers & make referral to community agency 4. Call from provider w/concerns re: NVLS & NRIC 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate to include interventional assessment
9-12 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 6. MCV 1. LABS 2. PharmD visit (by phone if needed) 3. VLS, RIC and TA 4. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a certificate and gift bag to CELEBRATE this milestone and affirming them.	INTERVENTION 1. Readiness for change assessment 2. Monthly check-ins 3. Educational Modules if it is determined that the client is ready 4. Quarterly cross checks & balances by teammate to include interventional assessment 5. Place client on an inactive list if it is determined that the client is not ready

12-18 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins for 12-18 months. At the 18 month mark the client will be contacted bi-monthly. 2. RWE/ADAP reminder 3. Continue with modules & client goals 4. Re-evaluation/screening 5. Appt reminders 6. Quarterly cross checks & balances by teammate 7. Client will receive a card celebrating milestones with affirmations.	INTERVENTION 1. Continue monthly check-ins 2. Place client on an inactive list if it is determined that the client is not ready

Source: East Caroline University Adult Specialty Care Clinic

Sample Care Plan II

Southern Nevada Health District
Case Management
Ryan White Program
Client Service Plan

Client Name:		
Problem/Need **Goal:**	**Intervention:**	**Progress Note: Date/Note**
Linkage to Medical Care	**Client will:** **Case manager will:** **CHW will:**	
Linkage to Community Assistance	**Client will:** **Case manager will:** **CHW will:**	

I have read, understand and agree with the above service plan. Signing below indicates that you have read, understand and will comply with the terms above. Your signature also verifies that you have received a copy of your service plan.

Client Signature:		**Date:**	
Case Manager Signature:		**Date:**	
CHW Signature:		**Date:**	
Other/Signature:		**Date:**	

Ryan White Part A Client Acuity Tool

Las Vegas TGA Ryan White Part A HIV AIDS Program

Client Name _____ Date _____

☐ Initial Assessment ☐ Follow-up Assessment

Barriers	**Level 0-1** "0"-no intervention needed. "1"-short term, focused, education/support/referrals.	**Level 2** "2" multiple barriers, provide education/support.	**Level 3** "3"-Multiple, complicated barriers, and/or is in crisis.	**Level**
Housing	Stable, clean housing.	Requires short term assistance with/rent, utilities.	Homeless, shelter resident, or frequent moves.	
Finances	Steady, adequate source of income.	Income source is inconsistent or too low to meet basic needs.	Has no income. Is in financial crisis. Consistently unable to meet basic needs.	
Transportation Issues	Has own transportation to get to and from clinic visits.	Some difficulties with access to transportation.	Consistent problems with accessing transportation.	
Social Support/Family Issues	Dependable network/family/friends/partner .	Gaps in support system (family/friends periodically) Pregnant but adherent.	No stable support other than professionals. Family in crisis. Pregnant but not adherent. Fear of disclosure.	
Behavior	Functions appropriately in most settings.	Repeated incidences of inappropriate behavior.	Abuse or threats to others; lack of control.	
Communication Issues	Speak, read and understand English at an adult level.	Some difficulties with speaking, reading and understanding English.	Not able to represent themselves in English. Unable to read or write.	
Cultural Issues	Minimal system barriers	Requires some assistance acclimating to system.	Chooses not to/unable to acclimate to system.	
System Issues	Minimal system barriers.	Needs help accessing the system.	Distrust of system/not accessing services.	
Legal Issues	Client reports no recent or current legal problems; all pertinent legal documents completed.	Needs assistance completing standard legal documents; recent or current legal problems.	Involved in civil or criminal matters; incarcerated or recently incarcerated; undocumented immigrant; unaware of standard documents, i.e. living will.	
Mental Health Issues	No current mental health illness but has a history of mental illness, now stable.	Mild to moderate symptoms or disorders.	Severe symptoms/disorders; long history of mental disorders.	
Substance Use/Abuse	No current use and/or history.	History of abuse and/or intermittent abuse.	Chaotic life, regular substance abuse.	
Side Effects	On medication, having no side effects.	Minimal side effects affecting some quality of life.	Moderate to severe side effects affecting quality of life.	
Adherence History	Reports ability or willingness to adhere to medications.	Reports inconsistent ability to adhere to medications.	Reports inability to adhere to medications. Treatment naïve.	
Educational Issues	Has been informed, able to verbalize basic knowledge of the disease.	Some understanding of the disease.	No understanding of HIV disease. New diagnosis. <18 years of age.	
Medical Needs	Stable health; goes for periodic MD appointments and lab monitoring.	Needs primary care referral. Being seen by MD for short term illness.	Poor health; medical emergency; rapidly deteriorating; with opportunistic infections. Pregnant.	
Comments Section:			**Combined Total**	0

If a client scores a 3 in any life categories of Medical Needs, Educational Issues, or Adherence History, a referral to Intensive Medical Case Management is strongly encouraged. If a client scores a 3 in the life categories of Cultural Issues, Educational Issues, Social Support/Family Issues, Housing or Finances, a referral to Moderate Medical Case Management is strongly encouraged.

Client Level Acuity Guidelines:

Acuity Level	***Range***	***Case Management Level***	***Referral Criteria***
Life Area 0-1	15 Points or Less	Medical or Non-Medical Case Management	Self referral as needed
Life Area 1 & 2	16-30 Points	Intensive Medical Case Management-Social	Refer to appropriate community partners
Life Area 2 & 3	31 Points or Higher	Intensive Medical Case Management-Medical	Intensive Medical Case Manager to follow

Signature of Case Manager _____

HIV/AIDS Medical Case Management Acuity Tool Form
Massachusetts Department of Public Health
Boston Public Health Commission

Area of Functioning		Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Adherence to Medical Care and Treatment & HIV Health Status									
HIV Care Adherence		☐	Has missed 2 or more consecutive HIV medical appointments in the last 6 months	☐	Has missed 1 or 2 (non-consecutive) HIV medical appointments in the last 6 months but has been seen by member of HIV medical team	☐	Has attended HIV medical appointments in the last 6 months as indicated by HIV medical provider	☐	Has attended all scheduled HIV medical appointments in the last 12 months as indicated by HIV medical provider
		☐	Requires on-going accompaniment or assistance with medical appointments due to limited language or cognitive ability	☐	Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.)	☐	Needs assistance with making and keeping HIV medical appointments	☐	Does not require any assistance or reminders to schedule or keep medical appointments
Acuity Score:		☐	Has not been seen by HIV medical team in the last 6 months	☐	Requests accompaniments to medical appointments from MCM or other member of the care team				

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Current HIV Health Status	☐	Has detectable VL and CD4 below 200	☐	Has detectable VL and is working towards viral suppression with the medical team	☐	Is on ARVs, in care, and being monitored by medical team, but unable to achieve viral suppression	☐	Is virally suppressed
	☐	Has current OI and is not being treated	☐	Has history of OI in last 6 months which are treated and/or client using prophylaxis (if indicated)	☐	Has no history of OIs in last 6 months	☐	Has no history of OIs in last 12 months
	☐	Has been hospitalized or visited the ER in last 30 days due to HIV related illness	☐	Has been hospitalized or visited the ER in last 6 months due to HIV related illness	☐	Has had no hospitalizations or visited the ER in last 6 months, but at least 1 hospitalizations or visit to the ER in the last 12	☐	Has no history of hospitalizations or visits to the ER in last 12 months due to HIV related illness
	☐	Newly diagnosed within last 6 months and concurrently diagnosed with AIDS	☐	Newly diagnosed within the last 6 months and/or is new to the MCM program				
Acuity Score:	☐	Demonstrates no understanding of HIV labs and lab results	☐	Demonstrates minimal understanding of HIV labs and lab results	☐	Demonstrates some understanding of HIV labs and lab results	☐	Demonstrates understanding/ Knows of HIV labs and lab results

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Other Non-HIV Related Medical Issues	☐	Has been hospitalized or visited the ER for non-HIV related illness in last 30 days	☐	Has been hospitalized or visited the ER in last 6 months due to non-HIV related illness	☐	Has had no non-HIV related hospitalizations or visits to the ER in last 6 months, but at least 1 in the last 12	☐	Has no history of non-HIV related hospitalizations or visits to the ER in last 12 months
	☐	Has 2 or more non-HIV related illnesses (chronic or non-chronic) that impact health and care adherence	☐	Has a non-HIV related illness (chronic or non-chronic) that impacts health and care adherence	☐	Has no current non-HIV related medical issues, but past illnesses require monitoring by a medical provider	☐	Has no non-HIV related illnesses
	☐	Currently receiving treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living	☐	Currently recovering from treatment for non-HIV related medical conditions (e.g. chemo, dialysis, HCV, on-going dental complications, etc.) that impacts daily living				
	☐	Requires assistance to make and keep non-HIV related medical appointments due to language or cognitive ability	☐	Needs referral to or help accessing a culturally competent service provider (e.g. LGBT, linguistically appropriate, etc.) for non-HIV related medical issues	☐	Requests assistance with reminders for non-HIV related medical appointments	☐	No assistance needed for reminders for non-HIV related medical appointments
Acuity Score:	☐	Requires accompaniments to specialty medical appointments due to language or cognitive ability	☐	Requests accompaniments to specialty medical appointments from MCM or other member of the care team	☐	Requests assistance with coordinating non-HIV related medical care	☐	No assistance needed with coordinating non-HIV related medical care
Comments (include referrals needed):								

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
HIV Medication Adherence	☐	Misses HIV medication doses daily	☐	Misses HIV medication doses weekly	☐	Misses HIV medication doses monthly, or on occasion	☐	Rarely or never misses a dose of HIV medications
	☐	Needs and is not currently enrolled in directly-observed therapy (DOT) or other intensive adherence support	☐	Needs and is enrolled in DOT or other intensive adherence support				
	☐	Experiences adverse side effects that consistently impact adherence to HIV medication	☐	Experiences adverse side effects that occasionally impact adherence to HIV medication	☐	Experiences side effects, but manages them with no impact on adherence to HIV medication	☐	No side effect concerns reported
	☐	Demonstrates no understanding of correlation between medication adherence and achieving/sustaining viral load suppression	☐	Demonstrates minimal understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression	☐	Demonstrates some understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression	☐	Demonstrates full understanding of correlation between HIV medication adherence and achieving/sustaining viral load suppression
	☐	Demonstrates no understanding of basic health or prescription information (e.g. drug resistance, drug interactions, etc.) due language barriers or cognitive function	☐	Needs assistance to understand health and prescription information due to language barrier or cognitive function	☐	Needs some assistance to understand health and prescription information	☐	Manages health and prescription information with no assistance
	☐	Not on ARVS against medical providers advice	☐	Is starting new ARV treatment regimen	☐	Not on ARVs in consultation/support from medical provider	☐	On ARVs and does not need additional assistance
Acuity Score:	☐	Cultural beliefs around medication prevent client from taking medication as prescribed by medical provider						

Comments (include referrals needed):

Area of Functioning		Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Insurance									
Health Insurance & HDAP Status		☐	Lacks health insurance (e.g. MassHealth/Medicaid, no access to employer-based health insurance, outside open enrollment period for private insurance, with no "qualifying event", etc.)	☐	Has health insurance and needs but lacks HDAP coverage	☐	Has health insurance, HDAP and/or other health benefits, but requires support to maintain coverage and complete re-certifications	☐	Has health insurance, HDAP and/or other health benefits and requires no support to maintain coverage and complete re-certifications
		☐	Is ineligible for Masshealth or other comprehensive insurance coverage (e.g. receives Health Safety Net)	☐	Client is uninsured and is awaiting enrollment (pending applications) in health insurance and/or other health benefits.				
Acuity Score:		☐	Has health insurance, HDAP and/or other benefits, but faces significant deductibles and/or medical co-pays.						
Comments (include referrals needed):									

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Sexual and Reproductive Health Status								
Sexual and Reproductive Health Status	☐	Does not or is unable to communicate with sexual partner(s) around sex and sexual health needs (e.g. negotiating condom use, PrEP use, partner's health status, etc.)	☐	Inconsistently communicates with sexual partner(s) around sex and sexual health needs (e.g. negotiating condom use, PrEP use, partner's health status, etc.)	☐	Requests support to communicate with sexual partner(s) around sex and sexual health needs (e.g. negotiating condom use, PrEP use, partner's health status, etc.)	☐	Consistently communicates with sexual partner(s) around sex and sexual health needs (e.g. can negotiate condom use, PrEP use, partner's health status, etc.)
	☐	Has not disclosed HIV status to sexual partner(s) and does not plan to	☐	Sometimes discloses HIV status to sexual partner(s)	☐	Has not disclosed HIV status to sexual partner(s) and requests assistance to do so	☐	Always discloses HIV status to sexual partner(s)
	☐	Demonstrates no understanding of HIV/HCV/STI transmission, and/or no understanding of correlation between HIV transmission and viral load suppression	☐	Demonstrates minimal knowledge of HIV/HCV/STI transmission, and minimal understanding of correlation between HIV transmission and viral load suppression	☐	Needs occasional assistance understanding HIV, HCV, STI transmission and/or assistance understanding correlation between HIV transmission and viral load suppression	☐	Demonstrates understanding of HIV, HCV, STI transmission, and/or understanding of correlation between HIV transmission and viral load suppression
	☐	Reports at least 1 STI in the past 6 months	☐	Reports at least 1 STI in the past 12 months	☐	No history of STI in the past 12 months	☐	Reports sexual abstinence
	☐	Engages in transactional sex (e.g. for money, drugs, a place to stay, etc.)			☐	No disclosure of HIV status to sexual partner(s), but maintains a suppressed viral load	☐	Sexual partner(s) currently on PrEP
Acuity Score:	☐	HIV+ female not on treatment and pregnant or desires pregnancy	☐	HIV+ female on treatment and is pregnant or desires pregnancy				

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Mental Health								
Current Mental Health Status	☐	Clinical diagnosis with no current mental health provider, no pending appointments, no desire and/or is resistant to seek treatment	☐	Clinical diagnosis or otherwise engaged with a mental health provider, but inconsistent with appointment attendance and/or treatment adherence	☐	Engaged with a mental health provider and is consistent with mental health treatment and/or appointments	☐	No indication of need for clinical mental health assessment
	☐	Currently awaiting treatment or appointment with mental health professional	☐	Referral to a new mental health professional in the past 6 months	☐	Receives MCM support to make and keep appointments with mental health professional	☐	No support needed to make and keep appointments with mental health professional
	☐	Consistent challenges with adherence to prescribed psychiatric medicines or treatment protocol	☐	Moderate challenges with adherence to prescribed psychiatric medicines or treatment protocol (missed doses more than a few times a month)	☐	Some challenges with adherence to prescribed psychiatric medicines or treatment protocol (occasional missed doses)	☐	No challenges with adherence to prescribed psychiatric medicines or treatment protocol
	☐	Indication of need for mental health support, clinical mental health assessment, and/or treatment and does not receive it	☐	Needs referral to or help accessing a culturally competent mental health provider (e.g. LGBT, linguistically appropriate, etc.)				
Acuity Score:	☐	Behavior relating to mental health status negatively impacts daily living, interactions with providers, and/or other social supports	☐	MCM or other member of the care team is an integral part of mental health support (e.g. regular check-ins etc.)				

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Alcohol and Drug Use								
Current Substance Use	☐	Chronic daily drug or alcohol use or dependence that consistently interferes with adherence to HIV care and treatment and/or activities of daily living and expresses no desire for treatment (e.g. methadone, Suboxone, detox, etc.)	☐	Current or recent drug or alcohol use or dependence that sometimes interferes with adherence to HIV care and/or daily living	☐	Current or recent drug or alcohol use does not interfere with adherence to care, treatment, and/or activities of daily living but MCM assesses a need for additional support or regular check-in	☐	Current or recent drug or alcohol use that does not interfere with adherence to care, treatment, or activities of daily living.
	☐	Intermittent engagement in drug and alcohol treatment (e.g. methadone, Suboxone, detox, etc.)	☐	Currently in residential or in-patient treatment for drug or alcohol use	☐	Currently receiving treatment for drug and alcohol use in an out-patient setting	☐	Receives sufficient supports around past substance use and/or no indication of need for additional support
	☐	Expresses a need or desire for drug or alcohol treatment (e.g. suboxone, methadone, detox, etc.) but has not yet received it	☐	Currently on a wait list to receive treatment for substance use disorder	☐	Currently attends 12-step groups (e.g. AA, NA, etc.)	☐	No current or past issues with drug or alcohol use
	☐	Imminent harm associated with substance use and no engagement/interest in harm reduction practices (e.g. sharing needles, narcan, etc.)	☐	Experiences harm associated with substance use with minimal ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)	☐	Experiences harm associated with substance use with some ability to engage in harm reduction practices (e.g. sharing needles, narcan, etc.)	☐	No harm associated with current or past alcohol and drug use. Is able to engage in harm reduction practices (e.g. no needle sharing, carries narcan, etc.)
Acuity Score:	☐	Ongoing alcohol use in the context of liver disease (e.g., HIV/HCV co-infection etc.)						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Housing								
Current Housing Status	☐	Currently lives in shelter or any place not meant for human habitation (e.g. street, car, etc.)	☐	Has chronic challenges maintaining housing	☐	Lives in permanent or stable/safe housing but needs short term rent or utility assistance to remain housed	☐	Has stable and affordable housing that meets client's needs
	☐	Current living situation has major health or safety hazards or limits the client's ability to care for themselves	☐	Has difficulties managing ADLs (e.g. navigating stairs, showering) in current living situation	☐	Requests assistance from MCM to complete paperwork to maintain eligibility for housing subsidies		
	☐	Needs a referral to a supportive housing program and/or other in-home support services to remain safe in their home	☐	Currently resides in a supportive housing program	☐	Currently working with a MCM to maintain housing subsidy		
	☐	Is expected to be released from incarceration in the next 3 months or was released from incarceration within the last 6 months	☐	Lives in transitional/temporary housing or is doubled-up with no eminent loss of housing				
Acuity Score:	☐	Faces imminent eviction or loss of current housing	☐	Seeks to relocate in order to improve proximity to medical care, safety of housing environment, or access to services and supports	☐	Currently working with a housing search and advocacy case manager		

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Legal								
Current Legal Status	☐	Has urgent legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, disability, eviction, or CORI	☐	Has pending legal issues related to benefits access, discrimination, employment, health insurance coverage, housing, or disability (e.g. appeal for SSI)	☐	Needs assistance completing standard legal documents	☐	No current or recent legal issues
	☐	Has time-sensitive need to complete standard legal documents (e.g., will, guardianship, etc.)	☐	Needs linkage to services to address legal issues that impact ability to obtain needed services or benefits	☐	Currently working with a provider to address legal issues	☐	All desired legal documents are complete
	☐	Has issues relating to immigration status						
	☐	Currently on parole or probation						
Acuity Score:	☐	Has outstanding warrants						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Relationships and Support Systems								
Support Systems and Relationships	☐	Reports no close relationships, family, or supportive relationships	☐	Reports feeling isolated or unsupported in current relationships (e.g. family and friends)	☐	Reports having a support system, but identified need for regular check-ins from MCM	☐	Has satisfactory social support
	☐	Has not disclosed HIV status to any members of social support system due to stigma, language barriers, cultural beliefs around HIV, etc. which directly impacts social interactions	☐	Has disclosed HIV status to some members of support system which moderately impacts social isolation	☐	Has disclosed HIV status to most members of support system	☐	Has disclosed HIV status to all members of support system
			☐	Relies on MCM, peer, or other program staff for social support				
Acuity Score:		Reports current or potential intimate partner violence and needs immediate intervention	☐	Has experienced intimate partner violence in the past that impacts current relationships, financial situation, housing status, etc.			☐	Past experience with intimate partner violence does not impact present care

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Income								
Current Income/Personal Finance Management Status	☐	Has no stable income or benefits established and no identified source of financial support	☐	Income inadequate to meet basic needs at the end of every month for 3 or more months in a 6 month period	☐	Income occasionally (no more than 2 times in a 6 month period) inadequate to meet basic needs	☐	Has steady income; manages all financial obligations
	☐	Requires but does not receive public benefits such as SSI/SSDI and has no pending applications			☐	Requests support with benefits applications or other means to increase and manage income	☐	Receives benefits and requires no assistance with maintaining benefits
	☐	Receives no public benefits such as SSI/SSDI and is ineligible to receive them due to immigration status						
	☐	Has immediate need for financial assistance to stay housed, maintain utilities, obtain food, or access medical care	☐	Expenses currently exceed income	☐	Requests assistance with budgeting		
	☐	Needs referral to representative payee	☐	Currently uses a representative payee			☐	No need for representative payee
Acuity Score:	☐	Application for benefits such as SSI/SSDI have been denied or are under appeal						

Comments (include referrals needed):

Area of Functioning	Intensive Need (3)	Moderate Need (2)	Basic Need (1)	Self Management (0)
Transportation				
Current Transportation Status	☐ Has limited or no access to transportation which impacts engagement in medical care, appointments, and other support services	☐ Has PT-1 or agency transport vouchers/passes but requires MCM assistance to complete applications and/or maintain eligibility	☐ Relies on PT-1 or agency supported transportation vouchers or family/friend	☐ Has consistent and reliable access to transportation with no need for agency support
Acuity Score:	☐ Has limited language or cognitive functioning that limits ability to coordinate transportation		☐ Occasionally needs assistance with transportation to stay engaged in medical care	
Comments (include referrals needed):				

Area of Functioning	Intensive Need (3)		Moderate Need (2)		Basic Need (1)		Self Management (0)	
Nutrition								
Current Nutritional Status	☐	Relies on food pantries, soup kitchens or other community food resources on a weekly basis	☐	Relies on food pantries, soup kitchens, and other community food resources 1x per month or more	☐	Relies on food pantries, soup kitchens, or other community food resources less than 1x per month	☐	All nutritional needs are met and/or MCM assistance not needed to access food assistance
	☐	Needs immediate linkage to medical care due to acute problems related to low body weight, poor appetite, nausea, vomiting, or other urgent health issues that impact nutritional status	☐	Needs linkage to nutritional counseling to help manage chronic or non-urgent health issues that impact nutritional status	☐	Needs information about nutrition, and/or food preparation to improve or maintain health		
	☐	Needs a referral to obtain food related benefits (e.g. SNAP, WIC, etc.)	☐	Receives food related benefits (e.g. SNAP, WIC, etc.) to meet nutritional needs for self or household	☐	Needs assistance completing applications to maintain current food related benefits (e.g. SNAP, WIC, etc.)		
	☐	Is ineligible for food related benefits (e.g. SNAP, WIC, etc.)	☐	Relies on access to an agency food program in order to obtain adequate food				
Acuity Score:			☐	Needs and is prescribed nutritional supplements to maintain health (e.g. Ensure)				

Comments (include referrals needed):

Summary & Signatures

Acuity Score:		Level of Need	(1-14) Basic Need
Client Code:			
MCM Name:			
MCM Signature:			

Success and Barriers to Collaboration

OBJECTIVES

At the end of this unit, participants will be able to:

- Use specific strategies to build partnerships with agencies and groups

INSTRUCTIONS

1. Prior to the session, prepare flip chart sheets with the headings: Challenges to Collaboration, Trust Building, and Reflection on Strategies.
2. Explain that now we will spend time discussing some of our own successes in collaborating with other agencies and some of the barriers to collaboration.
3. Hand out yellow and green sticky notes and a marker to each participant. Ask participants to write one thing that has helped them build trust and collaborate with community partners on the yellow note. On the green note, ask them to write one challenge they have experienced when collaborating with community partners. Ask participants to keep the agencies anonymous.
4. Ask each individual to read their notes aloud and place them on the corresponding flip chart sheets (Challenges to Collaboration, Trust Building).
5. Ask, "What are some strategies you have used to build and maintain relationships with other agencies? How have you navigated challenges to collaborating with other agencies?" Write answers on the Reflection on Strategies flip chart sheet.
6. Review tips for building relationships with agencies if they were not stated by the participants (slide 3).
7. Wrap Up. Thank everyone for sharing and explain that even though there are challenges and barriers to collaboration, one of the roles of a CHW is to collaborate across agencies to promote the well-being of the people they work with by ensuring that they are provided with culturally appropriate and accessible care.

Related C3 Roles

Care coordination, case management, and system navigation; cultural mediation among individuals, communities, and health and social service systems; advocating for individuals and communities; conducting outreach

Related C3 Skills

Service coordination and navigation skills, advocacy skills, outreach skills, professional skills and conduct

Method(s) of Instruction

Individual work, group discussion, brainstorm

Estimated time

30 minutes

Key Concepts

Collaboration, barriers, relationship building

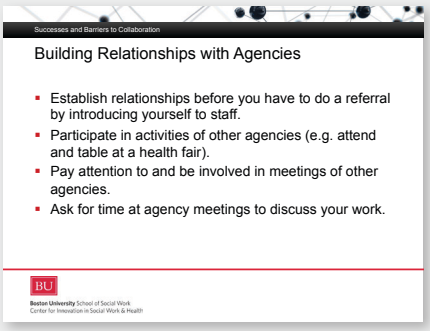
Materials

- Computer with internet access and projector
- PowerPoint slides
- Sticky notes in different colors (e.g. green and yellow)
- Flip chart
- Markers

SLIDE 1

SLIDE 2

Review the objectives.



SLIDE 3

Mention the following points about how to build relationships with agencies if they were not stated by the participants.

Empowering Leadership: Orientation to Power

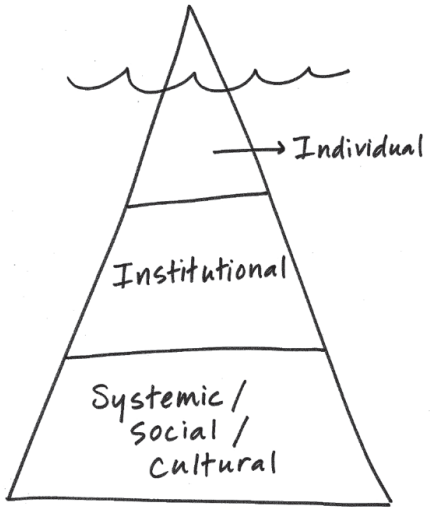
OBJECTIVES

At the end of this unit, participants will be able to:

- Name three levels at which power operates
- Describe four different models of leadership
- Identify and apply qualities and skills of an empowering leader

INSTRUCTIONS

1. Before the session begins, draw the following diagram about levels of power on flipchart paper.



2. Review objectives and session overview (slides 2–3)
3. Orientation to Power (15 minutes)
   - Review slides on definition of power and where power operates (slides 4–5).
   - Power plays out at three different levels in our society (show graphic drawn on flipchart paper). Lead a discussion about examples at each level and write them on the diagram.
   - Individual/interpersonal: Attitudes and behaviors can be intentional or unintentional. Ask, "What are examples of how power/privilege impacts people with HIV on an individual level?"

(continued)

Related C3 Roles

Building individual and community capacity, cultural mediation among individuals, communities, and health and social service systems

Related C3 Skills

Communication skills, interpersonal and relationship-building skills, capacity-building skills, advocacy skills, professional skills and conduct

Method(s) of Instruction

Brief presentation, brainstorming, small group activity, individual writing

Estimated time

90 minutes

Key Concepts

Power, systemic, institutional, individual, attitudes, behaviors, intentional, unintentional, authoritarian, paternalistic, participatory, empowering

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flipchart sheets
- Markers

Handouts

- Leadership Styles: Four Models
- Expressions of Power
- Empowering Leadership Scenarios
- Community Health Worker Skills
- Community Health Worker Qualities
- Characteristics of Empowering Leadership
- My Leadership Commitment Card

Empowering Leadership: Orientation to Power

INSTRUCTIONS (continued)

- Institutional: Privilege and/or oppression are enacted through laws, policies, procedures and practices within institutions and organizations (intentionally or unintentionally). Ask, "What are examples of how power/privilege impacts people with HIV on an institutional level?"
- Systemic/social/cultural: Values, beliefs, and norms create what's "right" and "normal" in society. The interplay of policies, practices, and programs of differing institutions enact privilege or oppression. Ask, "What are examples of how power/privilege impacts people with HIV on a systemic or socio-cultural level?"
- Say that we can think of this image as an iceberg. Often what we see and focus is on are the individual ways power, privilege, and oppression are enacted in our society. However, the systemic ways that power, privilege and oppression play out create the foundation for individual experiences of privilege and oppression.
- Ask, "How do you think power relates to how we understand and practice leadership?"
- Mention that how we understand and approach leadership is essentially about how we use power. Please keep this in mind as we move into our next activity about different leadership styles.

4. Four Models of Leadership (20 minutes)

- Discuss as a group the types of leadership: authoritarian, paternalistic, participatory, and empowering (follow notes and questions on slides 6–10).
- Distribute Leadership Styles handout.

5. Empowering Leadership Skills and Qualities (45 minutes)

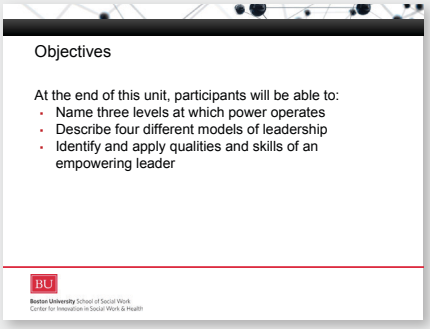
- Review slides on empowerment definition and quotes (slide 11). Ask, "What do you notice about these definitions/quotes? How do they connect with your work?"
- Activity: Empowerment Scenarios (30 minutes)
  - Distribute the Characteristics of Empowering Leadership handout and case scenarios and break participants into small groups.
  - Explain that participants will now have a chance to work in small groups to practice thinking through what an empowering approach to different scenarios would look like. Read the scenarios in your group and talk through what an empowering leadership approach to the scenario could be. You can use the CHW skills and qualities handout as a reference guide. We encourage you to add your own thoughts/ideas to the skills and qualities handout (slide 12).
  - Allow for 20 minutes for work in small groups. Reconvene the large group for report backs and discussion.
- My Commitment (10 minutes)
- As we conclude this session on empowering leadership, we want to give you some time to reflect individually on the leadership skills that you would like to improve and what steps you can take to strengthen those skills.
- Distribute My Leadership Commitment cards and ask participants to complete them.

6. Wrap up

- Close by thanking participants for their participation.

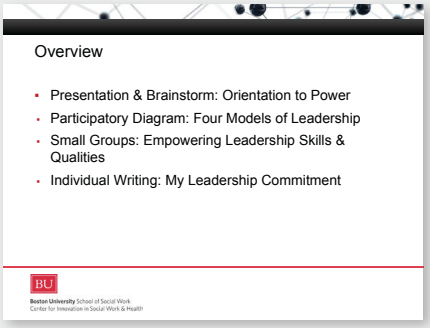
SLIDE 1

Welcome participants to the session on empowering leadership.



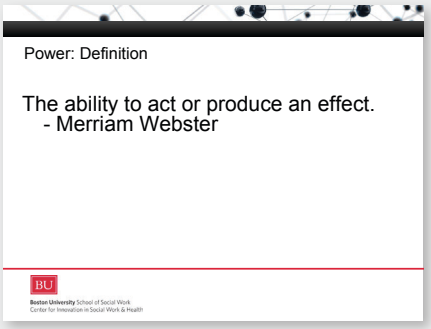
SLIDE 2

Review objectives.



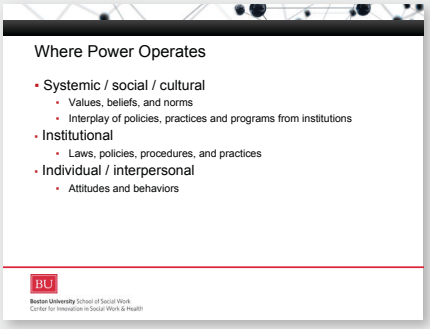
SLIDE 3

- Review the slide.
- Explain: In order to begin our conversation about empowering leadership, we first have to start with a discussion about power.
- Ask, "What comes to mind when you hear the word 'power'?"



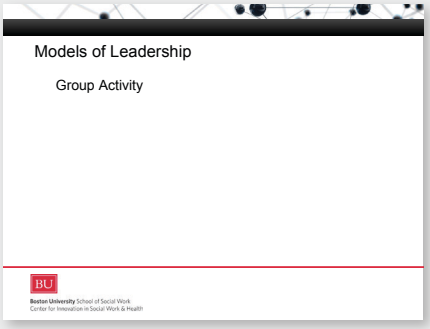
SLIDE 4

- Review the definition.
- Power is often tied into privilege based on one's identity or position of authority. For example, someone could be in a position of authority as a supervisor, but may or may not hold privilege in the institution or broader society based on their racial or gender identity or immigration status.



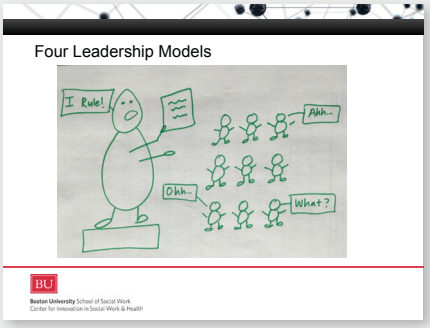
SLIDE 5

Review diagram of types of power, and lead discussion about examples of these types of power (see lesson plan).



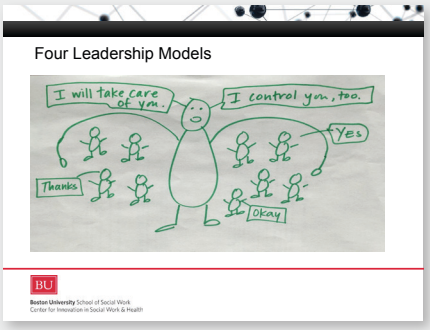
SLIDE 6

Explain that there are many different kinds of leadership. Now we will explore four different models of leadership.



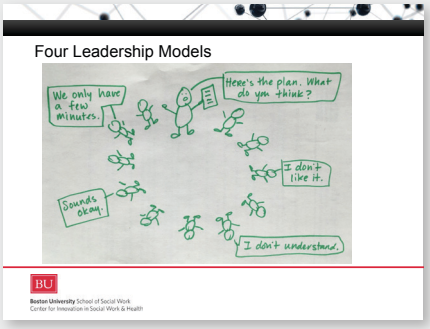
SLIDE 7

- Ask, "What does this model tell or suggest to you? What kind of a leader is this? What might we call this leader? When would it be appropriate to use this leadership model? What are the advantages or disadvantages of this model?"
- Explain that we could call this style "authoritarian" or "autocratic."
- *Clarify the meaning of each type of leadership by referencing the handout on the four leadership styles.*



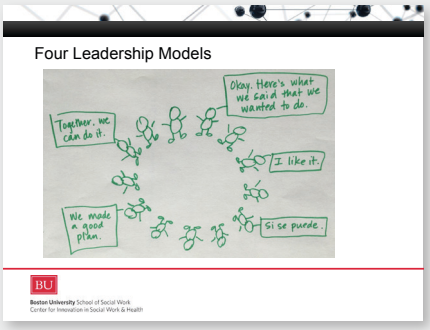
SLIDE 8

- Ask, "What does this model tell or suggest to you? What kind of a leader is this? What might we call this leader? When would it be appropriate to use this leadership model? What are the advantages or disadvantages of this model?"
- Explain that we could call this style "paternalistic" or "maternalistic."
- *Clarify the meaning of each type of leadership by referencing the handout on the four leadership styles.*



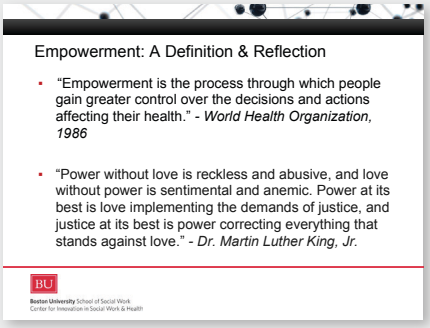
SLIDE 9

- Ask, "What does this model tell or suggest to you? What kind of a leader is this? What might we call this leader? When would it be appropriate to use this leadership model? What are the advantages or disadvantages of this model?"
- Explain that we could call this style "participatory."
- *Clarify the meaning of each type of leadership by referencing the handout on the four leadership styles.*



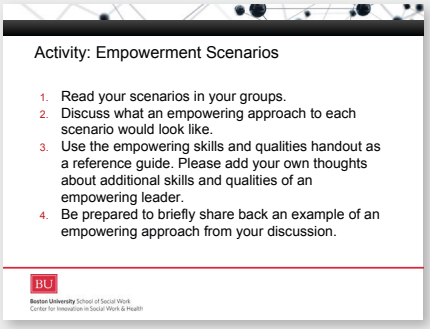
SLIDE 10

- Ask, "What does this model tell or suggest to you? What kind of a leader is this? What might we call this leader? When would it be appropriate to use this leadership model? What are the advantages or disadvantages of this model?"
- Explain that we could call this style "empowering."
- *Clarify the meaning of each type of leadership by referencing the handout on the four leadership styles.*
- Reflection: Ask, "Which style or styles of leadership will be most effective in your role as a CHW in your own community?"
- Reference the Expressions of Power handout. Share that the "power with," "power to," and "power within" models can be helpful ways for us to understanding an empowering approach to leadership.



SLIDE 11

- As we mentioned in the last activity, taking an empowering approach to how we lead and work with others is a best practice for CHWs. We wanted to offer some additional information about what empowerment is and some of the related skills and qualities.
- Read definition and Dr. King quote.
- Ask, "What do you notice about these definitions/quotes? How do they connect with your work?"



SLIDE 12

- Distribute the Characteristics of Empowering Leadership handout and case scenarios and break participants into small groups.
- Explain that participants will now have a chance to work in small groups to practice thinking through what an empowering approach to different scenarios would look like. Read through the scenarios in your group and talk through what an empowering leadership approach to the scenario could be. You can use the skills and qualities handout as a reference guide. We encourage you to add your own thoughts/ideas to the skills and qualities handout.
- Allow for 20 minutes for work in small groups. Reconvene the large group for report backs.

Leadership Styles: Four Models

Autocratic Leadership

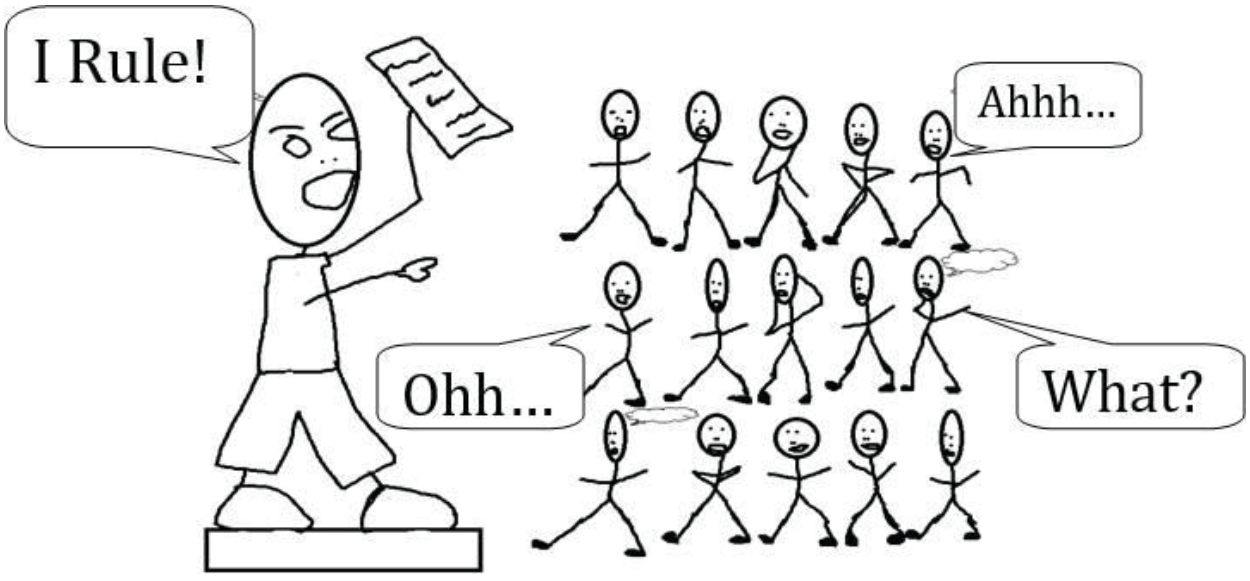
Autocratic leadership, also known as authoritarian leadership, is a leadership style characterized by control by the leader over all decisions with little or no input from group members.

Advantages:

- Autocratic leadership can be beneficial when decisions need to be made quickly without consulting with a large group of people. It may be necessary in times of crisis.
- In situations that are particularly stressful, such as during military conflicts or emergencies, this style allows group members to focus on performing specific tasks without worrying about making complex decisions. As a result, group members may become highly skilled at performing certain duties.

Disadvantages:

- Autocratic leadership does not encourage initiative, creativity, or personal responsibility from group members.
- Leaders who use autocratic leadership styles when they are not necessary are often viewed as bossy, controlling and dictatorial, which can lead to resentment among group members.
- Autocratic leadership can lead to a lack of creative solutions to problems, which can ultimately hurt the performance of the group.



Paternalistic Leadership

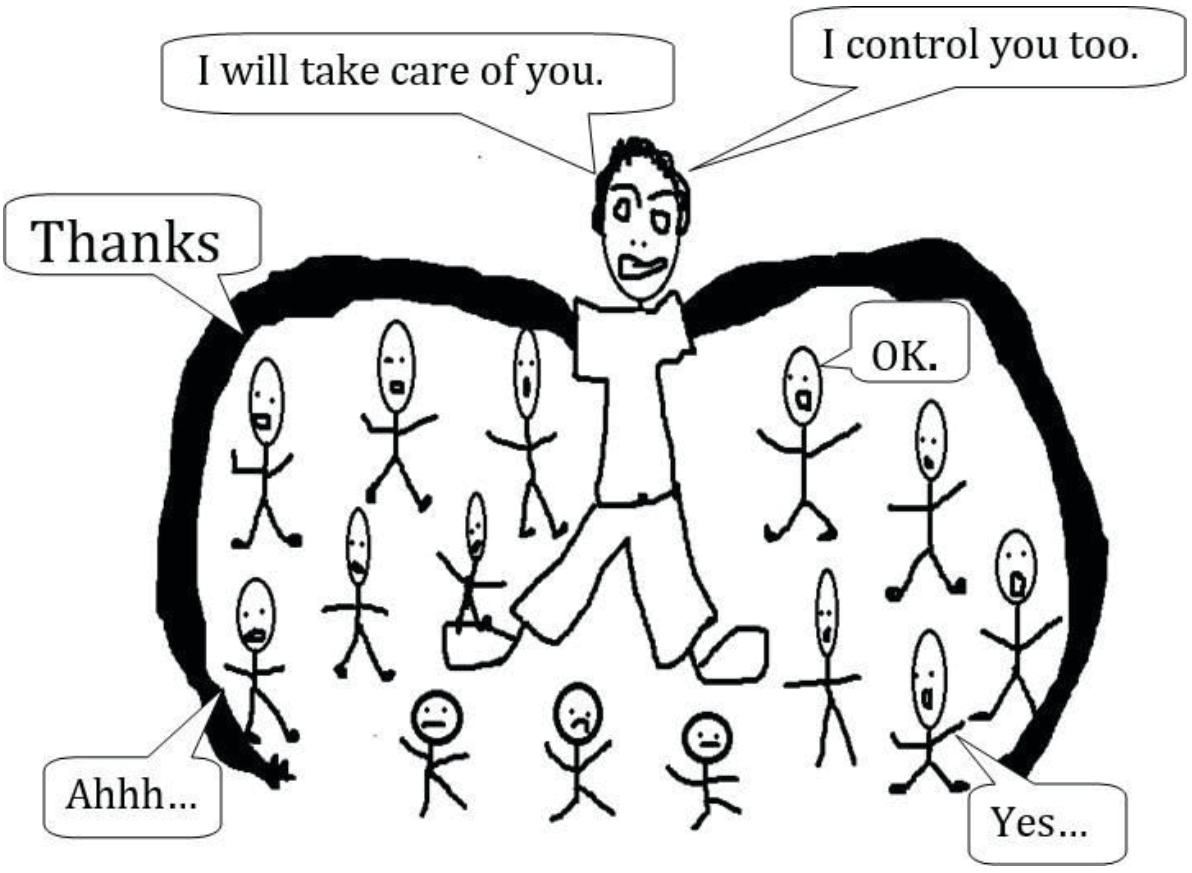
Paternalistic leadership is based on the idea that the leader is in a better position than the followers to know what is best for everyone. In a nutshell, it's the "leader as expert father figure" form of leadership.

Advantages:

- Leaders who display benevolent leadership can enhance reciprocity by helping others when they encounter difficulties and personal emergencies.
- Sometimes, people who are in a "follower" role may want to be led by someone whom they perceive as taking care of them.

Disadvantages:

- If a wrong decision is made, the followers may become dissatisfied with the leader.
- Group members become dependent on the leader to guide them, rather than learning to solve their own problems.



Participative Leadership

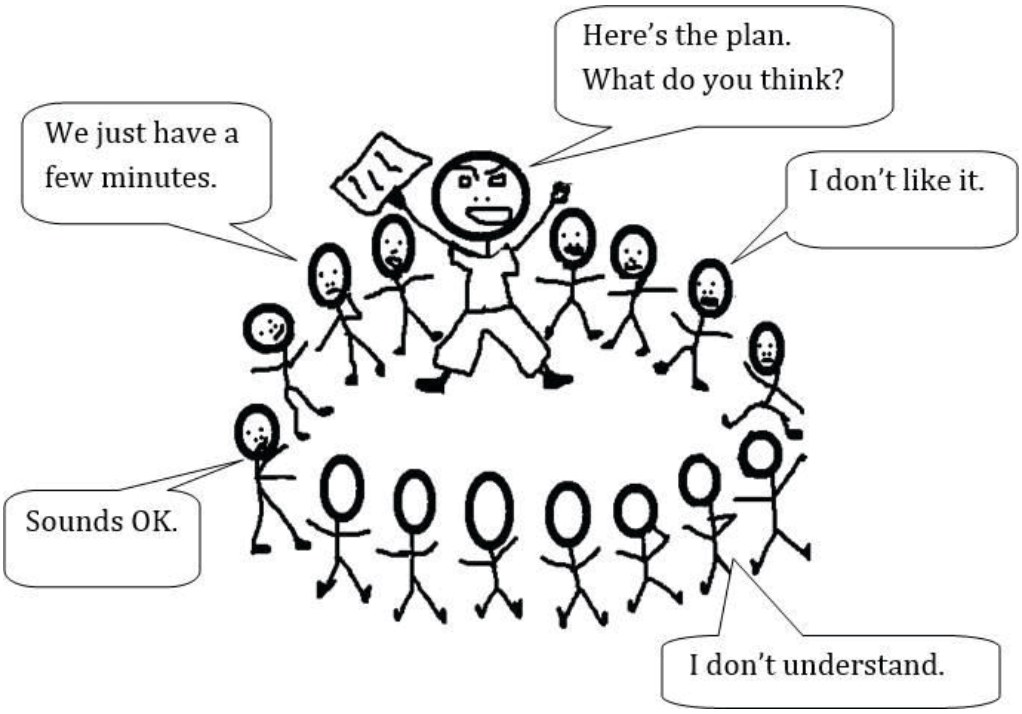
A participative leader seeks to involve other people in the decision-making process. How much influence others are given varies based on the preferences and beliefs of the leader. After a decision is proposed by either group members or the leader, the leader then listens to feedback and makes the final decision.

Advantages:

- Participative leaders encourage group members to participate and share ideas and opinions, even though the leader retains the final say over the decision.
- Group members feel engaged in the process.

Disadvantages:

- Participative leadership can be a sham when leaders ask for opinions and then ignore them, which will likely lead to feelings of betrayal.
- Ultimately, decision making power stays with those at the top.
- Group members are likely to stay involved because their basic needs are met. However, they are not motivated to give their best at all times.



Empowering Leadership

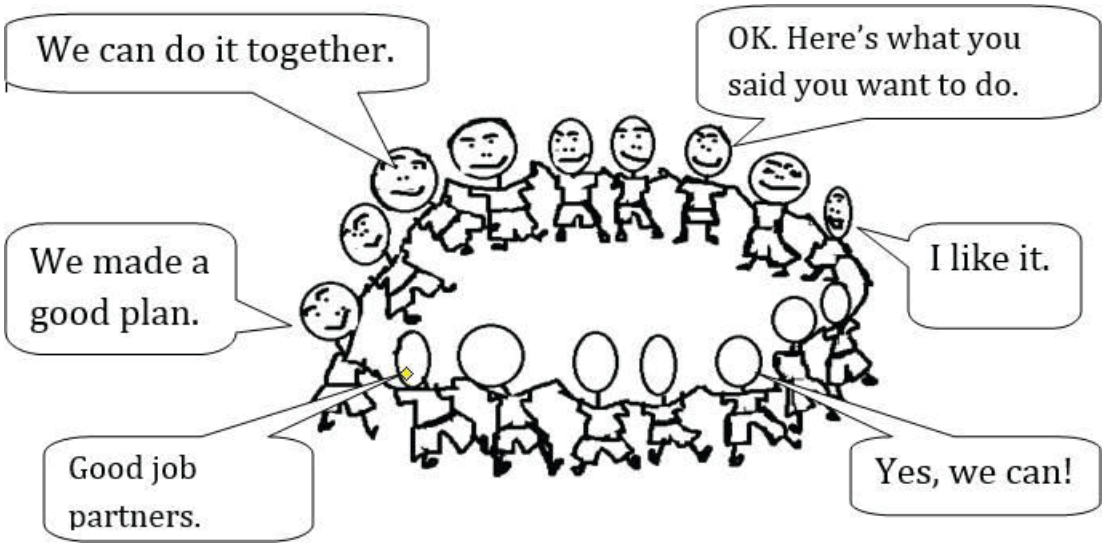
Empowerment is “a social-action process in which individuals and groups act to gain mastery over their lives in the context of changing their social and political environment.” (Wallerstein, 1994) Empowering leaders help others to develop the capacity to change their situation.

Advantages:

- Empowering leadership strengthens the leadership capacity of everyone and creates circumstances in which everyone can participate.
- Problems are identified and analyzed together. Everyone seeks the best solutions for their community.
- This style provides the opportunity for people to think, act, and take initiative and responsibility based on their own abilities.

Disadvantages:

- Empowering leadership requires a high level of experience and skill.
- Building trust and relationships within groups can take a lot of time.
- Few people have had experience with empowering leadership and have more often experienced authoritarian leadership. This may result in group members feeling lost in the process and returning to more familiar models of authoritarian or paternalistic leadership. This can negatively impact group members and impede progress that has been made by the group.



(Sources: Education for Transformation, 1992; Kendra Cherry; About.com Guide; James Withers; eHow Contributor; LeaderToday.org by Bacal and Associates; The Free Dictionary by Farflex; Michigan Leadership Studies; Wallerstein, 1994.)

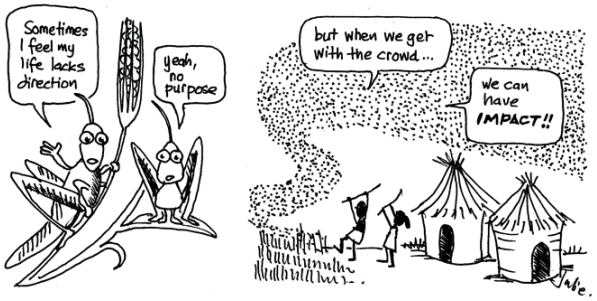
Expressions of Power

Power is often defined only in negative terms, and as a form of domination, but it can also be a positive force for individual and collective capacity to act for change. Lisa VeneKlasen and Valerie Miller in *A New Weave of Power* (2002, page 55) describe four "expressions of power" as follows:

Power Over

The most commonly recognized form of power, "power over," has many negative associations for people, such as repression, force, coercion, discrimination, corruption, and abuse. Power is seen as a win-lose kind of relationship. Having power involves taking it from someone else, and then, using it to dominate and prevent others from gaining it. In politics, those who control resources and decision making have power over those without. When people are denied access to important resources like land, healthcare, and jobs "power over" perpetuates inequality, injustice and poverty. In the absence of alternative models and relationships, people repeat the "power over" pattern in their personal relationships, communities, and institutions. This is also true of people who come from a marginalized or "powerless" group. When they gain power in leadership positions, they sometimes imitate the oppressor. For this reason, advocates cannot expect that the experience of being excluded prepares people to become democratic leaders. New forms of leadership and decision-making must be explicitly defined, taught, and rewarded in order to promote more democratic forms of power. Practitioners and academics have searched for more collaborative ways of exercising and using power. Three alternatives – "power with," "power to," and "power within" – offer positive ways of expressing power that create the possibility of forming more equitable relationships. By affirming people's capacity to act creatively, they provide some basic principles for constructing empowering strategies.

Power With



"Power with" has to do with finding common ground among different interests and building collective strength. Based on mutual support, solidarity, and collaboration, power with multiplies individual talents and knowledge. "Power with" can help build bridges across different interests to transform or reduce social conflict and promote equitable relations. Advocacy groups seek allies and build coalitions drawing on the notion of "power with."

Power To

"Power to" refers to the unique potential of every person to shape his or her life and world. When based on mutual support, it opens up the possibilities of joint action, or "power with." Citizen education and leadership development for advocacy are based on the belief that each individual has the power to make a difference.

Power Within

"Power within" has to do with a person's sense of self-worth and self- knowledge; it includes an ability to recognize individual differences while respecting others. "Power within" is the capacity to imagine and have hope; it affirms the common human search for dignity and fulfilment. Many grassroots efforts use individual storytelling and reflection to help people affirm personal worth and recognize their "power to" and "power with." Both these forms of power are referred to as agency – the ability to act and change the world – by scholars writing about development and social change.

See also Jo Rowlands' book *Questioning Empowerment: Working with Women in Honduras* (1997, page 13) published by Oxfam which also covers these forms of power.
https://www.powercube.net/other-forms-of-power/expressions-of-power/

Empowerment Scenarios

Empowerment Scenario #1

A project manager is introducing a new program to their team. They have had several meetings with leadership to try to get the resources needed so their team can do a good job and not get burnt out in the process. The project manager comes to their team to provide the goals and activities, but doesn't want to bore their team with the details. They provide time to talk through the program and the manager is interested in getting feedback. However, the team has the feeling that the organization has already made a commitment to move forward.

Empowerment Scenario #2

Every Monday morning our department gets together for a team huddle. Usually 10 people attend. It is social and snacks are provided. The department manager gives kudos on last week's successes and goes through a list of activities and challenges that may come up in the new week. At least 15 minutes are set aside at the end of the meeting for questions and answers.

Empowerment Scenario #3

A project is not meeting its goals or is running late. The project manager send out a detailed email with a course of action that will put it back on track. Later that week they call a meeting with the entire team and an internal "consultant" to discuss strategies to keep the project from running off the rails in the future.

Empowerment Scenario #4

Two team members have a personal falling out. This has caused tension to ripple across the team and the department. The manager talks to each staff person individually and tries to get to the bottom of the story. However, they make it clear that if the team members continue to disrupt the work environment they could each be subject to disciplinary action.

Empowerment Scenario #5

A three-year project supports the partial salary of four team members. The project is now at the end of its second year. Leadership at the organization is always working on bringing in new funding. They seem to be good at it, too. However, there has been no discussion about the future.

Empowerment Scenario #6

Our clinic will be opening a branch about 30 minutes away from its current location. They are going to try to provide the same services being offered at the main clinic. Leadership is excited that programs will be offered to residents in this once under-served area. Outreach will be an important activity. The manager has set aside a whole day to discuss how the team will handle this new endeavor. Lunch will be served.

Empowerment Scenario #7

The organization is developing a disaster-preparedness plan for its clinic. It has called together an interdisciplinary working group to develop this plan over the next six months. Leadership has contacted your team to volunteer two members to work on this committee.

Skills of Effective CHWs

CHWs and CHW program coordinators interviewed for the Community Health Worker Core Consensus Project (2016) reported that CHWs need the following skills to be effective in their work. *Skills* are abilities that can be gained through study and practice.

Communication Skills

- ✓ Ability to use language confidently
- ✓ Ability to use language in ways that engage and motivate
- ✓ Ability to communicate using plain and clear language
- ✓ Ability to communicate with empathy
- ✓ Ability to listen actively
- ✓ Ability to prepare written communication including electronic communication (e.g., email, telecommunication device for the deaf)
- ✓ Ability to document work
- ✓ Ability to communicate with the community served (may not be fluent in language of all communities served)

Interpersonal and Relationship-Building Skills

- ✓ Ability to provide coaching and social support
- ✓ Ability to conduct self-management coaching
- ✓ Ability to use interviewing techniques (e.g. motivational interviewing)
- ✓ Ability to work as a team member
- ✓ Ability to manage conflict
- ✓ Ability to practice cultural humility

Service Coordination and Navigation Skills

- ✓ Ability to coordinate care (including identifying and accessing resources and overcoming barriers)
- ✓ Ability to make appropriate referrals
- ✓ Ability to facilitate development of an individual and/or group action plan and goal attainment
- ✓ Ability to coordinate CHW activities with clinical and other community services
- ✓ Ability to follow-up and track care and referral outcomes

Capacity Building Skills

- ✓ Ability to help others identify goals and develop to their fullest potential
- ✓ Ability to work in ways that increase individual and community empowerment
- ✓ Ability to network, build community connections, and build coalitions
- ✓ Ability to teach self-advocacy skills
- ✓ Ability to conduct community organizing

Advocacy Skills

- ✓ Ability to contribute to policy development
- ✓ Ability to advocate for policy change
- ✓ Ability to speak up for individuals and communities

Education and Facilitation Skills

- ✓ Ability to use empowering and learner-centered teaching strategies
- ✓ Ability to use a range of appropriate and effective educational techniques
- ✓ Ability to facilitate group discussions and decision-making
- ✓ Ability to plan and conduct classes and presentations for a variety of groups
- ✓ Ability to seek out appropriate information and respond to questions about pertinent topics
- ✓ Ability to find and share requested information
- ✓ Ability to collaborate with other educators
- ✓ Ability to collect and use information from and with community members

Individual and Community Assessment Skills

- ✓ Ability to participate in individual assessment through observation and active inquiry
- ✓ Ability to participate in community assessment through observation and active inquiry

Outreach Skills

- ✓ Ability to conduct case-finding, recruitment, and follow-up
- ✓ Ability to prepare and disseminate materials
- ✓ Ability to build and maintain a current resources inventory

Professional Skills and Conduct

- ✓ Ability to set goals and to develop and follow a work plan
- ✓ Ability to balance priorities and to manage time
- ✓ Ability to apply critical thinking techniques and problem solving
- ✓ Ability to use pertinent technology
- ✓ Ability to pursue continuing education and life-long learning opportunities
- ✓ Ability to maximize personal safety while working in community and/or clinical settings
- ✓ Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA])
- ✓ Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements
- ✓ Ability to participate in professional development of peer CHWs and in networking among CHW groups
- ✓ Ability to set boundaries and practice self-care

Evaluation and Research Skills

- ✓ Ability to identify important concerns and conduct evaluation and research to better understand root causes
- ✓ Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR)
- ✓ Ability to participate in evaluation and research processes including:
    - Identifying priority issues and evaluation/research questions
    - Developing evaluation/research design and methods
    - Data collection and interpretation
    - Sharing results and findings
    - Engaging stakeholders to take action on findings

Knowledge Base

- ✓ Knowledge about social determinants of health and related disparities
- ✓ Knowledge about pertinent health issues
- ✓ Knowledge about healthy lifestyles and self-care
- ✓ Knowledge about mental/behavioral health issues and their connection to physical health
- ✓ Knowledge about health behavior theories
- ✓ Knowledge of basic public health principles
- ✓ Knowledge about the community served
- ✓ Knowledge about United States health and social service systems

CHW Core Consensus Project Report: https://www.c3project.org/

Qualities of Effective CHWs

CHWs and CHW program coordinators interviewed for the National Community Health Advisor Study also made it clear that in order for CHWs to do their complex and demanding work, they need certain qualities. *Qualities* are personal characteristics that can be enhanced but not taught.[1]

- ✓ Membership in or shared experience with the community in which they work
- ✓ Friendly, outgoing, sociable
- ✓ Internally strong and courageous, with healthy self-esteem
- ✓ Patient
- ✓ Open-minded and non-judgmental
- ✓ Motivated and capable of self-directed work
- ✓ Caring, compassionate
- ✓ Honest
- ✓ Committed and dedicated
- ✓ Respectful
- ✓ Open and eager to grow, change and learn
- ✓ Dependable, responsible, reliable
- ✓ Flexible and adaptable
- ✓ Desire the help the community
- ✓ Persistent
- ✓ Creative and resourceful
- ✓ Sense of humor
- ✓ Supportive (helping) rather than directive (telling what to do)
- ✓ Emotionally mature
- ✓ A model for trying to live a healthy lifestyle

The list of qualities from the NCHA Study has been expanded with input from Project Reach Out staff in Santa Barbara, Ca.

Characteristics of Empowering Leadership

- Creates an environment of trust
- Walks their talk
- Asks great questions
- Knows when to lead and when to manage
- Focuses on strengths
- Motivates and inspires others to reach their highest potential
- Are “What's Right” thinkers
- Asks for and gives respect
- Builds relationships
- Has a learning mindset
- Knows their limitations
- Is creative
- Is aware of power and uses it well
- Knows how to motivate others
- Balances participation
- Active listener
- Emotionally mature

"Humility leads to strength and not to weakness. It is the highest form of self-respect to admit mistakes and to make amends for them."

— John J. McCloy

My Personal Leadership Commitment

“Humility is to make a right estimate of oneself.”

— Charles H. Spurgeon

Leadership skills I would like to strengthen or improve:

Name: _____

Ways to strengthen these skills:

Name: _____

Harm Reduction

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand the philosophical basis of harm reduction, the movement's historical roots, and how it currently influences other service areas
- Explore attitudes and values related to harm reduction
- Brainstorm strategies for a "step-down" harm reduction approach for an identified behavioral challenge
- Identify next steps for integrating harm reduction approaches into your practice with clients

INSTRUCTIONS

1. Before the session begins, review PowerPoint slides with speaker notes. Test videos to make sure they work.
2. Welcome participants, share the objectives for the session.
3. Review slide 3. Ask for a participant to read the definition of harm reduction.
4. Show the video "Terrell's Story" (1 minute). Ask participants to share their reactions. What is something they learned from Terrell's story?
5. Review slides on the principles of harm reduction (slides 5–8). Ask for volunteers to read principles.
6. Show the video "Our Harm Reduction Stories: Working Toward Healthier Outcomes (12 minutes). This video includes people who identify as having been intravenous drug users, who are able to switch roles of provider and patient to demonstrate the importance of partnerships, patient/provider interaction, and agency policy. Ask:
   - What principles of harm reduction did you observe during the video?
   - Describe aspects of cultural awareness that you observed by the provider?
   - What policy could create change in your community?
7. Facilitate "What Do You Think?" activity
   - Distribute "What Do You Think" handout.
   - Give 20–30 minutes for the activity. See slide 10 notes for instructions.

(continued)

Related C3 Roles

Providing culturally appropriate health education and information, providing coaching and social support

Related C3 Skills

Communication skills, interpersonal and relationship building skills, education and facilitation skills, knowledge base

Method(s) of Instruction

Lecture, large group discussion, small group discussion, video, individual values-based activity

Estimated time

60 minutes

Key Concepts

Harm reduction, people who inject drugs, syringe exchange programs, safe spaces

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers
- Pens

Handouts

- What Do You Think?
- Harm Reduction Pyramid

Resources

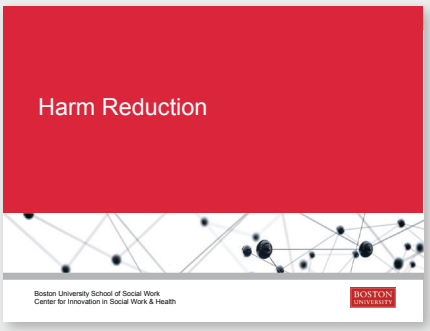
Harm Reduction Coalition, *https://harmreduction.org/*

Substance Abuse and Mental Health Services Administration (SAMSHA), *https://www.samhsa.gov/*

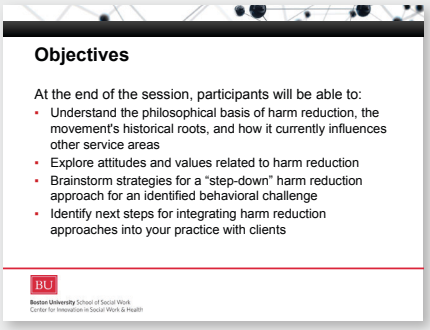
Harm Reduction

INSTRUCTIONS (continued)

8. Review slides 11–14 on the harm reduction pyramid, a user's story, and harm reduction services.
9. Facilitate "Harm Reduction Approaches with Your Clients" activity.
   - Break participants into groups for discussion of how to use harm reduction approaches.
   - Allow 15 minutes for group brainstorm, and 5 minutes for discussion.
   - See slide 15 for discussion questions and facilitation details.
10. Wrap up.
   - Acknowledge that maintaining boundaries with clients can be challenging in helping professions and requires continued review and education to ensure that boundaries are respected.
   - Have one or more participants read slide 16.
   - Thank participants for their contributions.

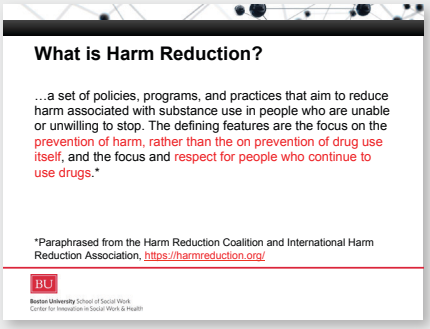


SLIDE 1



SLIDE 2

Review the objectives.



SLIDE 3

Ask for a volunteer to read the definition on the slide.

Make the following distinctions:

Harm reduction (HR) is a set of . . .

- Policies
- Programs
- Practices

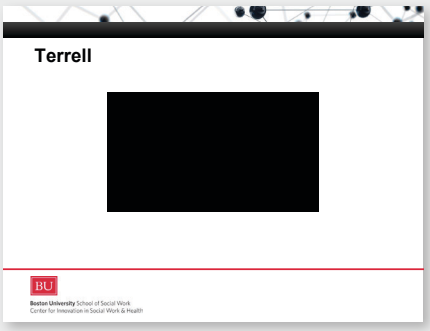
that aim to reduce harm associated with substance use in people who are unable or unwilling to stop.

Ask participants, "Why would this definition make a distinction about people who are unable or unwilling to stop?"

This definition clearly sets an intention to move the narrative from a one size fits all response to substance use that assumes everyone who has substance use challenges should stop. An abstinence only stance implies a value system that may not align with the values or desires of the person who uses.

HR focuses on the prevention of harm versus the prevention of drug use itself

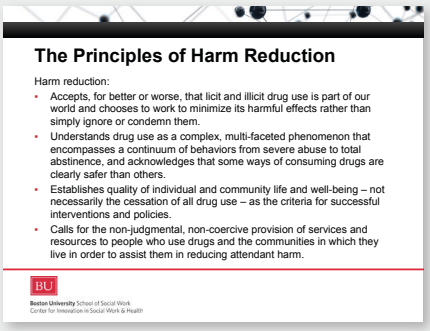
HR is a "people first" approach that is grounded in respect for people who continue to use drugs.



SLIDE 4

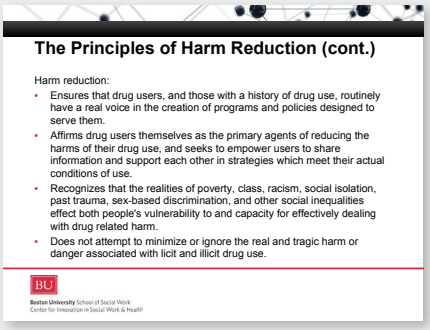
Terrell's story https://www.youtube.com/watch?v=L-xDvJ334ok

Illustrates the key elements of Harm Reduction as defined.



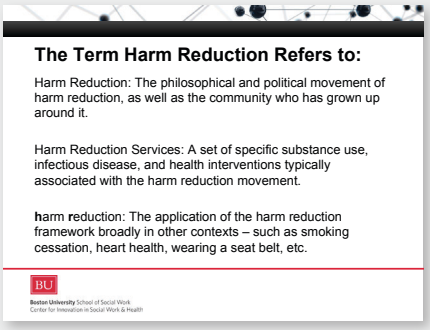
SLIDE 5

Ask participants to volunteer to read the principles.



SLIDE 6

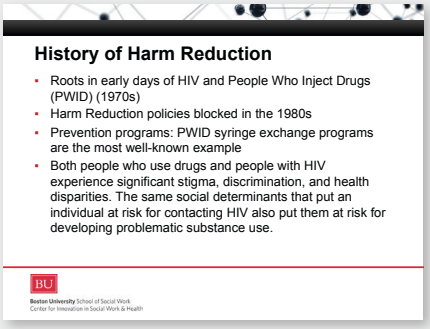
Ask participants to volunteer to read the principles.



SLIDE 7

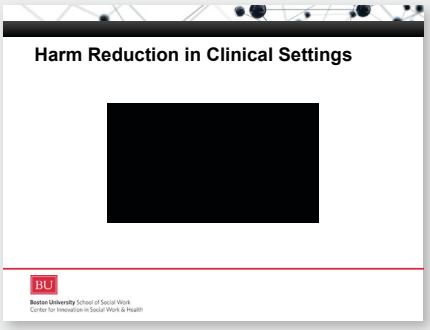
Review the slide.

These definitions can be found on the Harm Reduction Coalition website, https://harmreduction.org.



SLIDE 8

Review the slide.



SLIDE 9

Show video (12 minutes) https://www.youtube.com/watch?v=_VcMlS9dXo0

This video includes people who identify as having been intravenous drug users, who are able to switch roles of provider and patient to demonstrate the importance of partnerships, patient/provider interaction, and agency policy.

After the video, ask participants:

- What principles of harm reduction did you observe during the video?
- Describe aspects of cultural awareness that you observed by the provider?
- What policy could create change in your community?

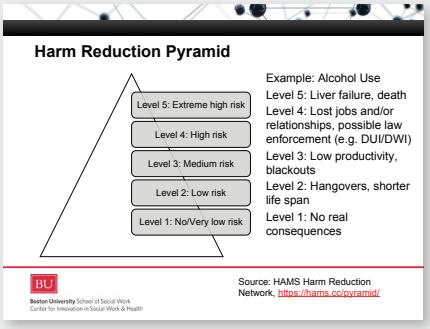
SLIDE 10

What Do You Think?

This activity will help participants explore varying perspectives related to concerns about harm reduction. Ask participants to answer these questions from an honest personal perspective.

- Time: 20–30 minutes
- Post flip chart sheets on opposite sides of the room labeled “Agree” and “Disagree.”
- Distribute “What Do You Think” handout.
- Have participants fill out the handout.
- Read each statement and ask participants to go to the side of the room that corresponds to their response.
- Participants will be invited to make an argument that supports the perspective listed on the paper, even if it differs from the participant’s personal beliefs.

Processing: Refer people back to the Principles of Harm Reduction.



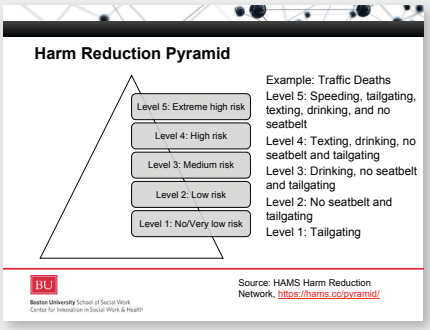
SLIDE 11

The harm reduction pyramid approach believes that some risks are worse than others, and that individuals can weigh the risks they take to find a way to reduce risk that works for them.

In this approach, individuals are encouraged to address what is most risky (see also Harm Reduction Pyramid handout). Think about examples from your own life where you have made decisions to lower your risk.

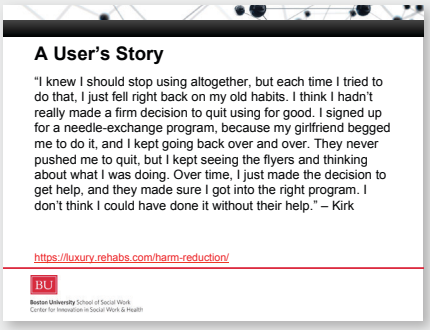
As a CHW, your work with clients may involve helping them to consider the risks they are taking in areas of their lives, and thinking of ways to reduce risk.

Ask the participants, "What is the value of using a harm reduction approach? (to the client, CHW, agency, community)"



SLIDE 12

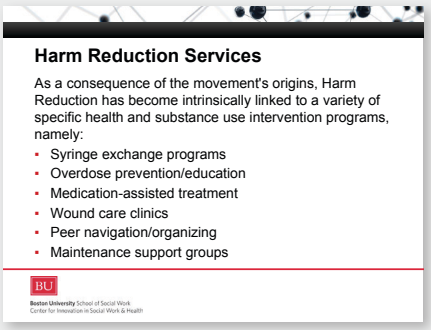
Review this additional example of the Harm Reduction Pyramid.



SLIDE 13

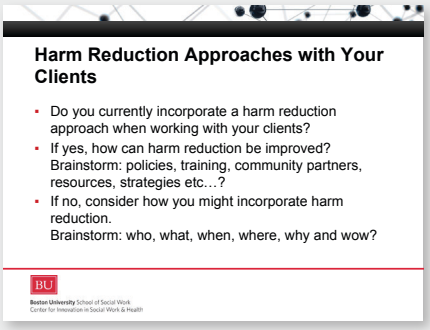
Ask a participant to read the story.

Ask for a volunteer to share their impression of the story.



SLIDE 14

Ask for a volunteer to read the slide.



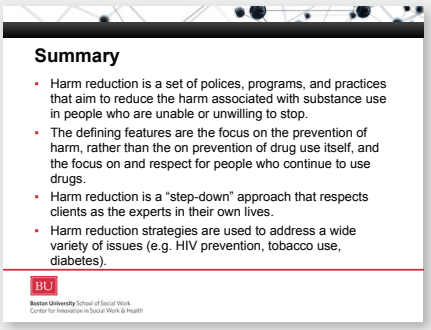
SLIDE 15

Break participants into small groups.

Provide flip chart sheets and markers for brainstorming.

Allow 15–20 minutes for brainstorm around the questions on the slide.

Spend 5–10 minutes asking for a few volunteers to share insights from their brainstorm.



SLIDE 16

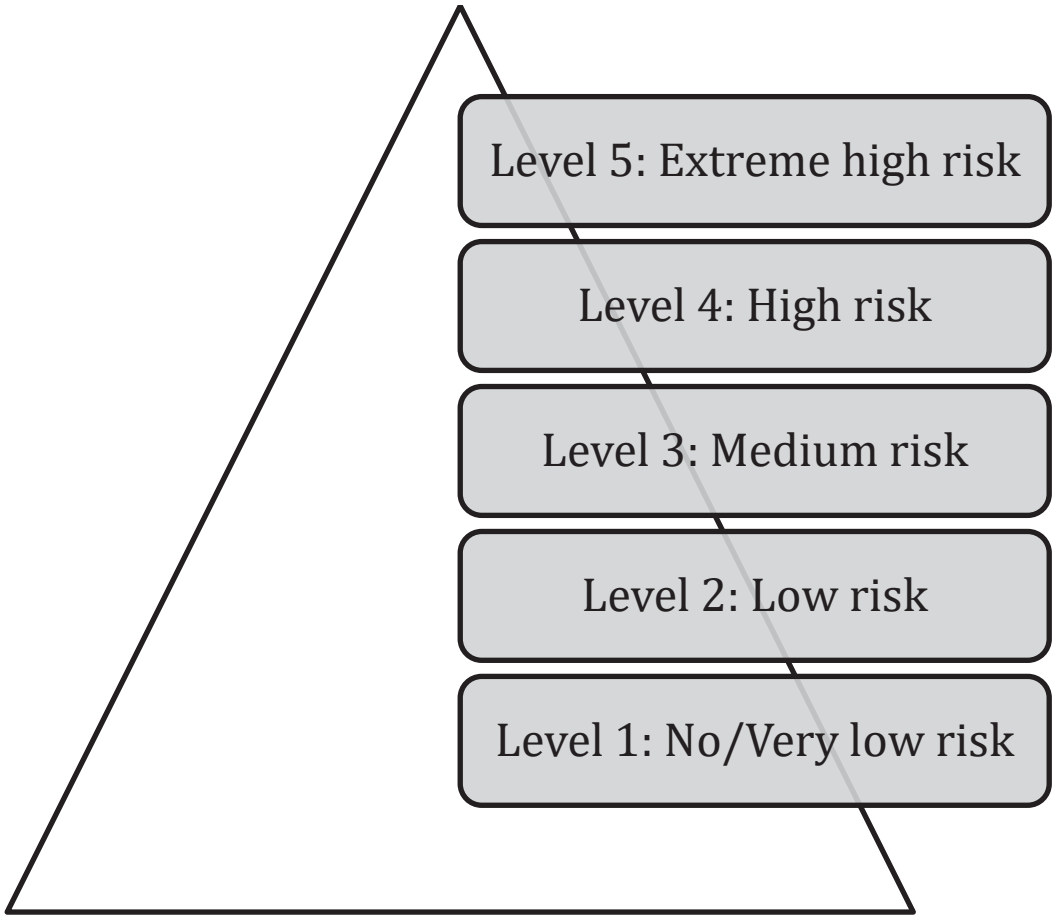
Ask for volunteers to read each bullet point on the slide.

What Do You Think?

Instructions:
Read each statement and check the box that best reflects your personal belief.

Statement	Agree	Disagree
1. Harm reduction encourages people to use substances or engage in risky behavior.		
2. Adopting a harm reduction approach means condoning substance use or risk behavior.		
3. People with substance use challenges will never have to "own up" to their substance use and quit with a harm reduction approach.		
4. A harm reduction approach places people at greater risk of harm and danger because of their lifestyle.		
5. People with substance use challenges cause their own problems and that's why they need to get clean/sober.		
6. A harm reduction approach encourages more crime and danger to the public because it doesn't mandate substance use treatment.		
7. Harm reduction is a move toward legalization of illicit drugs.		
8. People with substance use challenges can get over their problems if they want to.		
9. Abstinence from use is the best intervention for all substance users.		
10. Harm reduction should be condemned.		

Harm Reduction Pyramid



Source: HAMS Harm Reduction Network, https://hams.cc/pyramid/

Avenues of Formal Advocacy

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain what advocacy is and why it is needed
- Understand how advocates can use their voice
- Name five different types of advocacy groups for people with HIV
- Identify what advocacy opportunities exist and are missing in their community

INSTRUCTIONS

1. Before the session begins, prepare flip chart sheets for the small group activity. Write the following questions on a sheet, one for each group (3–5 groups).
   a. What qualities are needed to be an effective advocate?
   b. What activities/actions are included in advocacy?
2. Review slides on advocacy (slides 2–4) and engage participants in a discussion.
3. Facilitate brainstorm activity (slide 5).
4. Review History of Involvement of people with HIV (slide 6), and their successes in improving their lives and communities.
5. Review slides on GIPA, Greater Involvement of People with HIV/AIDS, and MIPA (slides 7–8), and Meaningful Involvement of People with HIV/AIDS. Discuss GIPA principles (see materials section to access entire documents).
6. Discuss areas where advocates can get involved at the local, state, and national levels (slide 9). Provide examples of advocacy organizations and ask participants if they can name other organizations in their own communities.
7. Review slide on selecting methods of involvement (slide 10).
8. Review slides on Ryan White (slides 11–14). Utilize the resource to learn more.
9. Review the HIV care continuum slide (slide 15).

(continued)

Related C3 Roles

Providing culturally appropriate health education and information; advocating for individuals and communities; building individual and community capacity; cultural mediation among individuals, communities, and health and social service systems

Related C3 Skills

Interpersonal and relationship-building skills, capacity-building skills, communication skills, advocacy skills, education and facilitation skills

Method(s) of Instruction

Lecture, brainstorm, group activity

Estimated time

60 minutes

Key Concepts

Advocacy, GIPA, MIPA, The Denver Principles, Ryan White Program

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart sheets
- Markers
- Placards (see handouts)

Handouts

- Placards (Print and laminate the following cards at 10x15 or preferred size, with the group name on one side and the definition on the other):
  1. Quality Improvement Committee
  2. Intra-agency and Regional Quality Management Teams
  3. Consumer Advisory Board (CAB)
  4. Community Planning Groups
  5. Consortia

Avenues of Formal Advocacy

INSTRUCTIONS (continued)

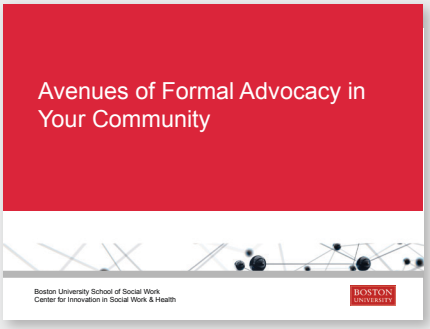
10. Facilitate the avenues for advocacy activity (slide 16). Use the placards that are in the handouts for this activity.
11. Facilitate community advocacy opportunities activity (slide 17, 10 minutes):
12. Share Dr. Martin Luther King, Jr. quote (slide 18).
13. Wrap up. To close, summarize and thank everyone for their participation.

Resources

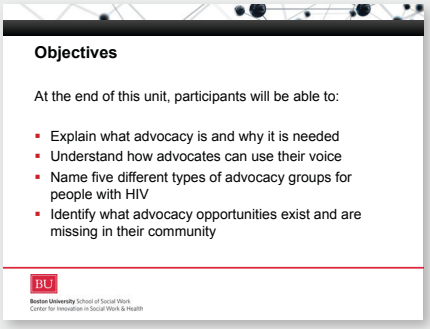
GIPA, MIPA and the Denver Principles: *http://vpwas.com/gipa-mipa-and-the-denver-principles/*

UNAIDS policy brief: The Greater Involvement of People Living with HIV (GIPA): *http://vpwas.com/wp-content/uploads/2014/10/d96596c4b961f1929dc8687ace6c44e6.pdf*

About Ryan White Programs Parts A–F: *https://hab.hrsa.gov/about-ryan-white-hivaids-program/about-ryan-white-hivaids-program*

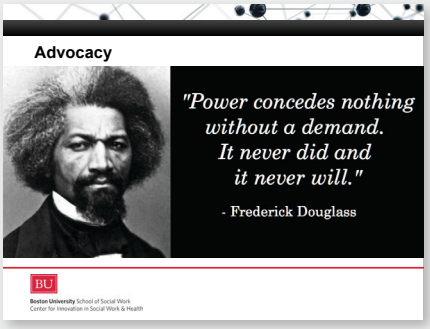


SLIDE 1



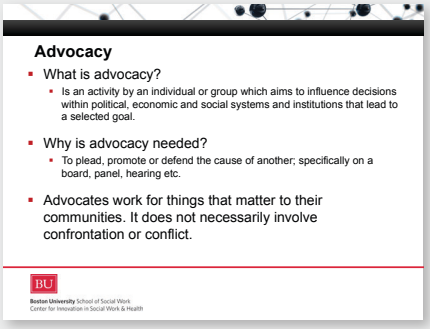
SLIDE 2

Review the objectives.



SLIDE 3

Why advocate, why speak out? Read Frederick Douglas quote.



SLIDE 4

Review the slide.

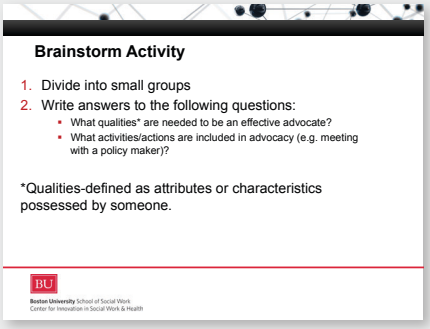
Why is advocacy needed?

Frederick Douglass's quote says, in essence, if you don't ask, you get nothing. You need advocacy to promote or defend the cause of another.

Advocacy can sometimes get a bad reputation, but advocates work for things that matter to their communities. It does not necessarily involve confrontation or conflict. It does not have to be political. The goal is to make things better for everyone, not just one person. Change comes about by fixing broken systems.

For example, a young woman with children found it difficult to get to the health department in her area because the bus stop was two blocks away from the health department. That was a problem for her individually but it also affected many people. However, she was the one person who asked about it, and the end result was that a bus stop and an awning were installed right in front of the health department, making access easier. She did not protest; she worked with members in the community, the health department, and other allies. She had meetings with the managers at the bus system who could make a difference.

Instructor can also provide their own example of advocacy and resulting change from their work or community.



SLIDE 5

Activity: 10 minutes

Say, "Now we're going to do a brainstorm activity about being an effective advocate. Similar to being an effective CHW, there are also qualities that make one an effective advocate. What are they?"

Divide participants into small groups and distribute flip chart sheets with questions.

Have each group choose a recorder to write group responses, and a reporter to share responses with the larger group. Allow five minutes to record responses to the prompts.

Allow five minutes for groups share their responses about:

- Qualities needed to be an effective advocate and
- Activities/actions are included in advocacy.

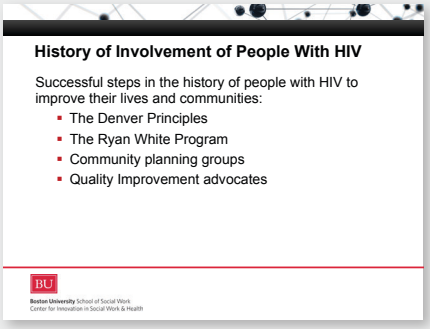
Examples of qualities

- Compassionate
- Helpful
- Patient
- Professional

Examples of activities/actions

- AIDS walk
- Leadership and/or support group network sharing
- Public speaking
- Contacting public officials via
  - Phone calls
  - Texting
  - Writing letters
  - Public speaking
- Meeting with policymakers, community leaders, or others in leadership positions
- Speaking to the media
- Filing an amicus brief

You can advocate from the privacy of your own home for people with HIV and others by calling to remind them of meetings, texting. In advocacy there is a place for all of us.



SLIDE 6

All people with HIV and their allies benefit from the work of advocates.

Here are some of the ways individuals have been involved in local, regional, or national community decision-making:

The Denver Principles

- A document written by people with HIV
- It made a strong statement of identity in relationship to the world and the healthcare system. Condemns the use of the word victim, and provides recommendations and rights for people with HIV.
- This document is still considered landmark and is referenced frequently as an example of empowerment, and demonstrates the community's ability to understand themselves in relationship to the world—a powerful voice when people speak together. The fingerprint represents the authorship of people with HIV.

Ryan White

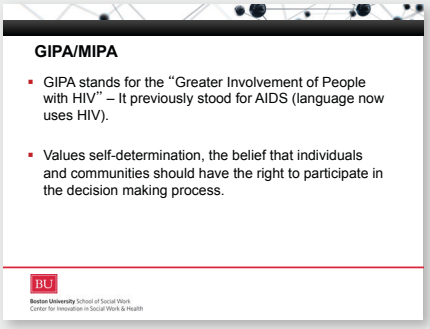
- Once the country heard the voice of people with HIV, funding slowly trickled in and finally reached the point of needing governmental management to address the HIV/AIDS crisis. This happened through the Ryan White legislation, enacted in 1990.
- Ryan White is represented by the blueprint because it is a system of care that was built in partnership with allies: legislative leaders, government workers, and communities. It was a piece of legislation that contained within it the ability to grow and change and give control to people with HIV .

Community planning members

Empowerment and legislation—community planning groups were built: planning councils, consortia, and consumer advisory boards. A system of care and prevention was built.

Quality Improvement

Involvement is needed and impactful in this area. People with HIV want to and need to be at the table before decisions are made to improve care. There is an opportunity to make systems the best they can be—this requires knowledge, passion, experience, and skills, and partnerships with doctors, nurses, data managers, case managers, etc.



SLIDE 7

GIPA (Greater Involvement of People with HIV/AIDS) began in 1994 and evolved over time into MIPA, Meaningful Involvement of People with HIV.

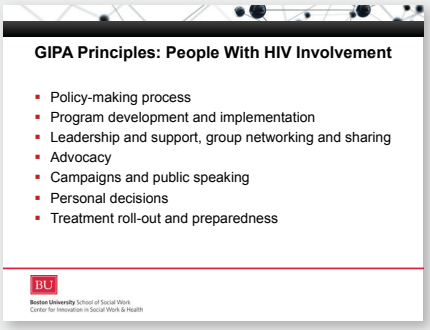
GIPA is not a project or program, GIPA is a principle that aims to realize the rights and responsibilities of people with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. GIPA also aims to enhance the quality and effectiveness of the AIDS response.

GIPA is an initiative to strengthen the capacity of people with HIV/AIDS, their networks, and community-based organizations to participate fully in regional, national, and global levels, stimulating the creation of supportive political, legal, and social environments.

GIPA stands for two important things:

1. To recognize the important contributions people with HIV can make in the response to the epidemic, and
2. To create space within society for our involvement and active participation in all aspects of that response.

The GIPA principles were formalized at the 1994 Paris AIDS Summit when 42 countries agreed to "support a greater involvement of people with HIV at all…levels… and to…stimulate the creation of supportive political, legal and social environments."



SLIDE 8

GIPA principles emphasize involvement and empowerment for people with HIV in all areas, including:

- Policy-making process—participating in the development and monitoring of HIV-related policies at all levels.
- Program development and implementation—providing knowledge and skills through participating in the choice, design, implementation, monitoring, and evaluation of prevention, treatment, care, and support programs and research.
- Leadership and support, group networking and sharing—people with HIV take leadership roles in HIV support groups or networks, seek external resources, encourage participation of new members, or simply participate by sharing their experiences with others.
- Advocacy—people with HIV advocate for law reform, inclusion in the research agenda, and access to services, including treatment, care, and support; and for resource mobilization for networks of people with HIV and for the broader response.
- Campaigns and public speaking—people with HIV are spokespersons in campaigns or speakers at public events.
- Personal decisions—people with HIV are actively involved in their own health and welfare. They take an active role in decisions about treatment, self-education, therapies, opportunistic infections, adherence, and positive prevention.
- Treatment roll-out through educating others on treatment options, side effects, and adherence. People with HIV are involved as home-based and community health care workers.

SLIDE 9

Review the slide.

Partnerships: Forming and evaluating partnerships is crucial to advocacy/involvement goals.

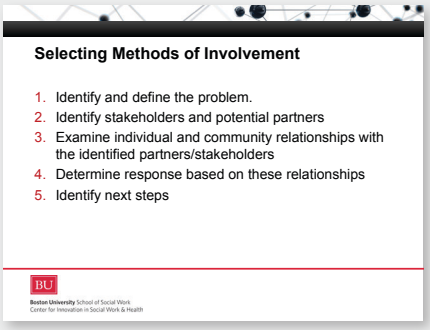
Allies: We need allies/collaborators/supporters

Whether it's picking up the phone, sending an email, meeting with your legislators, or hitting the streets, there is a place for you in advocacy.

Examples of advocacy organizations:

U.S. Positive Women's Network is primarily an advocacy organization that focuses on a nationwide community of women with HIV. Their mission is to involve women with HIV, in all their diversity, including gender identity and sexual expression, in all levels of policy and decision-making. PWN-USA inspires, informs, and mobilizes women with HIV to advocate for changes that improve their lives and uphold their rights.

Ask participants if they can name other organizations in their own communities.



SLIDE 10

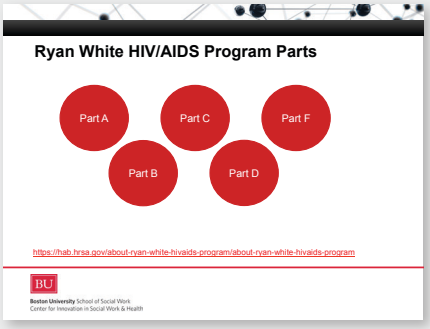
Review the slide.

Ask:

- How would you determine which area to become involved in/advocate for?
- What kind of leader do you want to be?
- What issues would you work on?
- What methods are you most comfortable with?

Emphasize that methods should focus on the problem and partners, not them.

Using these steps and your knowledge of your community, you can select the method that is more likely to achieve your desired goal.



SLIDE 11

The Ryan White program has multiple funding streams—meaning they spend money in different ways. Each of these parts funds different kinds of programs to deliver different services. Each RW part addresses a different part of the epidemic.

Part A – Grants funding for medical and support services to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs). EMAs and TGAs are population centers that are the most severely affected by the HIV/AIDS epidemic. Funding is given to office of a city/chief/mayor. TGA must have reported at least 1,000 new diagnosis in the previous 5 years.

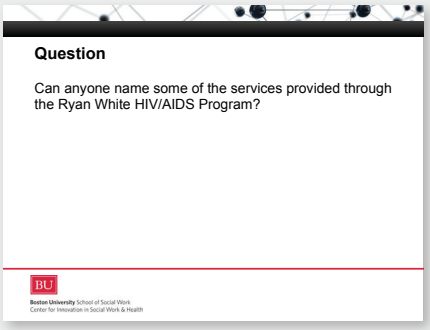
Part B – Grants funding to states and territories to improve the quality, availability, and organization of HIV health care and support services. A portion of funds in each state is designated for AIDS Drug Assistance Program (ADAP).

Part C – Grants funding to local, community-based organizations to support outpatient HIV early intervention services and ambulatory care.

Part D – Grants funding to support family centered, comprehensive care for women, infants, children, and youth with HIV.

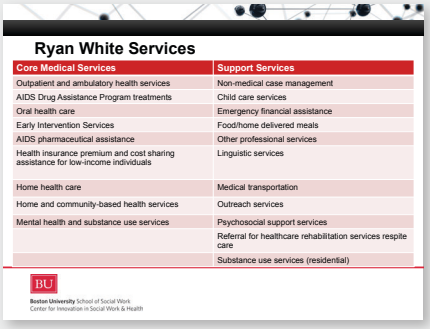
Part F – Grant funding that supports several research, technical assistance, and access to care programs. There are four programs—AIDS Education Training Sites (AETCs), Special Projects of National Significance (SPNS), Minority AIDS Initiatives (MAI), and Dental Reimbursement programs.

All of the parts together represent a system of care that has shown better outcomes than Medicare, Medicaid, and even private insurance. The parts create a safety net for people with HIV when working in concert, and when informed by community experience (the needs of different communities).



SLIDE 12

Review the slide.



SLIDE 13

Ryan White planning bodies are charged with making informed decisions about what services are offered and how much money can be spent in each category. Clinics and other community-based organizations apply at federal, state and regional levels for Ryan White program funds. These funds are awarded based on how well the applicant demonstrates their ability to meet identified priorities.

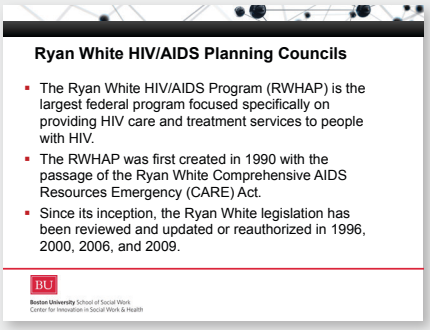
Review slide, listing Ryan White services provided.

Some states add additional funds to their Ryan White funding to offer more services. Because of this, and the mandates around local control, Ryan White programs aim to reflect the communities they serve.

As part of this aim, the involvement of people with HIV has been and continues to be a priority at all levels of the program. You can find people with HIV who work for the HIV/AIDS Bureau at the federal government, in local and state governments, in county health departments, and in thousands of clinics and hospitals across the country.

Another part of the structure for some states/territories is prevention dollars being funded through the CDC. Many HIV planning groups or councils have integrated their Ryan White Part A/B for care and treatment with prevention dollars through the CDC.

Five-year integrated community plans are created. An epidemiological profile, often called "Epi profile," gives a snapshot of the community, which helps in the design and implementation of research projects and new services.



SLIDE 14

Review the slide.

One of the primary structures that people with HIV are involved in are Planning Councils. Planning Councils that are not just advisory, but are decision-making bodies. Planning Councils have enormous control over what services are funded and how those services are delivered.

The legislation mandates that 33% of the Planning Council must be people with HIV. Other members will include representatives from providers and stakeholders from throughout the region.

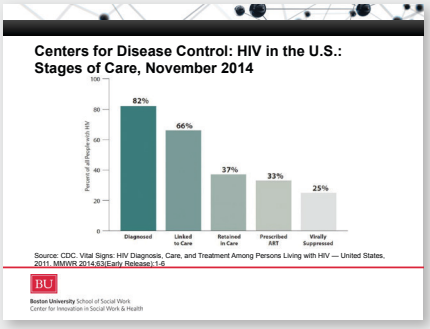
These planning bodies are tasked with regularly assessing the needs of the jurisdiction/state, prioritizing those needs into services, and then determining how much money to allocate to each service category.

Individuals have to apply to be members of Planning Councils and adhere to each council's by-laws and requirements.

Planning bodies use a parliamentary procedure to make decisions.

There are guides online and trainings to help better understand how parliamentary procedure works.

Avenues of Formal Advocacy



SLIDE 15

Reintroduce the HIV care continuum as a way to evaluate HIV care and treatment system outcomes.

Ask participants if they can name some services to help improve outcomes at any stage of the continuum (for example, free HIV screening support results in increased diagnosis). Take a few examples, then move to the next activity.

SLIDE 16

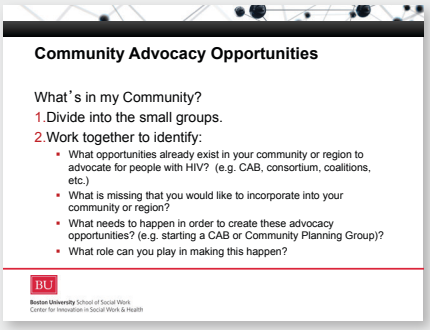
Activity: 15 minutes

Divide participants into five groups and distribute placards.

Ask volunteers to read the name of the type of advocacy group and then read the definition.

Ask, "Has anyone participated in one of these groups?"

Allow 3 minutes per type of group.



SLIDE 17

Community advocacy opportunities activity (10 minutes)

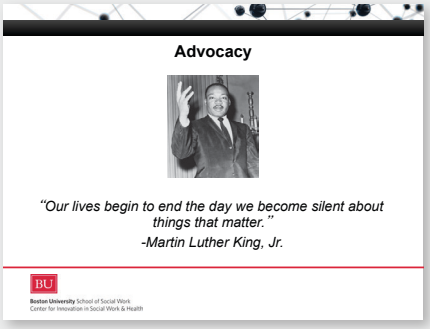
Divide participants into small groups.

Work together to answer questions on the slide.

At the end of the activity, ask participants to give the name of an advocacy group in their area that has not been discussed. Ask who is involved in advocacy, and if anyone plans to become involved.

There are many other types of involvement:

- Research advisory boards
- Technical expert panels
- Statewide advisory boards
- Completing satisfaction surveys
- Participating in focus groups
- Many more



SLIDE 18

Ask for a volunteer to read the quote.

Ask participants to share their reflection of these words.

QUALITY IMPROVEMENT COMMITTEE

QUALITY IMPROVEMENT COMMITTEE DEFINITION

What is Quality Improvement (QI)? In health care, the purpose of quality improvement is to improve and measure:

- the patient experience;
- health outcomes;
- employee satisfaction; and
- costs.

QI committees are usually multidisciplinary—they involve employees from various role groups and parts of the clinic and/or program—medical providers, CHWs, case managers, pharmacists, administrators, nurses, etc. Effective QI committees involve the patient, employee, and funder perspectives.

The QI committee works together to come up with better practices that will address a specific problem or weakness. An effective committee uses data to identify areas needing improvement and focuses on:

- systems and processes;
- patient needs and impacts;
- teamwork; and
- measuring the improvement and desired outcomes.

Usually committees make small improvements that contribute to greater successes over time.

QI efforts can lead to measurable improvements in health care services and the health status of targeted patient groups.

INTERAGENCY AND REGIONAL QUALITY MANAGEMENT TEAMS

QUALITY MANAGEMENT TEAM DEFINITION

- A quality management team builds capacity and capability for quality improvement.
- The team involves quality managers, program leaders and other key staff. It may link quality improvement to state, federal (including Ryan White) or an organization's overall quality program goals.
- Responsibilities may include strategic planning, providing guidance, facilitating change, allocating resources and establishing a common culture.

Ryan White recipients are required to have clinical quality management programs which must collect performance data and conduct improvement projects on at least one item annually (most teams conduct more). Traditionally these teams have been built with clinic or provider staff members but recently the National Quality Center developed a comprehensive training program for quality advocates (patients) which has helped people with HIV seek and obtain seats at quality management tables, allowing the community to have greater input into efforts to improve services.

Consumer Advisory Board (CAB)

CONSUMER ADVISORY BOARD DEFINITION

A CAB is an advisory committee of consumers that meet with the clinic leadership team on a regular basis. CAB members:

- Provide valuable feedback on services and systems;
- Give advice and input into program planning and quality improvement;
- Provide recommendations and bring new issues to the attention of the health center or clinic leadership;
- Initiate and assist with client engagement activities; and
- Identify gaps, needed service improvements and address other tasks as necessary.

CABs generally have by-laws and membership applications. Ryan White Parts C and D grantees are required to have CABs.

Community Planning Groups

COMMUNITY PLANNING GROUPS DEFINITION

- A core goal of community organizing is to represent the **community** (people with HIV) and **influence** key decision-makers on a range of issues over time.
- Community Planning Groups can be ad hoc (one time only) or ongoing. They address a range of issues such as housing, public safety, disease prevention, crime, transportation, etc.
- Ideally, you are at the table with planning groups early—*before* important decisions are made. You have a lot to contribute: your experiences (personal and clients), HIV specific data, Ryan White connections, etc.
- Community organizers work with and develop new local **leaders**, facilitating coalitions and assisting in the development of campaigns.
- Participating in local planning groups can:
  - Promote community awareness about HIV, including trends and programs
  - Increase the likelihood that the needs of people with HIV are better met
  - Strengthen community partnerships and alliances

CONSORTIA

CONSORTIA DEFINITION

- You may have a consortium of agencies and PLWH that are addressing HIV in your community.
- A consortium is a network of people and agencies dedicated to improving the health and well-being of individuals and communities impacted by HIV/AIDS.
- Members reflect the diversity of the communities served and include representatives from agencies that provide HIV/AIDS prevention and care services.
- A consortium is responsible for developing recommendations about programs and services, areas of greatest need, and the best methods to meet those needs.
- A consortium can be very influential in shaping policies and funding decisions.

Introduction to Popular Education Principles

OBJECTIVES

At the end of this unit, participants will be able to:

- Identify key principles and methods of popular education

INSTRUCTIONS

1. Before the session, review the resource, An Introduction to Population Education, and the facilitator's notes for the slides. Review the handout, Introduction to Popular Education, and write each principle of popular education on an index card for the activity.
2. Welcome participants. Provide an overview of popular education (slide 1).
3. Review "Basic Principles of Cooperative Learning" (slide 2). Ask volunteers to read the slide.
4. Review "Cooperative Learning Roles" (slide 3). Ask for volunteers to read the slide.
5. Facilitate Principles of Popular Education activity.
   - Divide participants into small groups of four to five people each.
   - Distribute the "principles of popular education" index cards.
   - Ask participants to read the principle they received, and discuss in their groups how they could present the principle in a creative way, using a skit, song, drawing, etc. They can think about how the principles apply to their work.
   - Give groups 15 minutes to work on their presentations.
   - Have each group present their principle.
   - Ask," Is there anything else anyone would like to add to the information that has been shared?"
6. Wrap up.
   - Distribute the "Introduction to Popular Education" and "House of Popular Education" handouts to the group.
   - Reference the Popular Education manual.
   - Thank participants for their presentations.

Related C3 Roles

Building individual and community capacity, providing culturally appropriate health education and information

Related C3 Skills

Communication skills, interpersonal and relationship-building skills, capacity building skills, advocacy skills, education and facilitation skills

Method(s) of Instruction

Small group work

Estimated time

40 minutes

Key Concepts

Popular education, cooperative learning

Materials

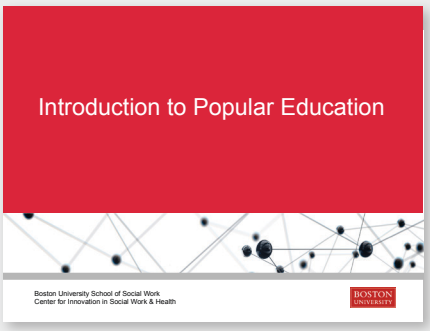
- Computer with internet access and projector
- PowerPoint slides
- Index cards

Handouts

- Introduction to Popular Education
- House of Popular Education

Resources

An Introduction to Popular Education manual: *https://multco.us/file/16372/download*



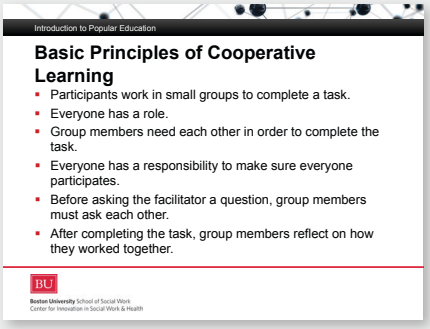
SLIDE 1

Popular education has a long history of being used all over the world to train Community Health Workers. One of the goals of popular education (PE) is to motivate people to organize collectively to create a truly democratic society. But many people, maybe most people, have not had much experience working collectively.

Therefore, two additional principles of PE are:

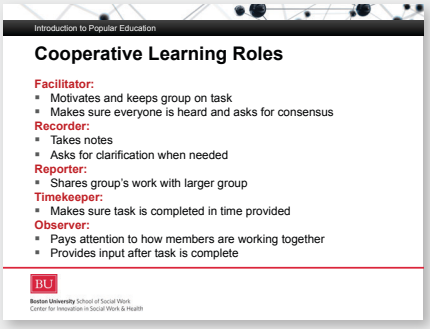
1. People know a lot and we should always start with what people already know
2. We need to create situations where people can learn the skills they need to work collectively

An excellent method for helping people build the skills they need to work together is cooperative learning.



SLIDE 2

Ask a volunteer to read the slide.



SLIDE 3

Ask a volunteer to read the slide.

Introduction to Popular Education

What is popular education?

Popular education is a philosophy and methodology of teaching and community organizing. It has many sources. Paulo Freire, a Brazilian, is the person best known for his contribution to popular education.

What are the goals of popular education?

- The creation of a truly democratic society where we all have equal access to the world's resources
- Human liberation, both personal and collective

How does popular education propose to achieve its goals?[1]

Step 1: Help each person come to believe that they are capable of changing their world.
Step 2: Connect people's personal problems to national and global realities (develop critical consciousness).
Step 3: Motivate people to organize collectively and take action to resolve their common problems.

What are the principles of popular education?[2]

- The current distribution of the world's resources is unjust and change is possible.
- We learn with our heads, our hearts, and our bodies.
- It is important to create an atmosphere of trust so that people can share their ideas and experiences.
- We all know a lot. As educators and organizers, we should always start with what people already know and/or do.
- The knowledge we gain through life experience is as important as the knowledge we gain through formal education.
- People should be active participants in their own learning process. They should not be passive recipients.
- Knowledge is constructed in the interaction between people.
- Popular education is an inclusive movement that combines influences from many sources.

- In each situation in which we try to teach or organize, the conditions should reflect the conditions of the society we are trying to construct. This means equality between "teacher" and "student," and democratic decision-making.
- It is important that educators and organizers share the life experience of those they want to teach and/or organize.
- The arts (music, drama, visual arts, etc.) are important tools for teaching and organizing.
- The purpose of developing a critical consciousness is to be able to take action to change the world. (Critical thinking alone is not enough.)
- The goal of popular education is organized action to change the world.

What are some of the values of popular education?[3]

- Love for the cause of the people
- Honesty
- Compassion
- Responsibility
- Dedication
- Solidarity
- Humility
- Comradeship/Compañerismo

[1] Serrano-García, Irma (1984). The illusion of empowerment: Community development within a colonial context. In J. Rappaport, C. Swift & R. Hess (Eds.) *Studies in empowerment: Steps toward understanding and action* (pp. 173-200). New York: The Haworth Press.

[2] Many of these principles, although not all, are drawn from: Horton, M. (2003). *The Miles Horton reader: Education for social change*, ed. Dale Jacobs. Knoxville: The University of Tennessee Press.

[3] Harnecker, Marta (2002). *Sin tierra: Construyendo movimiento social.* (Landless: Constructing a social movement.) Madrid, Spain: Siglo XXI de España Editores

The House of Popular Education (Wiggins and Rios, 2007)

Dinámicas	Brainstorm	Radio Plays	Cooperative Learning	Problem Posing	Sociodramas	Participatory Research	Grou p Evalu	Role Plays	Games	Songs
As educator/organizers, we must be humble and learn from our colleagues.										
Based on our expanded understanding, we need to organize with others to change the world.										
We need opportunities to connect our personal experience to national and global realities.										
We need opportunities to reflect on our personal experience and identify community problems.										
Feelings and emotions are an important part of learning. We learn with head, heart, and body.										
We learn more when we are having fun!										
We need to create situations where people can learn the skills they need to work collectively.										
People should be active participants (not passive recipients) in their own learning process.										
We all know a lot. We should always start with what people know and do.										
It is important to create an atmosphere of trust so people can share their ideas and experiences.										

Popular Education and Facilitation Skills

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain the difference between conventional and popular education
- Identify and apply popular education principles and methods

INSTRUCTIONS

1. Before the session begins, review the Population Education Manual resource. Write on flip chart the phrase "Conventional Education Methods." Review "Introduction to Popular Education handout.
2. Welcome participants and review session objectives (slide 2).
3. Conventional vs. popular education discussion.
   - Explain that as CHWs, one of our roles is to educate our community about ways to improve health outcomes. In today's session we are going to learn about a method called popular education.
   - Before we define popular education, we must first understand how it might be different from other methods.
   - Ask participants: "Describe your experience with education through school or other training programs you have attended. What methods were used? What do you remember about the structure? How did you feel during the process?
   - Record participants' responses on a flip chart sheet.
   - Review "Conventional vs. Popular Education" (slide 3). Compare with participant responses on the flip chart.
4. Facilitate Image Theater activity (slides 4–6).
   - Divide participants into groups of five or six.
   - Give each group 10 minutes to create two images: one that represents conventional education and one that represents popular education.
   - Have each group share their images and reflect.
5. Wrap up.
   - Thank participants for their participation.
   - Review some of the principles and methods of popular education using the house metaphor (slide 7).
   - Share reference manual on Popular Education and Introduction to Popular Education handout.

Related C3 Roles

Building individual and community capacity

Related C3 Skills

Communication skills, capacity building skills, education and facilitation skills

Method(s) of Instruction

Image theater, large group discussion

Estimated time

60 minutes

Key Concepts

Popular education, image theater

Materials

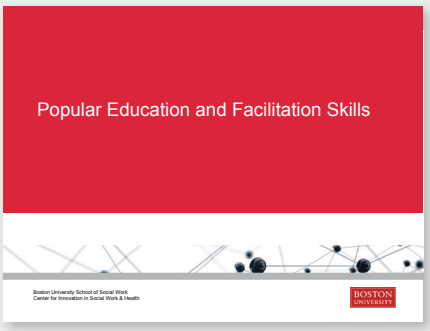
- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Handouts

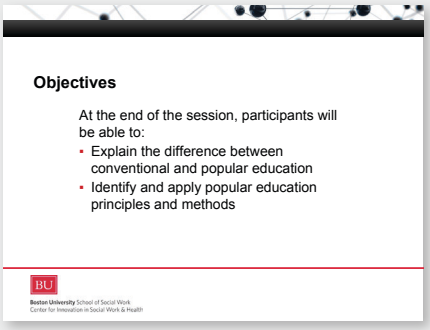
- Introduction to Popular Education

Resources

Popular Education Manual ***https://multco.us/file/16372/download***

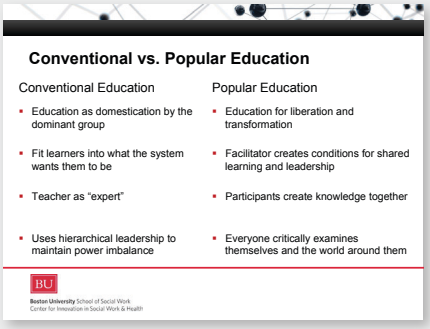


SLIDE 1



SLIDE 2

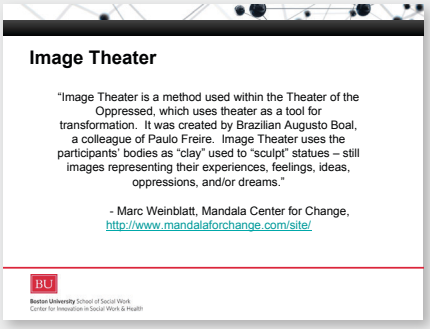
Read the slide.



SLIDE 3

Paolo Freire was a Brazilian educator who is known as one of the first people to write about popular education. He described conventional education as education for domestication by the dominant group. Another way to think of the purpose of conventional education is to fit the learners into what the system wants them to be. Conventional education centers the teacher as "expert" and uses hierarchical leadership to maintain a power imbalance.

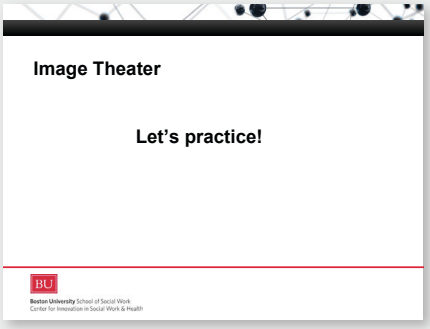
By contrast, Freire distinguished popular education as education for liberation and transformation. Popular education uses a facilitator to create the conditions for shared learning and leadership. Participants create knowledge together and critically examine themselves and the world around them.



SLIDE 4

Explain that to help us reflect on these two styles, we will use a method called Image Theater.

Ask for a volunteer to read the slide.

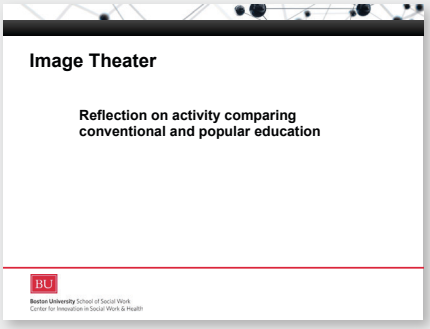


SLIDE 5

Divide participants into groups of five or six.

Give each group 10 minutes to create two images: one that represents conventional education and one that represents popular education.

Have each small group share their images with the larger group.

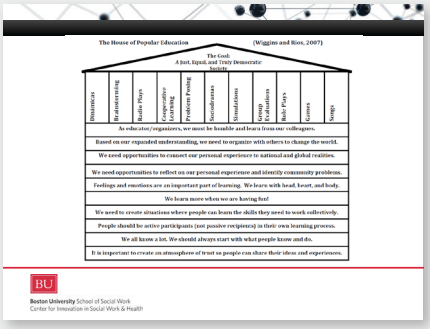


SLIDE 6

Thank everyone for their participation.

Ask, "What did you notice about the images related to conventional education? Popular education? Which style do you think will work better with your clients and community members?"

Write reflections on flipchart.



SLIDE 7

Explain that we often use a house as a metaphor for popular education. To review some of the principles and methods of popular education, we will now build the house together.

Ask for volunteers to read the principles (foundation stones, written horizontally). Ask volunteers to read the methods and share examples of each.

Reference the Popular Education manual for descriptions of the methods and dinamicas, and the Popular Education fact sheet for more information about the principles.

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Popular Education Methods

OBJECTIVES

At the end of this unit, participants will be able to:

- Apply popular education methods and instructional design steps to create a health education class

INSTRUCTIONS

1. Before the session begins, prepare index cards with "Thank you" written in different languages: "Merci" (French), "Gracias" (Spanish), "Asante" (Swahili), "Shukraan" (Arabic). Select languages that may be representative of your participants. Prepare enough cards so that each participant will receive a card (there will be multiple cards with the same language). Prepare flip chart sheets for small groups with the following headers:
   - Session context
   - Learner analysis
   - Learning objectives
2. Facilitate the session Context Analysis activity (15 minutes)
   - Explain that when we are preparing for a session, it is helpful to think through the organizational context, who the audience is, and how to best sequence the content and activities.
   - We often begin with analyzing the organizational context. Some issues to consider are:
     - Purpose: Why we are having this session?
     - Organization: What organization(s) will be represented during the session? What is the organizational culture? Who does the organization serve?
     - Facilitators (or potential facilitators): interests/experiences/preferences of facilitators; level of experience with the content, learners, or training styles/methodology
     - Facilities/equipment: Room setup; technology or equipment available
   - As you share the examples, write them on "Context" flipchart page.
   - Ask, "How do you think or imagine this information might impact how you plan your session?"
   - If it is not mentioned, share that the context informs your learning objectives, what kinds of activities you use, and the questions that you ask.

(continued)

Related C3 Roles

Building individual and community capacity

Related C3 Skills

Education and facilitation skills, capacity building skills

Method(s) of Instruction

Group brainstorm, small groups

Estimated time

60 minutes

Key Concepts

Popular education, facilitator skills

Materials

- Multicolored index cards
- Flip chart
- Markers

Handouts

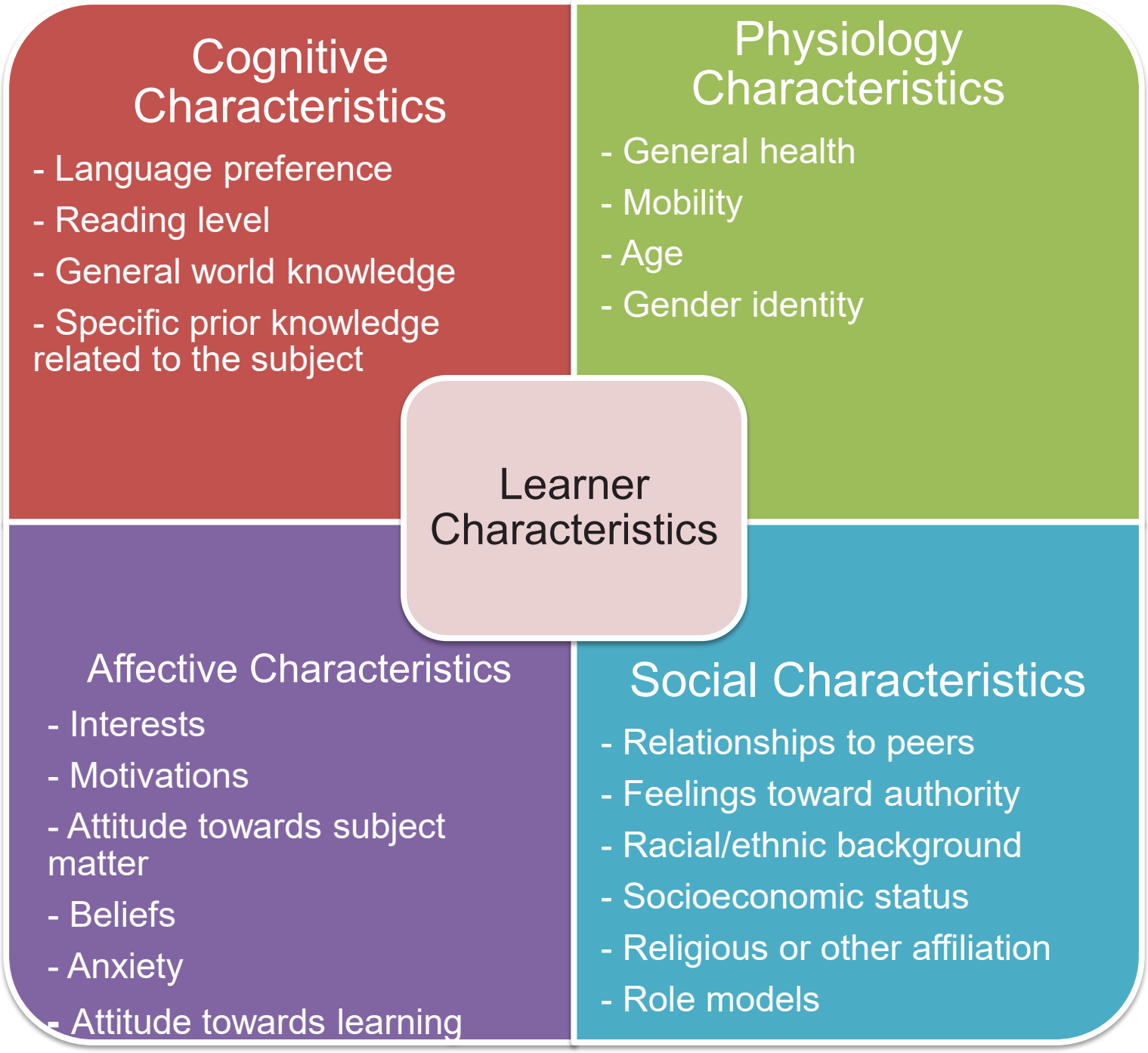
- Learner Characteristics
- Learning Objectives: Key Verbs
- Sample Lesson Plan

Popular Education Methods

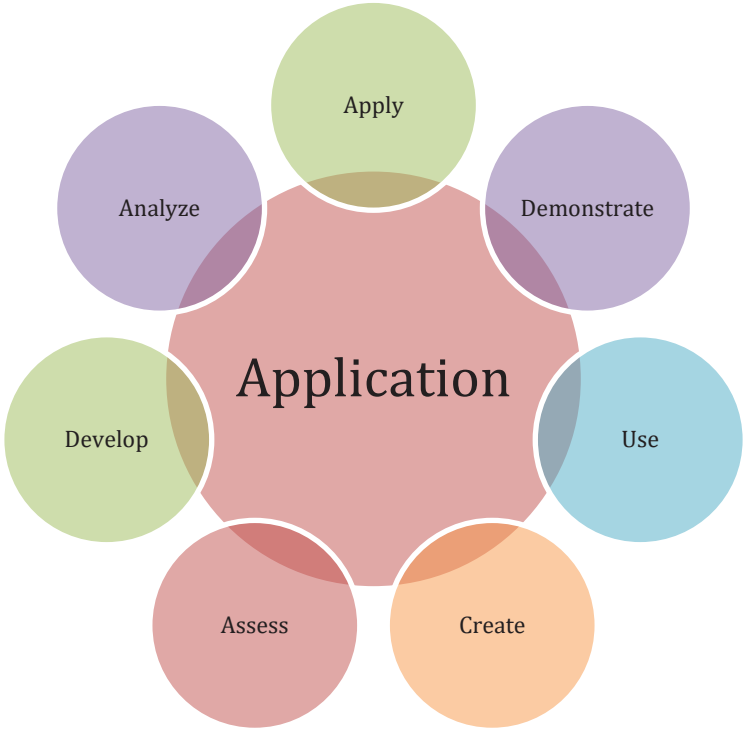
INSTRUCTIONS (continued)

3. Facilitate the Learner Analysis activity (25 minutes)
   - Explain that the next step in our preparation is to gather information about the participants or learners.
   - Ask, "When preparing a session, what would be helpful for you to know about your training participants?"
   - Divide the participants into small groups using the following method or one of your own.
     - Distribute the thank you cards in different languages. Pass out one card to each participant. They will form new groups, by finding the members who have a card with the same language as theirs. They will find their group members by saying thank you in the language on their card.
   - Their task is to make a list of learner characteristics on flip chart paper. Instruct each group to brainstorm a list of learner characteristics that they would want to know before preparing a session. Give each group a flip chart sheet and marker.
   - Ask participants to choose as a group the five most important criteria from their list and write their learner characteristic priorities on flip chart paper. If there is anything missing from the list that they want to add as a priority, they may do so.
   - Ask for a reporter from each group to share back their five priorities. Mention that each group's ideas may bring new insights to our session planning process.
   - Distribute Learner Characteristics handout to each of the participants. Review this handout and compare to the items drafted by the participants on the flipchart.
4. Facilitate the Content Analysis activity (20 minutes)
   - Distribute the Learning Objectives: Key Verbs handout.
   - Explain that another step in session preparation is the content analysis. This relates to the topics that will be covered in the session and how to sequence the topics so that they build upon each other and flow well.
   - Learning objectives are what you want the participants to be able to know or do as a result of your session or group. They always start with a verb. Some examples of verbs that relate to knowledge include "describe, identify, name, list, and understand." Examples of verbs related to doing are "apply, practice, demonstrate, and create." Reference the Learning Objectives: Key Verbs handout.
   - Ask everyone to remain in their small groups. Ask each group to choose a topic (for example: (a) sexual health; (b) HIV life cycle; or (c) medication adherence). After they choose a topic, then ask them to write 2–3 learning objectives related to that topic for a sample session. They can use the Learning Objectives Key Verbs handout for guidance.
   - Ask participants to take notes on flip chart paper. After 10 minutes, ask them to post their flipcharts on the wall and have everyone do a gallery walk by walking around the room and reading what the other groups wrote on their flip chart paper.
   - Ask, "Did anything catch your attention?"
5. Wrap up.
   - Distribute and review the Sample Lesson Plan handout as a format they can use to create lesson plans.
   - Thank participants for their contributions.

Learner Characteristics



Learning Objectives: Key Verbs



Sample Lesson Plan From: We Are Health: A Capacity-Building Curriculum for Community Health Workers

Leadership and Advocacy Skills

PLACE: DATE:

TIME: 3.5 hours FACILITATORS:

Objectives: By the end of the session, participants will be to:

- Describe four different models of leadership
- Identify qualities and skills of an empowering leader
- Describe and define the two levels of advocacy: individual and group
- Apply the skills of empowering leadership to advocacy at the individual level

Topic	Method	Process	Time	Materials	Facilitator
Introduction	Lecture	• Welcome participants to the session. • **Ask: "Do you have any reflections or comments from last week's classes (addictions/recovery and self-care) that you would like to share with the group?"** • Introduce the topic. During this session we will be focusing on leadership and advocacy skills for CHWs. • Present the agenda and objectives. • Explain that many of us are already recognized as community leaders. Our previous experiences with different types of leadership affect the way we teach and empower other community members and	20 min	❑ Flip chart: Topic ❑ PowerPoint: Agenda and Objectives	

		leaders. For that reason, it is very important to think critically about different types of leadership and learn how to use the style or styles that are appropriate in each setting. • Ask: **"Does anyone have questions before we proceed?"**			
Introduction to leadership skills	Dinámica and brainstorm	• We will start by exploring the meaning of the word "leader." • We are going to use a dinámica called "The Hot Ball." • Ask the participants to stand up and tighten the circle. • Explain that while the music is playing, the participants will pass the hot ball around the circle. When the music stops, the person holding the ball will share their answer to the question, and the facilitator will write it on the flip chart paper. • The facilitator will present a flip chart page with the question, **"What comes to mind when you hear the word 'leader'?"** • Play the dinámica and write responses on flipchart paper. • Reflect: **What catches your attention about the words we associated with the word "leader"?** • The facilitator will then present a definition of leadership: ***"Leadership means taking responsibility for the world around you. A leader is someone who can see the entire situation, organize the experience of the group, offer a vision of the future, and teach followers to be leaders. To be a leader means to have special opportunities to make a magnificent difference in the lives of those who allow the leader to guide them." (Miguel Angel Cornejo y Rosado)*** • Ask, **"What catches your attention about the definition?"**	15 min	❑ Flip chart: "Leader" in mind-map /bubble format ❑ PowerPoint: Definition of leadership ❑ Ball ❑ Music ❑ CD player/ smartphone ❑ Speakers	

		● Thank participants for their participation, and explain that we are going to continue discussing leadership in the next activity.			
Four models of leadership	Visual aid/drawing	● Explain that there are many different kinds of leadership. Now we will explore 4 different models of leadership. ● Present the PowerPoint to the group with the four models of leadership (one slide at a time): ● Ask them to reflect (one slide at a time): ● **What does this model tell or suggest to you? What kind of a leader is this? What might we call this leader?** ● Clarify the meaning of each type of leadership by referencing the handout on the four leadership styles. Reflection: ● **What are advantages and disadvantages of each model? When is it appropriate to use each model?** ● **Which style or styles of leadership will be most effective in your role as a CHW in your own community?**	25 min	❏ PowerPoint: Drawings of 4 leadership styles ❏ Handout: WAH Definitions of four leadership styles ❏ Flip chart: ❏ Page with names covered for four different leadership styles	
Our personal experience with empowering and disempowering leaders	Art posters and gallery walk	• Now we will explore the qualities and skills of an empowering leader. • Explain: Think about an experience that you have had with an empowering *and* a disempowering leader. • Ask them to create a drawing to represent both experiences, using half page for each experience. • Post their drawings on the wall. • Ask participants to go around the room and look at the gallery walk of empowering *and* disempowering posters. • Invite the group to come back to the circle.	15 min	❏ Blank flip chart paper for poster ❏ Markers	
Characteristics of an	Pairs with shapes	● Explain: Think about an experience that you have had with an empowering leader. Then, when you	20 min	❏ Flip chart: page divided in half:	

Empowering leaders		have that image in your mind, think about the characteristics that he/she has. ● Then, write on one of the shapes a positive characteristic that the leader used that made you feel empowered. ● Then, think of an experience that you have had with a disempowering leader. Then, in the other shape write a negative attitude or behavior that the leader used that made you feel disempowered. ● Then, ask participants to find a partner so they can share their work/experiences with each other. Invite participants to come to the front, read their shapes out loud and paste them on the flipchart page. Reflection: ● What catches your attention about the positive characteristics of **empowering** leaders? ● What catches your attention about the negative attitudes and behaviors of **disempowering** leaders? ● Why do you think it is important that we, as CHWs, use empowering leadership qualities/skills with our communities? ● Reference the handout on characteristics of an empowering leader.		empowering/ disempowering ❏ Shapes (2) ❏ Sharpies ❏ Handout: Characteristics of an Empowering Leader	
My personal commitment card	Individual reflection and writing	● Hand out “My Personal Leadership Commitment” cards. ● On the left hand side of the card, ask each participant to write 3-5 leadership skills that they would like to improve. ● Next to each skill, have them write one way that they will try to strengthen that skill. ● Give participants 5 minutes to fill out their cards. ● Explain that we want them to take this card home and use it as a reminder of their goals.	5 min	❏ Handout: Leadership Commitment Cards	
Break		● We will now take a 15-minute break and return to focus on advocacy skills.	15 min		

Re-integrating the group	Dinámica	● Welcome people back from the break. ● Invite them to play the dinámica of charades. ● Ask 4-5 people to stand in a line facing the same direction. The facilitator will share a scene with the person at the back of the line to act out. When the participant is ready, they will tap the shoulder of the person standing in front of them to have that person turn around and face the person in the back of the line. The "actor" will act out the scene without using words. The second person then taps the shoulder of the person in front of them and acts out the scene. The last person to watch the scene acted out will guess what the scene is. **Potential scenes (to act out):** ● A community leader teaching a class on breast health to a men's group. ● A leader advocating for a community member at a clinic ● A teacher teaching 5-year-olds and their parents to brush their teeth	10 min	❑ Scenarios written on paper	
Introduction to advocacy and effective individual advocacy	Sociodrama	● Explain: One of the skills of CHWs identified in the National Community Health Advisor Study was "Advocating for groups and individuals." Now we will discuss advocacy skills, which are connected to leadership skills. ● Present a definition of advocacy: ***An advocate is someone who argues for a cause – a supporter or a defender. To advocate is to act in support of a particular issue, cause or person. (Adapted from the American Public Health Association)*** ● Explain that it is important to remember that advocacy can happen on an individual level with a	45 min	❑ PowerPoint: Definition of advocacy ❑ Flip chart: page for reflection	

		community member *and* on a group level to address a problem or issue in the community. ● The difference between advocacy and organizing is that advocates often speak on behalf of others, while organizers get those affected to speak for themselves. ● Explain that we will now look at effective advocacy methods through sociodramas. ● Divide participants into groups of 5 people. Ask each group to prepare a sociodrama to demonstrate advocacy at the individual and/or community level. Each group can choose their own scenario. Allow 10 minutes for preparation. ● Have groups present their socio-dramas to larger group. ● After all groups have presented, ask, **"What advocacy skills did you see in the sociodramas?"** ● Write answers on flipchart.			
Empowering leadership and effective advocacy	Cooperative learning	● Explain that for our next activity, we will explore how the positive characteristics of an empowering leader can be used to do effective advocacy at the individual level. ● Divide participants into groups of 4-5 people. Remind them to choose new and different roles in their groups. ● Give each group a handout with Marta's Story. Ask each group to read through Marta's story and answer the question: **"If you were a CHW working with Marta, how could you use empowering leadership skills to effectively advocate for Marta?"** ● Encourage participants to refer to the Characteristics of an Empowering Leader handout. Ask each group to record their answers on flipchart	30 min 15 min group work 15 min report back	❏ PowerPoint: Question ❏ Blank flip chart pages ❏ Handout: Copies of Marta's story from Public Health session	

		paper. ● Gather participants back together and ask each group to report back on their discussion.			
Key points		● There are 4 commonly used leadership styles: authoritative, paternalistic, participatory and empowering. As a CHW, often the most effective style to use is empowering leadership. ● Some characteristics (skills and qualities) of empowering leaders are the ability to create an environment of trust, focus on strengths, and know their limitations. ● An advocate is someone who argues for a cause – a supporter or a defender. To advocate is to act in support of a particular issue, cause or person. ● To be an effective advocate, it is important to use empowering leadership skills.	5 min	❑ PowerPoint: Key points	
Evaluation	Individual work	● Hand out written evaluation for the session. ● Thank everyone for their participation.	5 min	❑ Handout: Written evaluations	

Facilitation Challenges

OBJECTIVES

At the end of this unit, participants will be able to:

- Know and practice effective facilitation skills

INSTRUCTIONS

1. Before the session begins, prepare flipchart sheet with the header: Facilitation Challenges.
2. Welcome participants and review the objectives for the session.
3. Explain that there are some challenges to facilitation that are related to certain kinds of behaviors and others that may be more contextual. For instance, a challenging behavior may be a participant who talks a lot. A contextual challenge may arise when you are facilitating a group with whom you don't share the same identity/culture.
4. Ask, "What are some challenges you have faced when facilitating or participating in a workshop or meeting?"
5. Take 5 minutes to brainstorm and write answers on flipchart. Then ask the group to choose 4 to 5 topics. Write each topic as a heading on a piece of flipchart paper. Post the flipchart pages in different areas of the room.
6. Explain that the participants will now have a chance to do a gallery walk. There will be 3 different rounds of 10 minutes each. Each participant can choose to go to whichever topic most interests them, discuss ideas for how to approach that challenge, and then write notes on the flipchart page. They can stay at the same challenge or change to another challenge when the facilitator rings the bell or gives a signal at the end of each 10-minute session.
7. At the end, have each group quickly read through what was written on their flipchart page.
8. Debrief, the session by asking:
   a. Who would like to share one thing they learned about facilitating a group today?
   b. As a CHW, how might you use this information in your work?
9. Wrap up
   - Distribute and reference handout on "Principles for Group Facilitation" for further reading on their own leisure time.
   - Thank participants for their contributions.

Related C3 Roles

Building individual and community capacity

Related C3 Skills

Communication skills, education and facilitation skills

Method(s) of Instruction

World Cafe/Gallery Walk

Estimated time

45 minutes

Key Concepts

Facilitation skills

Materials

- Flipchart
- Markers
- Bell or other alarm

Handouts

- Principles for Group Facilitation

Principles for Group Facilitation

Purpose and Preparation

- Think about what your goal or purpose is as a facilitator. How can you not only move groups through the agenda, but also guide them in a way to think more critically about how they see the world?
- Consider what your role is as a facilitator, particularly in groups that you are not familiar with.
- Get to know your audience. Information about their prior and current work, hopes for the training, and demographic data should be used to adapt your training to make it relevant for the audience.
- Although facilitators are not expected to be experts, they should be familiar with the content. Think about your process for including updated information into the training.
- For each activity, know what your objective is and the process (or methods) used to help the participants achieve that objective.
- Take the time to ground yourself and prepare mentally and emotionally before you arrive.
- Allow enough time to set up the space so that you don't feel rushed.

Sharing Power

- Think critically about how to balance power and privilege in the room.
- Share as much power as possible with the participants.
- Allow and provide space for groups to make their own decisions.
- Encourage participants to take risks.
- Facilitators should bring their own personality and life experience to the table. At the same time, be mindful about how much you are speaking and whether your comments are helping the group to move forward.

In the Moment

- Learn how to build trust with the participants. Do this early and often.
- Be humble and flexible.
- Remember that the agenda is a tool to help you achieve the objectives – don't feel like you have to strictly follow the agenda if the learning is happening in another way.
- Use different strategies to balance participation in the room.

- Think about how to actively involve participants in their learning.
- Provide enough space for participants to respond to questions and requests for input (i.e. allowing more than one or two people to respond; being comfortable with silence and counting to eight in your head before moving on).
- Invite, don't force, people to participate. Some people don't feel comfortable talking in front of a large group and may participate more in a pair or small group activity.
- Learn to read the energy in the room and know when to give space for healing, for exploration or extension of the topic addressed, or to move on.
- Use a "Question Warehouse" or "Bike Rack" when there is a question that cannot be answered or if a discussion is off topic and the group would like to return to it at a future time.
- Be aware of your own perceptions, judgments, or prejudices in the moment and how this may be influencing your behavior.
- When a group member raises a question, first put it back to the group to see what others already know. Clarify as needed.
- Consider how you will clarify information that is shared that is not up to date or correct in a way that is respectful and not shaming.
- Know how you react to conflict and feelings of discomfort. Recognize when conflicts arise and do your best to handle it in a healthy way.

Facilitation Skills

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand basic facilitation skills: push, pull, and balance
- Practice facilitation skills

INSTRUCTIONS

1. Before the session begins, select and print icebreakers and energizers from the PETS toolkit prior to the training session. Select two or three easy activities that can be accomplished in a short period of time. Review the handout on "Balancing Skills" to be familiar with the facilitation skills.
2. Welcome participants, introduce the topic, and share objectives.
3. Conduct the activity "Three Basic Facilitation Skills" (15 minutes)
   - Explain that CHWs may have roles that include group facilitation in educational, support, or social groups. There are 3 basic facilitation skills that serve as a starting point for effective group facilitation.
   - Distribute the Balancing Skills handout.
   - Describe each skill: Push, pull, and balance. Write the skills on flip chart sheets to create a visual aide (optional).
   - Push skills occur when information flows from the facilitator to participants. Push skills involve transmitting (giving) information. Participants can imagine an arrow pointing away from the facilitator to remember the directional flow of information.
     - Examples: welcome, facilitator introduction to the group, giving instructions.
     - Ask participants to give another example of a push skill.
   - Pull skills occur when the facilitator requests information from the participants. Pull skills often involve the use of open-ended questions to receive information and invite participation. Participants can image an arrow pointing to the facilitator to remember the directional flow of information.

(continued)

Related C3 Roles

Building individual and community capacity

Related C3 Skills

Communication skills, education and facilitation skills

Method(s) of Instruction

Small group

Estimated time

60 minutes

Key Concepts

Facilitation skills, leading groups, support group skills, group facilitation skills

Materials

- Flip chart
- Markers
- Practice assignments (Icebreakers from PETS toolkit *https://ciswh.org/wp-content/uploads/2016/05/HIV-peer-training-activities.pdf*)

Handouts

- Balancing Skills

Resources

Icebreakers and Energizers from PETS toolkit *https://ciswh.org/wp-content/uploads/2016/05/HIV-peer-training-activities.pdf*

Facilitation Skills

INSTRUCTIONS (continued)

- Examples: eliciting information from participants using open questions, inviting group members to participate in an ice breaker, polling the group.
- Ask participants to give an example of a pull skill.

- Balancing skills are a collection of skills used to create and maintain a safe and supportive group atmosphere. This collection of skills helps the group function well. In addition to the examples below, draw participants' attention to the handout "Balancing Skills" for more information.
  - Examples: creating safety within the group via group agreements, trust building activities, managing silence, sharing power.
  - Ask participants to provide examples of push, pull and balancing skills they have noticed during this training session. Affirm their responses and provide examples that have not been shared.

4. Conduct the practice activity **(35 minutes. Note: The time allotted is not sufficient for every participant to facilitate. Adjust according to your needs.)**
   - Introduce the activity. Tell participants they will have an opportunity to practice push, pull, and balancing skills by facilitating an icebreaker or energizer.
   - Divide participants into small groups of 4–5 participants.
   - Tell participants to select a volunteer from their group who will lead an activity. The remaining members of the group will role-play session participants.
   - Once the volunteer facilitators are identified, distribute an icebreaker or energizer to each. Allow 3–5 minutes for them to read the instructions and prepare to facilitate.
   - Inform volunteer facilitators that they will not have time to facilitate each step of the activity. They are to focus on using their facilitation skills, push, pull, and balance. Executing the activity perfectly is not the goal.
   - Inform remaining group participants to stay in role, but simultaneously observe the facilitator's use of push, pull, and balance skills to provide feedback at the end of the activity.
   - Allow 7 minutes each for group to practice push, pull, and balancing skills during their facilitations.
   - At the end of the first practice session, allow participants (within their small groups) 1–2 minutes to share with each other the facilitation skills they observed.
   - Next, repeat the steps with a new facilitator and new activity. (Note: Time allotted allows for 2 practice sessions.)
5. Debrief and close (10 minutes)
   - Reconvene the large group.
   - Ask participants for examples of when they saw the facilitators using push, pull, and balancing skills. Ask them to note instances when the facilitator did well and areas that would strengthen their ability.
   - Invite practice facilitators to share feedback on their facilitation by responding to these questions.
     - What did you do well during your facilitation practice?
     - What do you think would strengthen your facilitation skills?
   - Points to remember:
   - Too much push can stifle participation. Too much pull can lead to disorder and lack of direction. Balancing skills are effective in establishing an effective atmosphere for learning and sharing.
6. Wrap up
   - Summarize and close.
   - Ask participants if there are any questions.
   - Ask, "What is one new thing you learned to use in your work as a Community Health Worker?"
   - Take responses from 2–3 participants.
   - Thank participants for their contributions.

Balancing Skills

Giving and receiving feedback is a balancing act. Effective facilitators correct misinformation and give an affirming response to a participant at the same time. They know how to give feedback, how to receive it, and how to apply it.

Maintaining a nonjudgmental perspective is another balancing act. In order to learn, people need to feel safe and willing to participate in the session. Part of this safety is in knowing that their values and beliefs will be respected. By remaining nonjudgmental, effective facilitators balance many skills at once. They apply skills they have learned, such as avoiding labels, and instead use language that describes behavior. They also give affirming feedback to all participants even when their own values differ from those of the participants.

Setting the climate allows effective learning to take place. Although we often think of climate setting as the opening of a training session (for example, the icebreaker), the opening is only part of the overall process. Climate setting continues throughout the session in different ways: by providing affirming feedback to participants, by bouncing back questions and comments to stimulate greater participation, by removing distractions in the physical environment such as noise, interruptions, uncomfortable chairs, and maintaining a comfortable room temperature, and by having all necessary audio-visual equipment ready and working.

Keeping on topic can also be a balancing act because the facilitator is often trying to cover content using push and pull skills and thus meet participant needs by responding to their comments or questions. When a question or comment takes the group off topic, the facilitator must decide whether the detour creates a learning opportunity (a teachable moment), or whether he/she needs to bring the group back on track. This may mean that they will put some questions aside for discussion later. A parking lot is a good way of keeping track of questions that have been put aside for later. These are publicly posted sheets of paper on which questions are written to be addressed later.

Managing time is finding a balance between meeting group needs, taking advantage of teachable moments, and staying on schedule. Managing time includes getting agreement from the group on starting, ending, and break times, being responsible for starting and ending sessions on time, making sure that all important agenda items fit into the schedule, and reaching agreements with participants regarding time and content issues.

Reference:
Building Blocks to Peer Success, April 2009: Facilitation Skills
https://ciswh.org/wp-content/uploads/2016/05/HIV-peer-training-toolkit-guide.pdf

Care Planning

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand approaches/models to use in care planning
- Practice creating a care plan by using templates
- Discuss successes and challenges of care planning with colleagues
- Understand strategies to address challenges

INSTRUCTIONS

1. Before the session, review the PowerPoint slides and handouts.
2. Welcome participants and review objectives (slide 2).
3. Describe the components of a care plan (slides 3–4). Clarify that many agencies have their own format for care plans. Ask, "How many of you use a care plan at your agency? How similar or different is your agency care plan to the one on the slide?"
4. Distribute blank sample care plans (at least 2 per participant) and the Care Planning Case Scenarios (also on slides 5–6).
5. As a group, review the scenarios. Give participants time to create a care plan on their own or in pairs.
6. Distribute the handout RAP Documentation: Patient Case Notes and review the RAP model (slide 7).
7. Distribute the handout Gibbs Reflective Cycle. Walk through each step describing how these questions can help CHWs work with clients to identify and complete care plans (slide 8).
8. Wrap up. Review the questions and facilitate a brief group discussion (slide 9), encouraging the group to share additional points about care plan documentation.

Related C3 Roles

Care coordination, case management, and system navigation; providing coaching and social support; providing direct service; implementing individual and community assessments

Related C3 Skills

Interpersonal and relationship-building skills, communication skills, service coordination and navigation skills, capacity building skills, individual and community assessment skills, outreach skills

Method(s) of Instruction

Lecture, group discussion, demonstration

Facilitator's note: This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

60 minutes

Key Concepts

Care plans, documentation, consultations, team, client-centered care

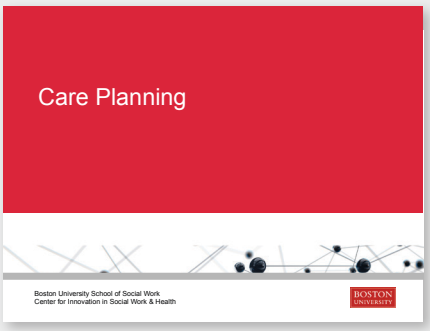
Materials

- Computer with internet access and projector
- PowerPoint slides

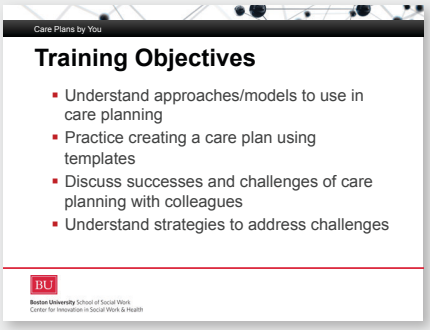
Handouts

- Sample Care Plan I
- Sample Care Plan II
- Care Planning Case Scenarios
- RAP Documentation: Patient Case Notes
- Gibbs Reflective Cycle

Care Planning

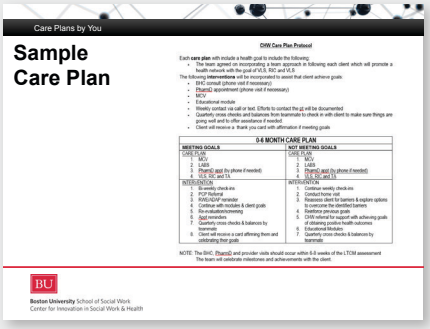


SLIDE 1



SLIDE 2

Review the slide.

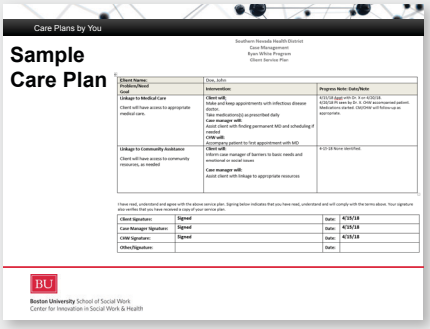


SLIDE 3

Review the slide and answer questions.

Ask, "How many of you use a care plan at your agency? How similar or different is your agency care plan to the one on the slide?"

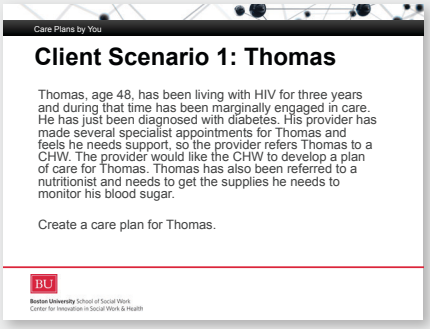
Facilitate a brief discussion.



SLIDE 4

Review the slide.

Distribute two blank sample care plans and the handout Care Planning Case Scenarios.

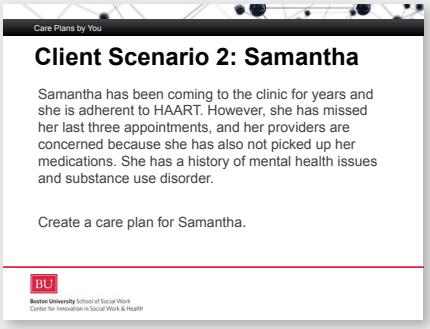


SLIDE 5

Tell the group we are going to review a few scenarios and practice filling out a care plan.

Ask for a volunteer to read the client scenario. Solicit input from the group for examples of what to include in the care plan.

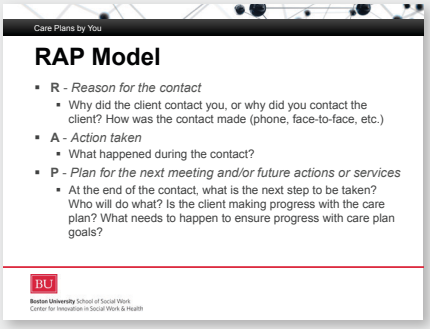
Give participants 10 minutes to complete their care plan for Thomas, then discuss as a group.



SLIDE 6

Ask for a volunteer to read the client scenario. Solicit input from the group for examples of what to include in the care plan.

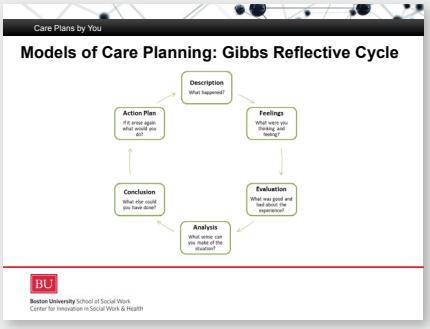
Give participants 10 minutes to complete their care plan for Samantha, then discuss as a group.



SLIDE 7

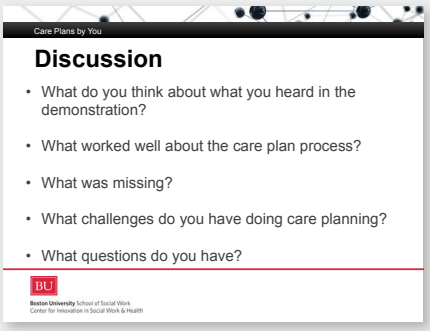
The RAP model is a simple way to structure a encounter note.

Review the slide and discuss as a group.



SLIDE 8

Review the steps in the graphic.



SLIDE 9

Review the questions and facilitate a group discussion.

Sample Care Plan I

CHW Care Plan Protocol

Each **care plan** with include a health goal to include the following:

- The team agreed on incorporating a team approach in following each client which will promote a health network with the goal of VLS, RIC and VLS

The following **interventions** will be incorporated to assist that client achieve goals:

- BHC consult (phone visit if necessary)
- PharmD appointment (phone visit if necessary)
- MCV
- Educational module
- Weekly contact via call or text. Efforts to contact the patient will be documented
- Quarterly cross checks and balances from teammate to check in with client to make sure things are going well and to offer assistance if needed.
- Client will receive a thank you card with affirmation if meeting goals

0-6 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA	CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA
INTERVENTION 1. Bi-weekly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Conduct home visit 3. Reassess client for barriers & explore options to overcome the identified barriers 4. Reinforce previous goals 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate

NOTE: The BHC, PharmD and provider visits should occur within 6-8 weeks of the LTCM assessment

The team will celebrate milestones and achievements with the client.

6-9 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Home visit from LTCM and CHW 3. Reassess client for barriers & make referral to community agency 4. Call from provider w/concerns re: NVLS & NRIC 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate to include interventional assessment
9-12 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 6. MCV 1. LABS 2. PharmD visit (by phone if needed) 3. VLS, RIC and TA 4. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a certificate and gift bag to CELEBRATE this milestone and affirming them.	INTERVENTION 1. Readiness for change assessment 2. Monthly check-ins 3. Educational Modules if it is determined that the client is ready 4. Quarterly cross checks & balances by teammate to include interventional assessment 5. Place client on an inactive list if it is determined that the client is not ready

12-18 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins for 12-18 months. At the 18 month mark the client will be contacted bi-monthly. 2. RWE/ADAP reminder 3. Continue with modules & client goals 4. Re-evaluation/screening 5. Appt reminders 6. Quarterly cross checks & balances by teammate 7. Client will receive a card celebrating milestones with affirmations.	INTERVENTION 1. Continue monthly check-ins 2. Place client on an inactive list if it is determined that the client is not ready

Source: East Caroline University Adult Specialty Care Clinic

Sample Care Plan II

Southern Nevada Health District
Case Management
Ryan White Program
Client Service Plan

Client Name:		
Problem/Need Goal:	**Intervention:**	**Progress Note: Date/Note**
Linkage to Medical Care	**Client will:** **Case manager will:** **CHW will:**	
Linkage to Community Assistance	**Client will:** **Case manager will:** **CHW will:**	

I have read, understand and agree with the above service plan. Signing below indicates that you have read, understand and will comply with the terms above. Your signature also verifies that you have received a copy of your service plan.

Client Signature:		**Date:**	
Case Manager Signature:		**Date:**	
CHW Signature:		**Date:**	
Other/Signature:		**Date:**	

Care Planning Case Scenarios

Thomas

Thomas, age 48, has been living with HIV for three years and during that time has been marginally engaged in care. He has just been diagnosed with diabetes. His provider has made several specialist appointments for Thomas and feels he needs support, so the provider refers Thomas to a CHW. The provider would like the CHW to develop a plan of care for Thomas. Thomas has also been referred to a nutritionist and needs to get the supplies he needs to monitor his blood sugar.

Create a care plan for Thomas.

Samantha

Samantha has been coming to the clinic for years and she is adherent to HAART. However, she has missed her last three appointments, and her providers are concerned because she has also not picked up her medications. She has a history of mental health issues and substance use disorder.

Create a care plan for Samantha.

RAP Documentation: Patient Case Notes

Various entities (HRSA, ADPH, United Way, etc.) require program staff to compose case notes to record actions taken in a patient's treatment plan. Case note entries are used to reflect significant contacts related to a patient's care. Entries should be written in a manner in which an auditor or surveyor would be able to obtain a running history and general overview of the patient, their needs, services provided, the staff person's observations, and progress with the case or a lack of progress.

Below you will find a general guide for practical record keeping.

Minimum Requirements for Documentation

- Patient/client's full name
- Date
- Time
- Outside agency (if applicable)
- Title
- Author's signature if possible

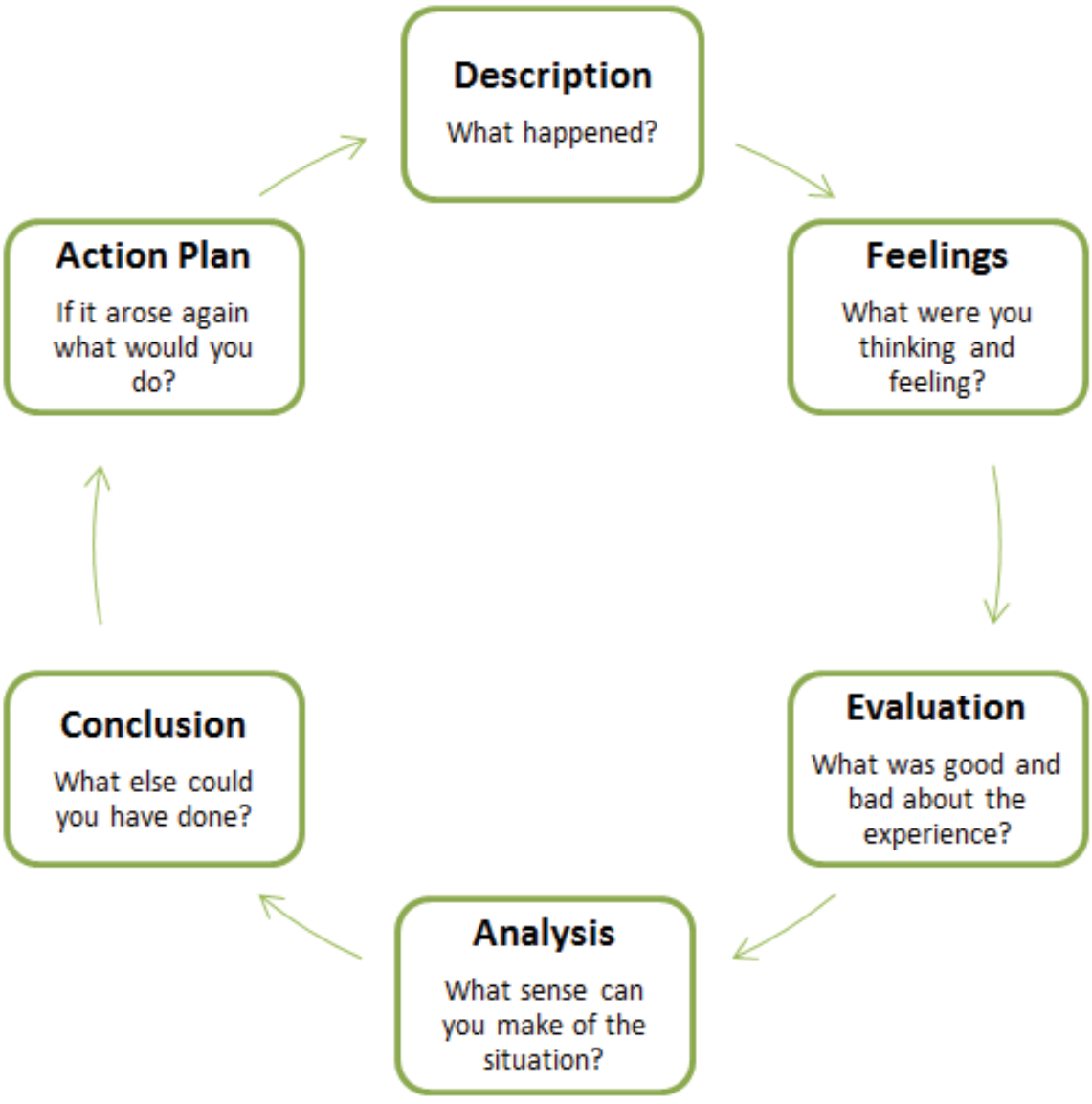
The SOAP (Subjective, Objective, Assessment and Plan) format is one that is sometimes used in documentation. Another common format is RAP. RAP stands for

R - Reason for the contact
- Why did the client contact you or why did you contact the client? How was the contact made (phone, face-to-face, etc.)?

A - Action taken
- What happened during the contact?

P - Plan for the next meeting and/or future actions or services
- At the end of the contact, what is the next step to be taken? Who will do what? Is the client making progress with the care plan? What needs to happen to ensure progress with care plan goals?

Gibbs Reflective Cycle



Source: Gibbs, G. (1988). *Learning by Doing: A Guide to Teaching and Learning Methods*. Further Educational Unit, Oxford Polytechnic, Oxford.

Acknowlegements

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (https://ciswh.org/resources/HIV-peer-training-toolkit) and the Community Capacitation Center, Multnomah County Health Department (https://multco.us/health/community-health/community-capacitation-center)

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This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30462 "Improving Access to Care: Using Community Health Workers to Improve Linkage and Retention in HIV Care" ($2,000,000 for federal funding). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Suggested Citation:

Boston University Center for Innovation in Social Work & Health. (2019). A Training Curriculum for Using Community Health Workers to Improve Linkage and Retention in HIV Care. Retrieved from: http://ciswh.org/chw-curriculum

BOSTON UNIVERSITY

Boston University School of Social Work
Center for Innovation in Social Work & Health

Documentation Skills for Community Health Workers

OBJECTIVES

At the end of this unit, participants will be able to:

- Create documentation using the SOAP note format
- Identify the purpose and common elements of good case notes
- Identify the challenges associated with completing case notes in an effective manner
- Identify best practices and what you as a CHW bring to the process
- Practice writing a progress note based on a case study

INSTRUCTIONS

1. Before the session, review the PowerPoint slides and handouts. This section is divided into two parts:
   - Learning how to write effective case notes, including the SOAP note approach for documentation
   - Critiquing case notes and practicing writing a SOAP note
2. Review the objectives and introduce the topic (slide 2).
3. Review the slides on why documentation is important, challenges of documenting work, observational skills, what CHWs bring to the process, and important points about case notes. Facilitate discussion throughout as indicated in slide notes (slides 3–12).
4. How to write effective case notes and SOAP note format
   - Explain that a helpful method for documenting our work is the SOAP note format.
   - Distribute the handouts on SOAP notes. Ask a volunteer to read what each letter stands for and the examples.
   - Review the slides about the content that should be included in the notes and facilitate discussion (slides 13–18).
   - Refer to the "Do's and Don'ts" section on the SOAP Note Definitions and Examples handout.
   - Review slides about other considerations when writing case notes, time management, and charting goals (slides 19–24).

(continued)

Related C3 Roles

Care coordination, case management, and systems; providing direct service; implementing individual and community assessments

Related C3 Skills

Communication skills, service coordination and navigation skills, capacity building skills, individual and community assessment skills

Method(s) of Instruction

Lecture, group discussion

Facilitator's note: Both CHWs and supervisors should attend this session. Participants could be trained together or separately.

This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

60 minutes

Key Concepts

Documentation, SOAP notes, case notes

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Handouts

- SOAP Notes
- SOAP Definitions and Examples
- Example of a Better Case Note
- Blank SOAP Note

Documentation Skills for Community Health Workers

INSTRUCTIONS (continued)

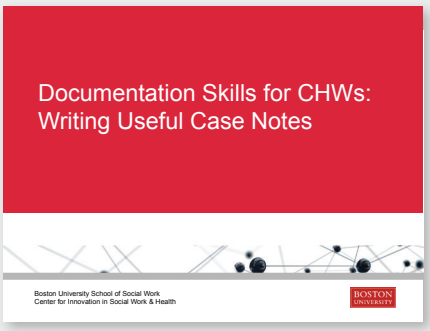
5. Practice writing case notes
   - Explain that we are now going to practice reviewing and writing case notes.
   - Review examples of a substandard case note and discuss how it could be better (slides 26–27).
   - Review example of a better case note (slide 28).
   - Facilitate the activity for Sheila's visit (slide 29). Participants can be placed into pairs. Distribute blank SOAP notes. Allow participants 15 minutes to complete.
   - Bring the group back together to discuss their SOAP notes and care plans for Sheila.
6. Wrap up. Summarize documentation content (slide 30) and ask participants to think about how they currently write notes (slide 31). Ask, "What one thing are you taking away from today's session to use in your work?" Be sure to solicit responses from both supervisors and CHWs if they are in the session together.

Resources

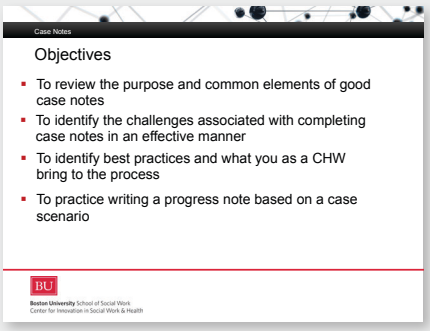
National Career Development Association Tips for writing case notes available at: *https://www.ncda.org/aws/NCDA/pt/sd/news_article/5443/_PARENT/CC_layout_details/false*

Learning to Write Case Notes article available at: *https://onlinelibrary.wiley.com/doi/abs/10.1002/j.1556-6678.2002.tb00193.x*

Additional sample forms for documenting work can be found in the Building Blocks to Peer Program Success resources in Section 7 at *https://ciswh.org/resources/HIV-peer-training-toolkit*



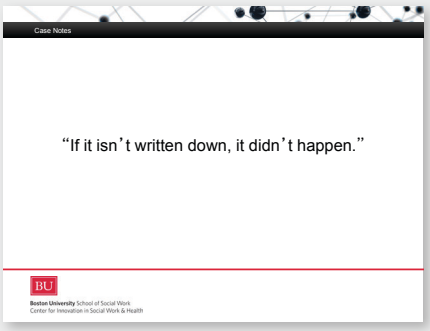
SLIDE 1



SLIDE 2

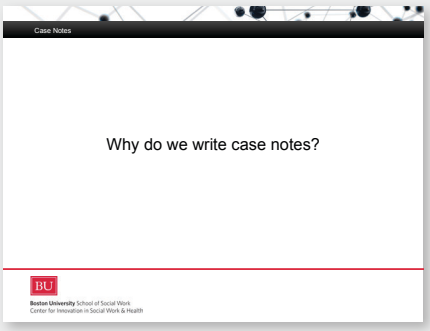
Review the slide.

Explain that in this session we will learn how to document our work with clients using the SOAP note approach, so we can share updates with the care team. Different organizations use different database systems and other forms of health information technology to record participant information. For our purposes today, we are going to focus on how to appropriately document our work as CHWs, knowing that each agency may use different technology to record information.



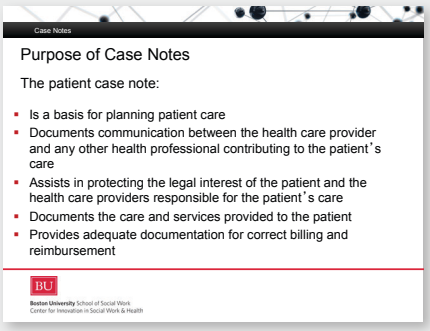
SLIDE 3

Ask, "Have you heard this phrase from supervisors or other people? What is your reaction to this statement?" Hold a brief discussion.



SLIDE 4

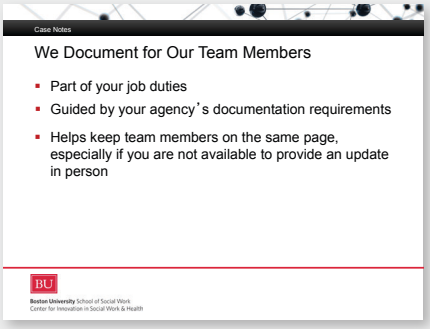
Ask, "Why do we write case notes?" Write responses on a flip chart sheet.



SLIDE 5

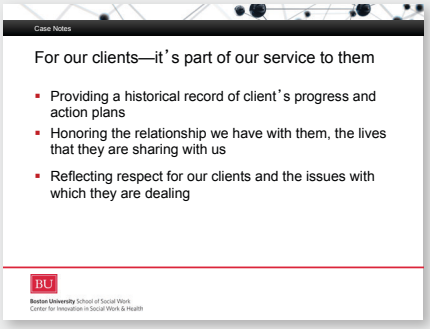
After the brainstorm, thank everyone for sharing.

The next few slides summarize some of the common reasons for documentation. Review the next slides quickly; the facilitator can ask for volunteers to read them if desired.



SLIDE 6

Review the slide.

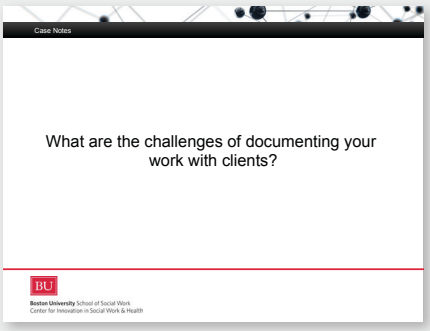


SLIDE 7

Review the slide.

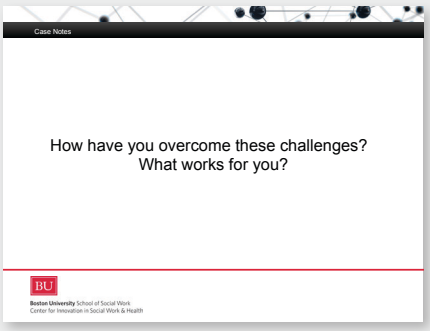
SLIDE 8

Review the slide.



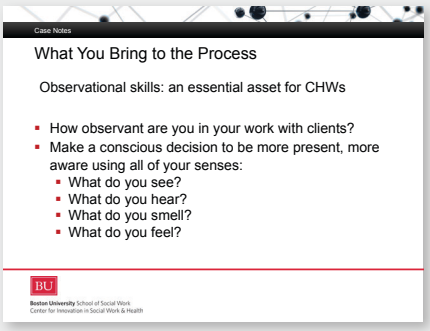
SLIDE 9

Brainstorm with participants to identify challenges. Write responses on flip chart.



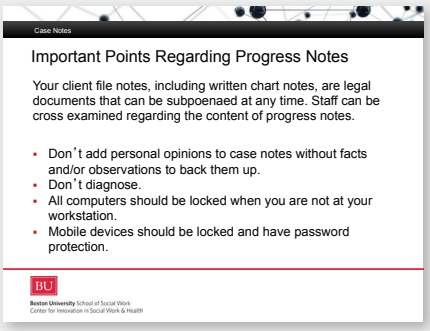
SLIDE 10

Invite participants to share their experiences and best practices. Write responses on flip chart.



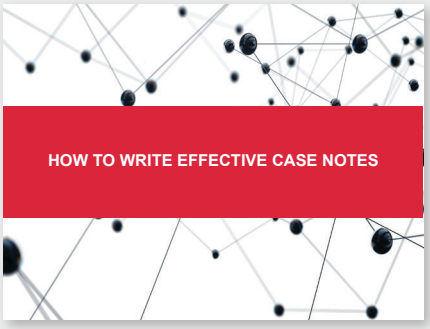
SLIDE 11

Review the slide.



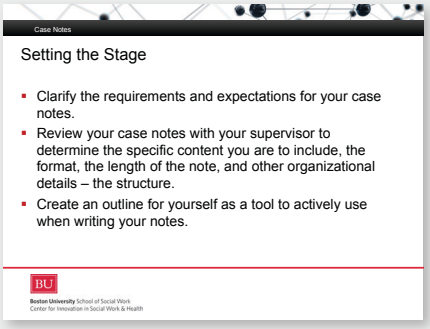
SLIDE 12

Read the slide.



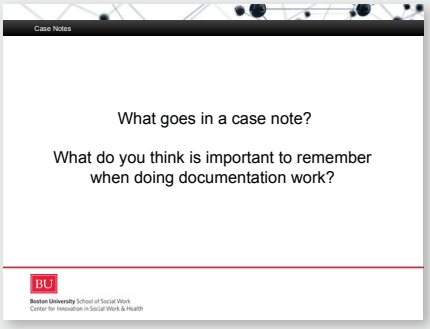
SLIDE 13

Next we are going review how to write effective case notes.



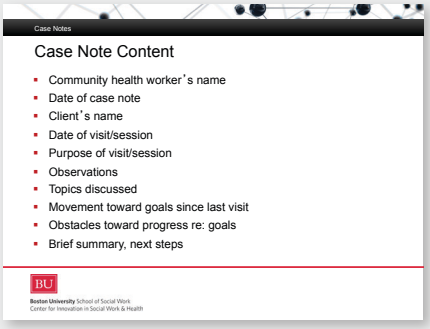
SLIDE 14

Review the slide.



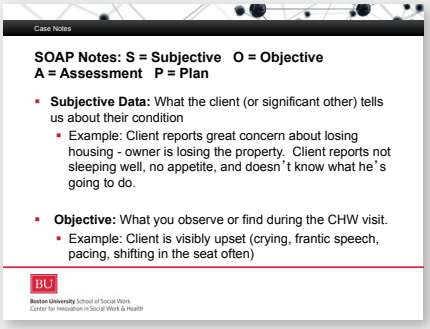
SLIDE 15

Briefly invite participants to share ideas. Write responses on flipchart.



SLIDE 16

This slide lists the core elements of a good case notes. . . . Ask a volunteer to read the slide.

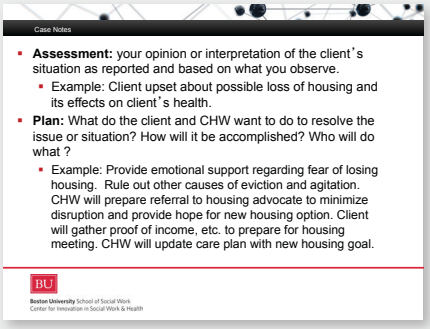


SLIDE 17

Distribute and refer to the SOAP note handout.

Emphasize that the Subjective section should include what the client tells us.

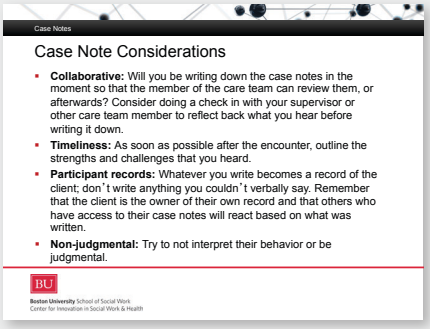
Objective data includes what we can observe that is measurable and describable—what did we see, count, hear, smell or measure?



SLIDE 18

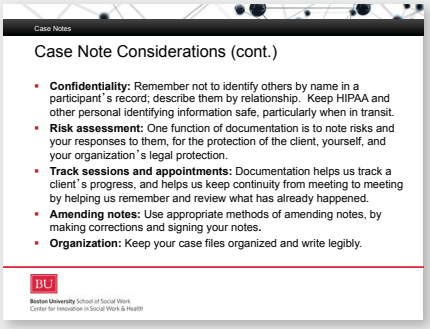
The Assessment section should include what is happening and/or needed with the client.

The Plan is the joint plan of action for the CHW and the client.



SLIDE 19

Review the slide.



SLIDE 20

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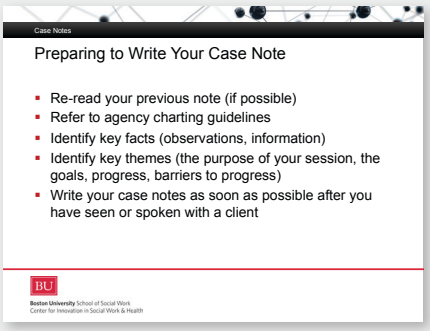
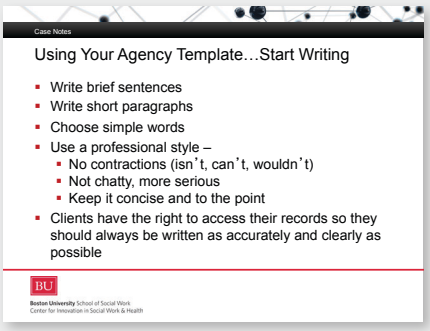


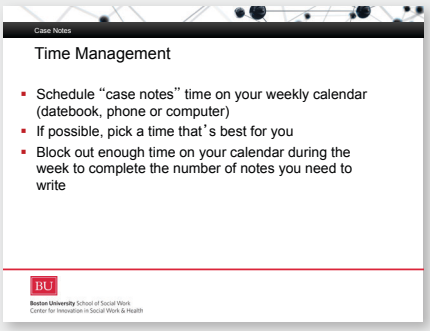
SLIDE 21

Review the slide.



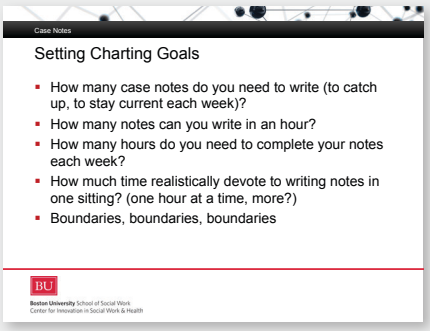
SLIDE 22

Review the slide.



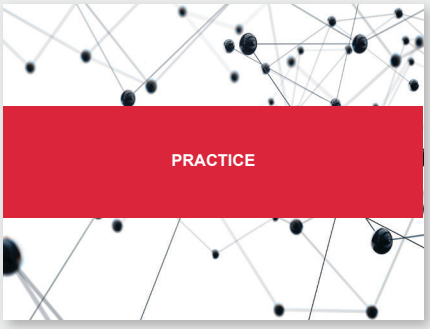
SLIDE 23

Review the slide.



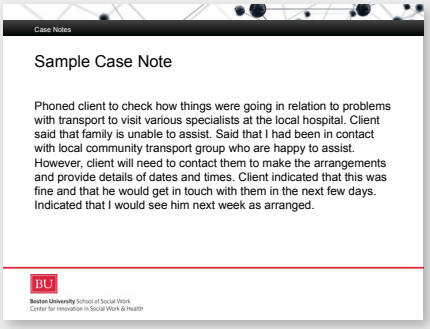
SLIDE 24

Review the slide.



SLIDE 25

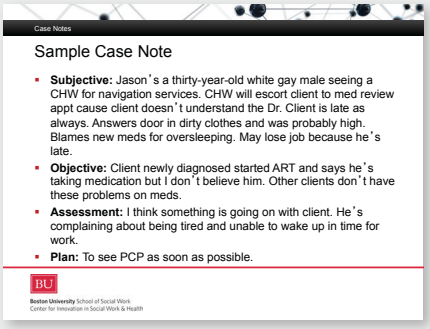
We are now going to critique sample chart notes to identify weaknesses and ways to improve the note.



SLIDE 26

Ask for a participant to read the slide.

Then ask, "Do you think that these case notes are useful? If not, why not? How would you improve them?"



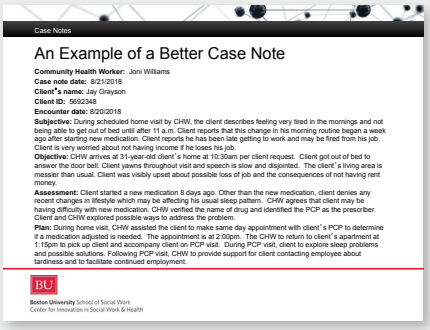
SLIDE 27

Ask for a participant to read this SOAP note.

Ask, "Why is this a substandard case note?"

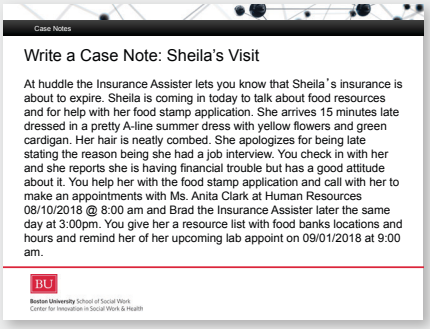
Possible answers:

- No documentation of who wrote note, date, time, place
- Judgmental: Client is late AS always. Client is high.
- Not objective: "I don't believe him…Other clients don't have these problems."
- Risk assessment: Too subjective: "I think something is going on with the client."
- Casual/unprofessional writing style.



SLIDE 28

Review the slide.

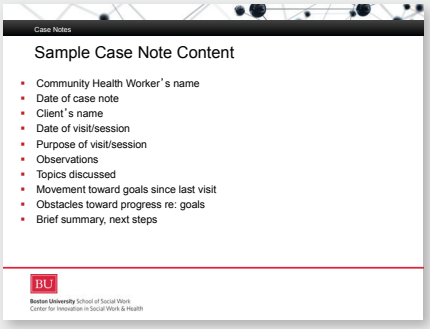


SLIDE 29

Now we will write our own case note and care plan. Here are your rough notes about work you did today with Sheila. How would you turn this into a chart note?

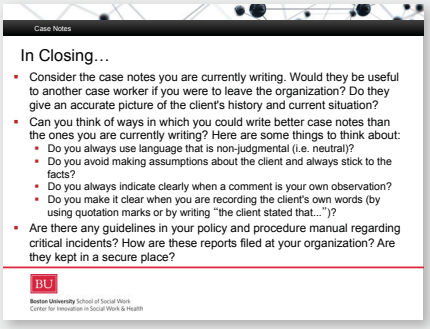
Divide participants into pairs and pass out the blank SOAP note. Have participants write a SOAP note for her visit. Allow 15 minutes for completion.

Bring the group back together to share their notes.



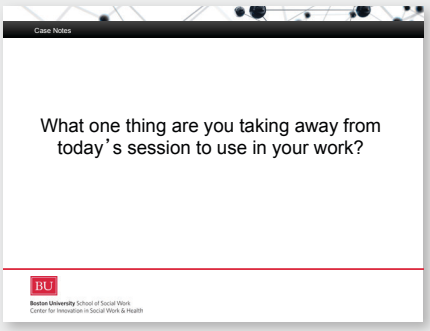
SLIDE 30

As participants discuss their SOAP notes, reference the content that should appear in the case note.



SLIDE 31

Encourage participants to add their thoughts on how they could improve the case notes they write.



SLIDE 32

Ask, "What one thing are you taking away from today's session to use in your work?" Be sure to solicit responses from both supervisors and CHWs if they are in the session together.

SOAP Notes

S=Subjective, O- Objective, A=Assessment, P-Plan

Subjective Data: What the client (or significant other) tells us about their condition. **Example:** Client reports great concern about losing housing - owner is losing the property. Client reports not sleeping well, no appetite, and does not know what he is going to do.

Objective: What you observe or find during the medical case management visit. **Example:** Client is visibly upset (crying, frantic speech, pacing, shifting in the seat often.

Assessment: The CHW's opinion or interpretation of the client's situation as reported and you observe. The conclusions made in the assessment are more than a restatement of the problem as it determines whether or not the situation can be resolved.

Example: Client upset about possible loss of housing and its effects on client's health.

Plan: What do the client and case manager want to do to resolve the issue or situation? How will it be accomplished? Who will do what part of the service? This can often be incorporated into the care plan.

Example: Provide emotional support regarding fear of losing housing. Rule out other causes of eviction and agitation. CHW will prepare referral to housing advocate to minimize disruption and provide hope for new housing option. Client will gather proof of income, etc. to prepare for housing meeting. CHW will update care plan with new housing goal.

SOAP Definitions and Examples

Section	Definitions	Examples
Subjective (S)	• What the community member tells you • What pertinent others tell you about the community member • Basically, how the community member experiences the world	• Community member's feelings, concerns, plans, goals, and thoughts • Intensity of problems and impact on relationships • Pertinent comments by family, case managers, behavioral therapists, medical professionals, etc. • Community member's orientation to time, place and person • Community member's verbalized changes toward helping
Objective (O)	• Factual • What the CHW personally observes/witnesses • Quantifiable: what was seen, counted, smelled, heard or measured • Outside written materials received	• The community member's general appearance, affect, behavior • Nature of the helping relationship • Community member's demonstrated strengths and weaknesses • Test results, materials from other agencies, etc. are to be noted and attached
Assessment (A)	• Summarizes CHWs thinking • A synthesis and analysis of the subjective and objective portion of the notes	• How would you describe the community member's behavior and the reasons (if any) for this behavior?
Plan (P)	• Describe the parameters of the intervention • Consists of an action plan and prognosis	• Action plan: Include interventions used, progress towards goals, and direction. CHWs should include the date of the next appointment. • Prognosis: Include the anticipated gains from the interventions

Guidelines for Subjective, Objective, Assessment, Plan (SOAP) Noting

Do

- Be brief and concise
- Keep quotes to a minimum
- Use an active voice
- Use precise and descriptive terms
- Record immediately after each session
- Start each new entry with date and time of session
- Write legibly and neatly
- Use proper spelling, grammar and punctuation
- Document all contacts or attempted contacts
- Use only black ink if notes are handwritten
- Sign-off using legal signature, plus your title

Avoid

- Avoid using names of other clients, family members, or others named by community member
- Avoid terms like “seems, appears,” etc.
- Avoid value-laden language, common labels, opinionated statements
- Do not use terminology unless trained to do so
- Do not erase, obliterate, use correction fluid, or in any way attempt to obscure mistakes
- Do not leave blank spaces between entries
- Do not try to squeeze additional commentary between lines or in margins

Example of a Better Case Note

Community Health Worker: Joni Williams

Case note date: 8/21/2018

Client's name: Jay Grayson

Client ID: 5692348

Encounter date: 8/20/2018

Subjective: During scheduled home visit by CHW, the client describes feeling very tired in the mornings and not being able to get out of bed until after 11 a.m. Client reports that this change in his morning routine began a week ago after starting new medication. Client reports he has been late getting to work and may be fired from his job. Client is very worried about not having income if he loses his job.

Objective: CHW arrives at 31-year-old client's home at 10:30am per client request. Client got out of bed to answer the door bell. Client yawns throughout visit and speech is slow and disjointed. The client's living area is messier than usual. Client was visibly upset about possible loss of job and the consequences of not having rent money.

Assessment: Client started a new medication 8 days ago. Other than the new medication, client denies any recent changes in lifestyle which may be affecting his usual sleep pattern. CHW agrees that client may be having difficulty with new medication. CHW verified the name of drug and identified the PCP as the prescriber. Client and CHW explored possible ways to address the problem.

Plan: During home visit, CHW assisted the client to make same day appointment with client's PCP to determine if a medication adjusted is needed. The appointment is at 2:00pm. The CHW to return to client's apartment at 1:15pm to pick up client and accompany client on PCP visit. During PCP visit, client to explore sleep problems and possible solutions. Following PCP visit, CHW to provide support for client contacting employee about tardiness and to facilitate continued employment.

Blank SOAP Note

Subjective (S)	
Objective (O)	
Assessment (A)	
Plan (P)	

Outreach and Personal Safety

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand outreach principles and best practices for working with clients
- Protect personal safety when doing field work and working at the agency

INSTRUCTIONS

1. Prior to the session, review the PowerPoint slides and notes. Using the construction paper, cut out two shapes, such as a circle and star. One shape is for things participants should do to protect their safety and the other is for things participants should not do. Post two flip chart sheets with the words "Do" and "Don't."
2. Welcome participants and review the objectives for the session.
3. Review slides about safety and outreach (slides 1–10).
4. Think, pair, share activity (slide 11)
   - Tell participants, "We are going to use the think, pair, and share technique to increase our awareness about safety tactics."
   - Pair off participants and hand out shapes, markers, and tape. Each pair will receive two shapes. Ask the participants to write on their shapes some things CHWs should do and not do to protect their safety when doing fieldwork depending on their community/culture.
   - Ask participants to tape their shapes on the corresponding flip chart sheets (Do/Don't)
   - Read the responses aloud.
   - Ask, "Should any of the shapes be moved to the other side? Why? Any additional questions or comments?"
5. Wrap up. Share the handouts Outreach Tips and Personal Safety, Safety in the Outreach Setting, and Steps to Develop an Outreach Plan. These are resources to share with your agency especially if the agency is developing a policy on outreach. Whether you are providing services within the agency or in the field, safety should always be considered first. Have a safety plan for emergencies and dangerous situations. Let your supervisor know where you are at all times (location and time of appointment) and work with a partner at every opportunity.

Related C3 Roles

Conducting outreach

Related C3 Skills

Professional skills and conduct, outreach skills

Method(s) of Instruction

Think, pair, and share

Estimated time

30 minutes

Key Concepts

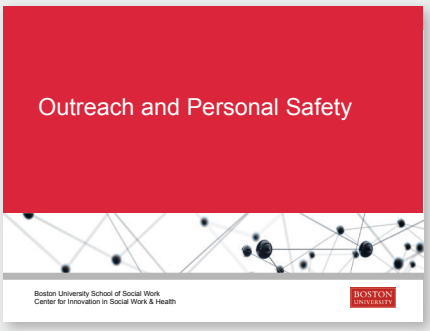
Personal safety, outreach, best practices

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart (divided into two halves)
- Markers
- Shapes made out of colored construction paper
- Tape to post shapes

Handouts

- Safety in the Outreach Setting: Community and Home Visit—Sample Work Policy
- Outreach Tips and Personal Safety
- Steps to Develop an Outreach Plan



SLIDE 1

Ensuring that you have a safe working environment regardless of the setting is paramount. Fieldwork is sometimes conducted in areas that can be unsafe; therefore we need ways to protect our personal safety when doing home visits or individual outreach in the community.

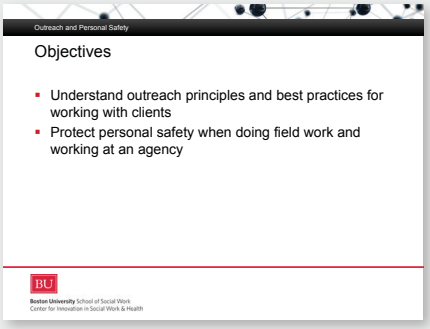
Make sure you have established your own personal boundaries before conducting outreach.

You may anticipate dangerous situations that may come up when doing fieldwork and ways to handle them in advance. In this session we will review some best practices for outreach and personal safety.

Before going on home visits or conducting field work-check in with your supervisor about any agency policy.

Ask, "How many know your agency's policy about conducting field work?"

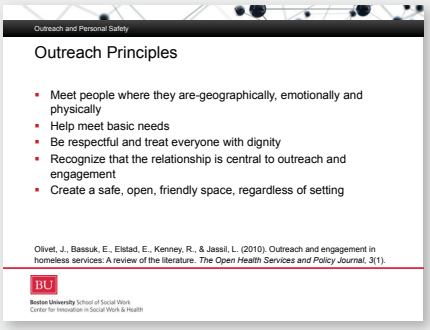
Acknowledge that that this session is designed to complement that policy and provide additional tips for being safe when conducting field work



SLIDE 2

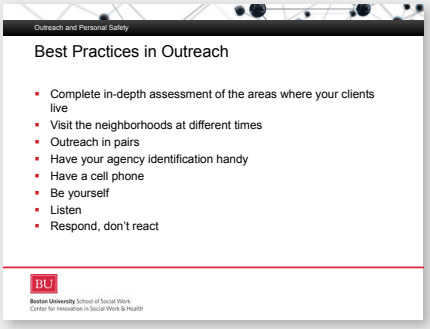
Review the objectives.

Acknowledge that that this session is designed to complement agency policies and provide additional tips for being safe when conducting field work



SLIDE 3

Review the slide.



SLIDE 4

Ensuring that you have a safe working environment regardless of the setting is paramount. Fieldwork is sometimes conducted in areas that can be unsafe; therefore we need ways to protect our personal safety when doing home visits or individual outreach in the community.

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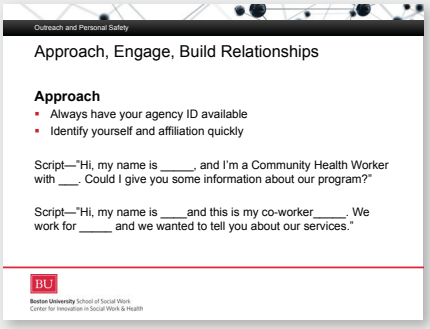
Before going on home visits or conducting field work-check in with your supervisor about any agency policy.

Ask, "How many know your agency's policy about conducting field work?"

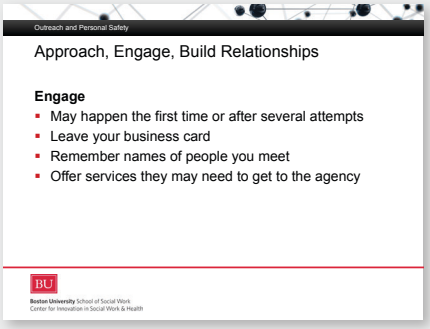
Review the points on the slide.



SLIDE 5

Review the slide.

Ask participants if they have any examples they would like to share on how they approach a client.

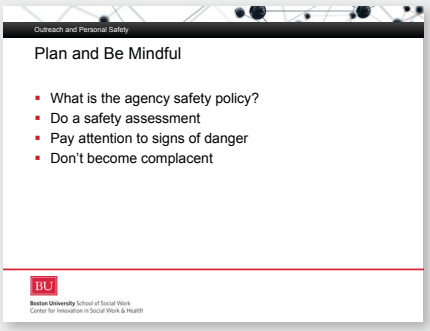


SLIDE 6

Ask a volunteer to read the slide.

SLIDE 7

Review the slide.



SLIDE 8

The first step in addressing personal safety is to plan and be mindful. Planning and being mindful is your best defense against workplace violence.

For example, the human service employees with the highest rates of work place victimization include those with very little experience and those with extensive experience. Newer employees may not have not gained the experience necessary to assess violence among clients and may be trying to remember all of the aspects of their job and its requirements, leading them to forget to pay attention to even the most obvious signs of client aggression. And when that aggression occurs, they have no idea how to respond.

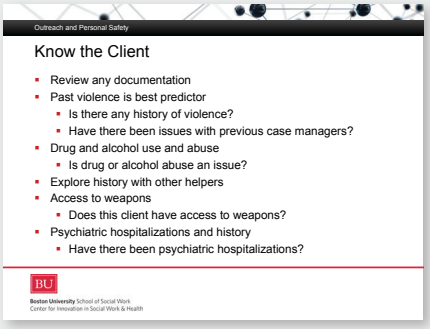
On the opposite end of the spectrum, longer-term employees may begin to feel complacent and ignore potential dangers around them. Many have never been the victim of work-related violence and therefore do not see it as a threat in the future.

Planning and being mindful are separate skills that work together to prepare you to stay safe in an event of violence. These skills should be applied to how you set up your office, completing a safety assessment, paying attention to signs of danger, and avoiding complacency. We will explore these areas as we move through this session.

SLIDE 9

There are three things which need to be managed before, during, and after an episode of aggression. First is your client, second is yourself, and third is your environment.

Each area may include not only the reason for client aggression, but also things which exacerbate violent behavior. Therefore, effectively managing these three areas will help to prevent and diffuse violence. We will be taking a closer look at just how to manage each of these areas in the following set of slides.



SLIDE 10

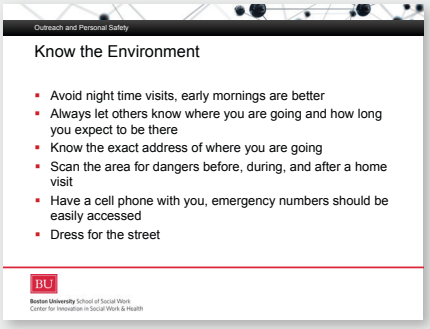
A thorough assessment of your client's potential for violent behavior begins with a review of any documentation available to you. Since the best predictor of future violent behavior is a history of past violent behavior, any available records should be reviewed for incidents of past violent behavior.

Since drugs and alcohol use can lead to erratic and sometimes violent behavior, it is important to review for a history of substance abuse. Even the most timid client can become threatening and violent while under the influence, so it is important not to assume that since a client's usual personality is timid and shy that he or she will always be so.

It's also a good idea to check with other colleagues about the client's history and reputation. Asking colleagues about their experiences with that client may produce much needed and valuable information on individual idiosyncrasies and behavior.

Since weapons are often used by clients during violent behavior and aggression, it is important to assess your client's access to them. Review their record for any information which indicates the client's past access to and use of weapons. It is important to remember that in violent episodes almost anything can be used as a weapon. A pen, for example, in the hands of a calm client may be a great for instrument for writing reports and signing forms, but in the hands of a violent client that same pen may become a weapon. So it is important not to exclude ordinary items in your assessment of weapon access and use.

Finally, it is important to review the record for a history of crises which precipitate any medical or psychiatric hospitalizations. Although a history of psychiatric hospitalization does not in and of itself indicate whether the client is likely to become violent in the future, the information on how the client responded to the crisis will provide powerful insight into how that client may attempt to cope with future crises. And if the client has a history of attempting to cope through violent behavior you will be more prepared in the future to address that behavior.



SLIDE 11

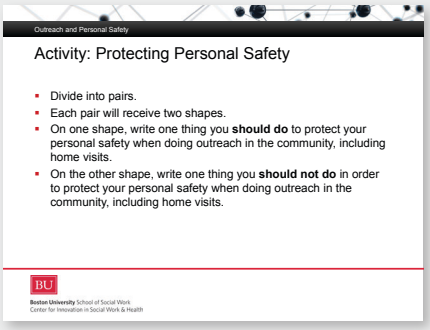
For most case managers, community and home visits are an essential part of the job. Sometimes this means going into a neighborhood that is unfamiliar or dangerous. Therefore, it is important that they pay close attention to and continually assess their surroundings.

Attending home visits early in the morning may increase safety since most crimes are committed in the evening. Criminals are less likely to be awake and "on the job" early in the morning than late at night.

Never leave the office without telling other staff where you are going. Informing others where you are going and the address will help to ensure that emergency services and/or other staff will be able to come to your aid.

Even if there appears to be no imminent aggressive behavior from your client, the environment is constantly changing. Dangers from other sources could appear at any time. Scanning the environment throughout the entire visit will help to ensure that if something changes for the worse you will be ready.

Lastly, carry a cell phone and use GPS. Some of us will remember the days of having to run to find a pay phone and some change to make an emergency call. Thankfully those days are over. Having a cell phone on you at all times will increase the response time of emergency services and will help keep open communication between you and your colleagues.



SLIDE 12

Review the slide.

Safety in the Outreach Setting: Community and Home Visits—Sample Work Policy

Purpose:
The need to promote worker safety in the outreach setting is clear. Safety guidelines are critical to the effective provision of services. To create a climate of safety, Boston Health Care for the Homeless Population (BHCHP) aims to assure that outreach workers are well informed about risks of danger and that they consistently exercise safe practices to minimize risks.

Reports of violence against social service employees during the past decade are notable.[1] An Act to Promote the Public Health through Workplace Safety for Social Workers, H3864, was signed into Massachusetts law in February 2013 in response to recommendations of the National Association of Social Workers Safety Task Force, which convened after the 2008 death of a social worker on a home visit.

Policy:
All workers who participate in outreach work, defined as home visits, street visits, or any encounter with a patient that occurs in a non-clinic setting, must consistently exercise safe practices by following the procedures listed below.

Procedure:

Training: All workers who participate in outreach work must complete a safety training determined by BHCHP at least every other year. This training will include personal safety techniques, de-escalation techniques, risk assessment, and non-violent crisis intervention.

Safety Planning and Visit Preparation

- **Track whereabouts**: Workers are required to report all planned patient encounters on their BHCHP Outlook calendar and to make their calendar accessible to the supervisor. Any deviation from the schedule while workers are out of the office must be reported to the supervisor immediately by the method determined by the supervisor (either via phone call, text, email, or a change in their Outlook calendar). Workers are expected to start and end the day in the office, with exceptions only as approved by the supervisor. If a worker doesn't check in when expected, the supervisor should contact the worker's emergency contact.
- **Risk assessment**: Note there is a procedure in place to communicate violent history to staff in the EMR when danger is known to exist (see policy called "Communication of Known Patient Safety Risks"). A risk assessment is ideally conducted in a clinic setting prior to initiating outreach or home visits. It must include consideration of both potential safety issues with the particular patient and safety issues ascribed to the particular setting in which the visit will take place. What is the potential for violence with this particular patient or this particular environment? The following categories assist in determining factors that may be associated with risk of violence:[2]

[1] Creating a Climate of Safety. National Association of Social Workers, Massachusetts Chapter, 2013. www.naswma.org
[2] Adapted conservatively from Family Continuity Safety Assessment Scale (Assessing Risk to Staff), 2009. http://www.naswma.org/displaycommon.cfm?an=1&subarticlenbr=51

- **Level I Risk Factors**
  - Family history of suicide or homicide
  - Past history of impulsivity or disinhibition
  - Past history of intimate partner violence
  - Past history of drug activity in the home or outreach setting
  - Past history of self-mutilation
- **Level II Risk Factors: Moderate Risk** (must trigger a safety plan review with supervisor and visitation only in teams of two, with exceptions only at the discretion of the supervisor)
  - Active drug/gang activity in the family or neighborhood
  - History of restraining orders in the distant past (either obtained by the patient or placed upon the patient)
  - Known person in the home with history of criminal violent offense, including sex offense
  - History of suicide attempt or violence directed against others in the distant past (>2 years ago) or history of suicidal or homicidal gestures
  - Unexpected or unreported strangers in the home
- **Level III Risk Factors: High Risk** (must trigger a safety plan review with supervisor, which could include decision to hold encounters at alternative setting, visitation in teams of two to include a clinician, or prohibition of home/outreach visits)
  - No cell phone reception at the place of the outreach/home visit
  - Past history of suicide attempt or current suicidal preoccupation with plan or intent but able to contract for safety (exception in the case of Behavioral Health clinicians, who are not required to review safety plan with supervisors)
  - History of violence directed against others or property within the past year or current homicidal preoccupation
  - Persistent self-destructive or aggressive behavior
  - Unable or unwilling to contract for safety
  - Hallucinations instructing harm to self or others
  - Active or recent intimate partner violence
  - Active or recent restraining orders (either obtained by the patient or placed upon the patient)
  - Active drug activity in the home
  - Patient is under the influence of drugs
  - Patient states worker is not welcome in the home

- **Level IV Risk Factors: Highest Risk** (absolutely no home visits should occur)
  - Unsecured weapons in the home or on the person
  - Past threats to a worker

- **Dress and valuables**: Consider avoiding items around the neck like scarves, jewelry, which can pose a choking risk; leave valuable bags and jewelry at home; leave vehicles locked at all times and keep valuables out of sight; use of headphones can diminish the ability to hear and may increase vulnerability; BHCHP IDs should be worn at all times (if a lanyard is used, it should be breakaway).
- **Teams of two**:[3] Outreach workers can ask for accompaniment for *any* outreach visit in which there is a safety concern and that request will be honored by their supervisor. For situations involving moderate or high-risk factors, upon review with supervisors, outreach visits will be made *only* in teams of two, with exceptions only at the discretion of the supervisor. Workers may consider meeting a patient in a public setting or in the office if they are unable to find a partner for a home visit.
  - Teamwork requires trust and cooperation. In teams of two, both staff members leave when the either staff person indicates the need to leave a potentially unsafe situation. No one stays behind. Because it may be difficult to leave a potentially dangerous situation without escalating tension, and because one staff person may perceive a threat that the other is entirely unaware of, it is important that both agree to leave at any sign the other is ready.
- **Safety equipment** will be provided to staff:
  - Breakaway ID lanyards
  - Personal safety alarms (for example, www.streetdefender.com/MC-231.htm)
- **Plan of action** should be developed prior to visit, to be initiated at the first signs of agitation. This includes consideration of how to immediately end a potentially dangerous situation and when to evacuate a facility.
- **General safety tips**:[4]
  - Use “universal precautions,” meaning that every person and every environment is considered potentially dangerous.
  - It is important during visits to be friendly and kind but to stay focused on the working relationship and help the patient reach their goals. Remember, this is a professional relationship, not a friendship.
  - Trust your instincts. Leave when you sense potential danger.

[3] Adapted from Pine Street Inn’s Low Threshold Housing Safety Policy from April 2013
[4] Adapted from Pine Street Inn’s Low Threshold Housing Safety Policy from April 2013

- Stay alert.
- Know what behaviors provoke you, and ways to respond to those behaviors without placing yourself in danger.
- Keep your hands free.
- Keep car keys in your pocket or hand.
- When indicated, consider developing a contract with patients to outline appropriate and inappropriate behaviors, establishing clear boundaries.
- It is important that patients either manage their own money or work with a formal payee service. Staff may not ever borrow, save, give, use, or exchange money or other valuables, including ATM or EB cards, with patients. This helps to avoid any possible misunderstandings about financial transactions.

- **Safety before the visit**
  - As stated above, a safety risk assessment is conducted in a clinic setting prior to initiating outreach or home visits.
  - Call ahead of arriving to a patient's home to remind them of the visit. It may be helpful to explain expectations to the patient, including that the visit won't be made in the presence of others who are unknown to the worker.
  - Schedule home visits early in the day when possible.
  - Scan the environment before getting out of the car/bus to be aware of any potentially dangerous activity. Do not talk on the phone, which is distracting, while walking.
  - Have an excuse to leave prepared in advance, just in case. For example, press the ringer of your cell phone and pretend to take the call and excuse yourself; excuse yourself to retrieve something out of your car.
- **Safety during the visit**
  - Remember you are a guest in the patient's home.
  - Never enter a home if there is yelling, screaming, or other noises coming from within.
  - Immediately leave the scene if there are weapons on site.
  - Be aware of exits in case of emergency and maintain clear access to an exit at all times.
  - If there are unexpected or unapproved visitors present when you arrive, assess the situation and consider rescheduling the appointment and leaving immediately.
  - If you perceive the presence of drugs or paraphernalia, leave immediately. Staff must never touch or discard any drugs or paraphernalia.
  - Be aware of personal space – keep at least an arm's length between you and the patient.
  - Avoid sitting on the patient's bed.

- **Safety after the visit**
    - Be aware of surroundings as you exit the home or outreach setting.
    - Do not make phone calls until you are out of view of the home.
    - Lock your car doors as soon as you get in.

Extreme Weather Conditions: Note that some weather conditions can affect the safety of an outreach environment. For example, when parking is limited in a neighborhood due to significant snowfall, this can result in parking further away from the site of a planned encounter. When weather emergencies affect workers' ability to reasonably park, this may result in increased potential for danger and workers should discuss the feasibility of the outreach visit with their supervisors in this situation.

Expectations of Supervisors

- Keep a list of emergency contacts for each worker who does outreach.
- Develop a safety plan with staff, especially for outreach visits involving moderate or high risk factors. This plan should be re-evaluated as factors change, according to the need for safety and staff should be supported in order to implement the safety plan.
- If a worker asks to be accompanied during an outreach or home visit due to safety concerns, every attempt should be made to honor this request. If it is not possible for a team of two to make the visit together, an alternative plan may include arranging for a clinic visit instead or postponing the visit until a team of two is available.
- Address the threat of violence or the aftermath of violence by attending to the needs of the worker, co-workers, and affected patients. Present an open environment for discussion.
    - Provide ample opportunity for debriefing with all involved and offer trauma counseling.
    - Provide option of escorts to cars, or other measures that might help a worker feel more secure.
- Document details of any incident in a written record kept by the supervisor.
- Immediately communicate with the Chief Operating Officer to report any serious incident and consider if, and when, legal action should be taken.
- Communicate to other staff instances of work-related violence or significant threats of violence, as per our protocol (see policy called "Communication of Known Patient Safety Risks").

Steps to Develop an Outreach Plan

Outreach Plans: Structure Outreach Activities
The process of developing an outreach plan involves setting goals, action steps, timelines, and evaluation measures; it helps structure outreach activities in a logical way and targets them to where they are most needed. The outreach plan creates a means to look at what has been done, celebrate accomplishments, assess miscalculations, and revise strategies as needed to make progress in the future. Such evaluation may be more difficult when outreach is conducted without an outreach plan.

1. **Identify and Prioritize Needs and Assess Resources Available**
   What do you need to do? To increase caseload? To increase your organization's referrals? To maintain a caseload? What are the particular underserved areas or unmet needs in your community (for example, pregnant teens, specific ethnic groups, geographical areas)? What staff and program resources do you have to implement outreach activities?

2. **Identify your Audience(s) – Community of Focus**
   Whom do you want to reach? Potentially eligible people? The general public? Specific cultural communities? Health or social service providers who refer community members?

3. **Define Goals and Objectives**
   What is it you would like your audience to do once they have heard your message? Who will do what, how, where, and by when?

4. **Identify Outreach Strategies**
   What outreach methods and tools will you use? Will outreach be one-time, short term, or ongoing or a combination? At a minimum, your outreach plan should include ongoing outreach activities.

5. **Implement Plan**
   Put your plan into action. Monitor to make sure that implementation is going as planned. Make adjustments as needed.

6. **Evaluate Plan**
   Before you implement your plan, identify how you will evaluate it. How will you know if your plan is working? What baseline information will you obtain before you implement the plan? What outcomes will you be measuring? What feedback will you gather from participants, potential participants, providers, etc.? What can you learn that may help you be more successful in the future?

Source: Adapted from Villie M. Appoo, MA, MSW. Outreach to Residents of Public Housing: A Resource Tool Kit for Health Centers. National Center for Health in Public Housing.

Outreach Tips and Personal Safety

- Do conduct a strengths and needs assessment and evaluate areas where your community of focus spends time
- Be flexible with scheduling
- Accommodate the community of focus
- Establish contacts with police precincts in all areas where you conduct outreach
- Carry identification at all times
- Let someone know where you are at all times
- Work with a partner and be aware of your surroundings
- Be aware of how you are feeling and how your partner is feeling
- Have a safety plan for emergencies and dangerous situations
- Find a hook or way to engage people in conversation on the streets
- Know when it is appropriate to engage with a client and when it's not appropriate
- Behave respectfully to all people (people who use drugs, dealers, pimps, sex workers, etc.) in order to win personal trust and confidence
- Have good listening skills; hear people out
- Be ready to direct community members to social, health, school, and justice system services
- Assure community members that you will maintain confidentiality
- Provide follow up and deliver on promises
- Tell community members when you will be back and how to reach you

History of Community Health Workers (CHWs)

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain how the CHW profession grew out of efforts to increase health equity and health care access

INSTRUCTIONS

1. Explain: We will talk about the history of the CHW profession.
2. Ask, "Why might it be important to understand the history of the CHW profession? What do we already know about the history of CHWs?"
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9. Wrap up. Share that the CHW profession grew out of efforts in communities around the world to increase health equity and health care access. It is important to keep these proud roots in mind as CHWs become more integrated into the health care system.

Related C3 Roles

All

Related C3 Skills

All; emphasis on education and facilitation skills

Method(s) of Instruction

Radio play

Estimated time

25 minutes

Key Concepts

History, Community Health Worker

Materials

Handouts

- CHW Radio Play

Radio Play

Voices from the History of Community Health Work

Introduction

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2. Community member
3. Russian feldsher
4. Chinese barefoot doctor
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Who are Community Health Workers?

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain who Community Health Workers (CHWs) are
- Define community health work

INSTRUCTIONS

1. Review the objectives of the session: to explain who are CHWs and define CHW work.
2. Review the PowerPoint slides with the group.
3. Wrap up. Bring the group back together and ask for volunteers to share what they learned from their partner about CHWs and how it is similar and/or different to their work.

Related C3 Roles

All

Related C3 Skills

All

Method(s) of Instruction

Think, pair and share; brainstorm

Estimated time

25 minutes

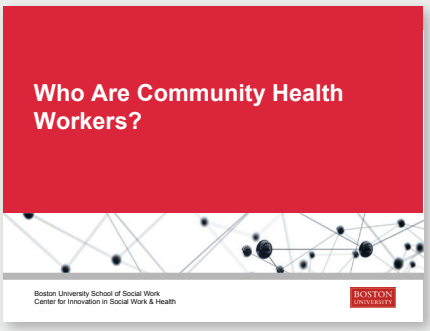
Key Concepts

Community health worker (CHW)

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Who are Community Health Workers?

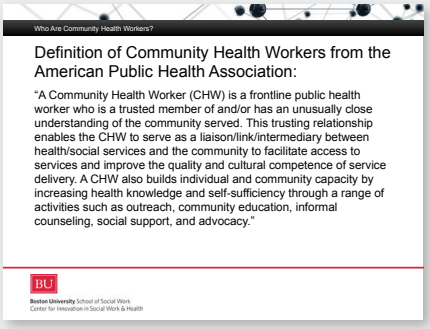


SLIDE 1

- One main idea of Popular Education is that no matter who we are, we all know a lot as a result of our life experience. Therefore, we should always start with what people already know.
- We want to start with what you know about Community Health Workers through a brainstorming activity in pairs.

SLIDE 2

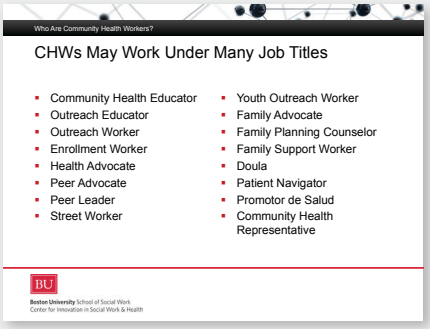
Ask the question on the slide. Give participants about two minutes to talk in pairs. Bring the large group back together, asking each pair to share one idea. Record answers on a flip chart sheet.



SLIDE 3

Ask for a volunteer to read the slide.

Ask the participants, "What catches your attention about this definition?



SLIDE 4

Explain that there are dozens of titles used to refer to CHWs. Ask, "What are some other titles you have used or heard others use when doing this kind of work?"

- What titles do they have in their work? Ask them to get back into their pairs and spend 10 minutes sharing with each other the following information:
- What title do they have in their work at their agency?
- Who do they work with on a daily basis?
- What are some of the key tasks in their work?

History of Community Health Workers (CHWs)

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain how the CHW profession grew out of efforts to increase health equity and health care access

INSTRUCTIONS

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Related C3 Roles

All

Related C3 Skills

All; emphasis on education and facilitation skills

Method(s) of Instruction

Radio play

Estimated time

25 minutes

Key Concepts

History, Community Health Worker

Materials

Handouts

- CHW Radio Play

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Community Health Worker (CHW) Role, Skills, and Qualities

OBJECTIVES

At the end of this unit, participants will be able to:

- Identify the roles, skills, and qualities of CHWs

INSTRUCTIONS

1. Prior to the session, review the C3 Report in resources.
2. Welcome participants and review the objectives for the session.
3. Explain that now we will review the different roles, qualities and skills of CHWs. Review some of the roles that people mentioned in the brainstorming activity during the "Who Are CHWs" session.
4. Discuss C3 Roles
   - Explain that there have been a number of efforts to define the roles of CHWs. One such effort was the National Community Health Advisor (NCHA) Study. That study established seven key roles of CHWs in 1998. Currently, the Core Consensus project has updated the list of CHW roles and skills to include 10 roles. Referred to as the C3 Roles, the newly formed National Community Health Worker Association (NCHWA) is following the C3 Roles and Skills for CHWs.
   - Review the C3 roles in the PowerPoint (slide 2).
5. Video and discussion
   - To hear from other CHWs about their work, we will now watch a video about the roles of CHWs from the Oregon Community Health Worker Association (12 minutes): *https://www.youtube.com/watch?v=69csBE4y1Uo*
   - Ask, "What caught your attention in the video? Which role(s) are you most excited about?"
   - Clarify that while you may not immediately play all these roles in your work as a CHW, over time you may find that you will need to play many or all of these roles to be most effective as a CHW.
6. Wrap up. Review CHW skills and qualities. Distribute handouts on CHW roles, skills, and qualities and review slides 3 and 4.

Related C3 Roles

All

Related C3 Skills

All

Method(s) of Instruction

Video, large group discussion

Estimated time

30 minutes

Key Concepts

Roles, skills, qualities, C3 Project

Materials

- Computer with internet access and projector
- PowerPoint slides
- ORCHWA video: *https://www.youtube.com/watch?v=69csBE4y1Uo*

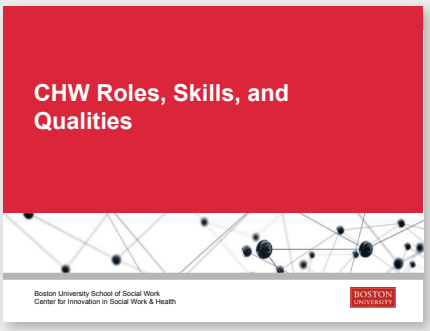
Handouts

- Roles of CHWs
- Skills of CHWs
- Qualities of CHWs

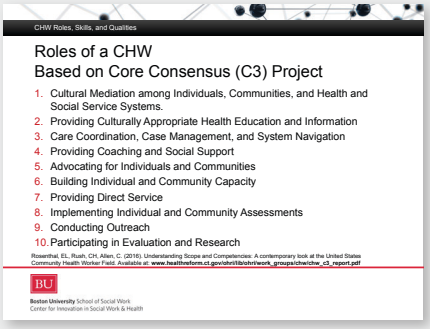
Resources

- Rosenthal, EL, Rush, CH, Allen, C. (2016). Understanding Scope and Competencies: A contemporary look at the United States Community Health Worker Field. Available at: *www.healthreform.ct.gov/ohri/lib/ohri/work_groups/chw/chw_c3_report.pdf*

Community Health Worker (CHW) Role, Skills, and Qualities

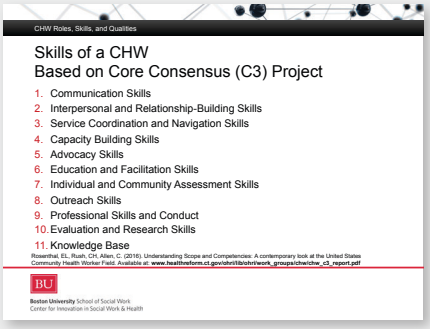


SLIDE 1



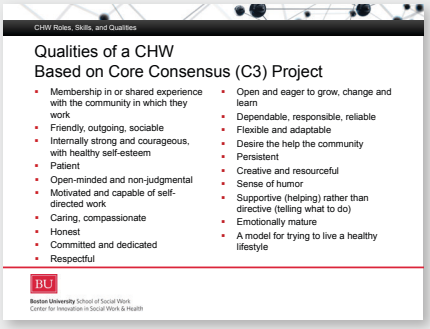
SLIDE 2

Ask a volunteer to read through the CHW roles on this slide.



SLIDE 3

While presenting this slide, reference the CHW Skills handout, which has more detailed information. Ask for a volunteer to read each skill and give an example of how CHWs might use each skill in their work.



SLIDE 4

While presenting this slide, reference the CHW Qualities handout, which has more detailed information.

Community Health Worker (CHW) Roles

Cultural Mediation among Individuals, Communities, and Health and Social Service Systems

- ✓ Educating individuals and communities about how to use health and social service systems (including understanding how systems operate)
- ✓ Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards)
- ✓ Building health literacy and cross-cultural communication

Providing Culturally Appropriate Health Education and Information

- ✓ Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community
- ✓ Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)

Care Coordination, Case Management, and System Navigation

- ✓ Participating in care coordination and/or case management
- ✓ Making referrals and providing follow-up
- ✓ Facilitating transportation to services and helping to address other barriers to services
- ✓ Documenting and tracking individual and population level data
- ✓ Informing people and systems about community assets and challenges

Providing Coaching and Social Support

- ✓ Providing individual support and coaching
- ✓ Motivating and encouraging people to obtain care and other services
- ✓ Supporting self-management of disease prevention and management of health conditions (including chronic disease)
- ✓ Planning and/or leading support groups

Advocating for Individuals and Communities

- ✓ Advocating for the needs and perspectives of communities
- ✓ Connecting to resources and advocating for basic needs (e.g., food and housing)
- ✓ Conducting policy advocacy

Building Individual and Community Capacity

- ✓ Building individual capacity
- ✓ Building community capacity
- ✓ Training and building individual capacity with CHW peers and among groups of CHWs

Providing Direct Service

- ✓ Providing basic screening tests (e.g., height and weight, blood pressure)
- ✓ Providing basic services (e.g., first aid, diabetic foot checks)
- ✓ Meeting basic needs (e.g., direct provision of food and other resources)

Implementing Individual and Community Assessments

- ✓ Participating in design, implementation, and interpretation of individual-level assessments (e.g., home environmental assessment)
- ✓ Participating in design, implementation, and interpretation of community-level assessments (e.g., windshield survey of community assets and challenges, community asset mapping)

Conducting Outreach

- ✓ Case-finding/recruitment of individuals, families, and community groups to services and systems
- ✓ Follow-up on health and social service encounters with individuals, families, and community groups
- ✓ Home visiting to provide education, assessment, and social support
- ✓ Presenting at local agencies and community events

Participating in Evaluation and Research

- ✓ Engaging in evaluating CHW services and programs
- ✓ Identifying and engaging community members as research partners, including community consent processes
- ✓ Participating in evaluation and research
    - Identification of priority issues and evaluation/research questions
    - Development of evaluation/research design and methods
    - Data collection and interpretation
    - Sharing results and findings
    - Engaging stakeholders to take action on findings

CHW Core Consensus Project Report: https://www.c3project.org/

Community Health Worker (CHW) Skills

CHWs and CHW program coordinators interviewed for the Community Health Worker Core Consensus Project (2016) reported that CHWs need the following skills to be effective in their work. *Skills* are abilities that can be gained through study and practice.

Communication Skills

- ✓ Ability to use language confidently
- ✓ Ability to use language in ways that engage and motivate
- ✓ Ability to communicate using plain and clear language
- ✓ Ability to communicate with empathy
- ✓ Ability to listen actively
- ✓ Ability to prepare written communication including electronic communication (e.g., email, telecommunication device for the deaf)
- ✓ Ability to document work
- ✓ Ability to communicate with the community served (may not be fluent in language of all communities served)

Interpersonal and Relationship-Building Skills

- ✓ Ability to provide coaching and social support
- ✓ Ability to conduct self-management coaching
- ✓ Ability to use interviewing techniques (e.g. motivational interviewing)
- ✓ Ability to work as a team member
- ✓ Ability to manage conflict
- ✓ Ability to practice cultural humility

Service Coordination and Navigation Skills

- ✓ Ability to coordinate care (including identifying and accessing resources and overcoming barriers)
- ✓ Ability to make appropriate referrals
- ✓ Ability to facilitate development of an individual and/or group action plan and goal attainment
- ✓ Ability to coordinate CHW activities with clinical and other community services
- ✓ Ability to follow-up and track care and referral outcomes

Capacity Building Skills

- ✓ Ability to help others identify goals and develop to their fullest potential
- ✓ Ability to work in ways that increase individual and community empowerment
- ✓ Ability to network, build community connections, and build coalitions
- ✓ Ability to teach self-advocacy skills
- ✓ Ability to conduct community organizing

Advocacy Skills

- ✓ Ability to contribute to policy development
- ✓ Ability to advocate for policy change
- ✓ Ability to speak up for individuals and communities

Education and Facilitation Skills

- ✓ Ability to use empowering and learner-centered teaching strategies
- ✓ Ability to use a range of appropriate and effective educational techniques
- ✓ Ability to facilitate group discussions and decision-making
- ✓ Ability to plan and conduct classes and presentations for a variety of groups
- ✓ Ability to seek out appropriate information and respond to questions about pertinent topics
- ✓ Ability to find and share requested information
- ✓ Ability to collaborate with other educators
- ✓ Ability to collect and use information from and with community members

Individual and Community Assessment Skills

- ✓ Ability to participate in individual assessment through observation and active inquiry
- ✓ Ability to participate in community assessment through observation and active inquiry

Outreach Skills

- ✓ Ability to conduct case-finding, recruitment, and follow-up
- ✓ Ability to prepare and disseminate materials
- ✓ Ability to build and maintain a current resources inventory

Professional Skills and Conduct

- ✓ Ability to set goals and to develop and follow a work plan
- ✓ Ability to balance priorities and to manage time
- ✓ Ability to apply critical thinking techniques and problem solving
- ✓ Ability to use pertinent technology
- ✓ Ability to pursue continuing education and life-long learning opportunities
- ✓ Ability to maximize personal safety while working in community and/or clinical settings
- ✓ Ability to observe ethical and legal standards (e.g. CHW Code of Ethics, Americans with Disabilities Act [ADA], Health Insurance Portability and Accountability Act [HIPAA])
- ✓ Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements
- ✓ Ability to participate in professional development of peer CHWs and in networking among CHW groups
- ✓ Ability to set boundaries and practice self-care

Evaluation and Research Skills

- ✓ Ability to identify important concerns and conduct evaluation and research to better understand root causes
- ✓ Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR)
- ✓ Ability to participate in evaluation and research processes including:
  - Identifying priority issues and evaluation/research questions
  - Developing evaluation/research design and methods
  - Data collection and interpretation
  - Sharing results and findings
  - Engaging stakeholders to take action on findings

Knowledge Base

- ✓ Knowledge about social determinants of health and related disparities
- ✓ Knowledge about pertinent health issues
- ✓ Knowledge about healthy lifestyles and self-care
- ✓ Knowledge about mental/behavioral health issues and their connection to physical health
- ✓ Knowledge about health behavior theories
- ✓ Knowledge of basic public health principles
- ✓ Knowledge about the community served
- ✓ Knowledge about United States health and social service systems

CHW Core Consensus Project Report: https://www.c3project.org/

Community Health Worker (CHW) Qualities

CHWs and CHW program coordinators interviewed for the National Community Health Advisor Study also made it clear that in order for CHWs to do their complex and demanding work, they need certain qualities. *Qualities* are personal characteristics that can be enhanced but not taught.[1]

- ✓ Membership in or shared experience with the community in which they work
- ✓ Friendly, outgoing, sociable
- ✓ Internally strong and courageous, with healthy self-esteem
- ✓ Patient
- ✓ Open-minded and non-judgmental
- ✓ Motivated and capable of self-directed work
- ✓ Caring, compassionate
- ✓ Honest
- ✓ Committed and dedicated
- ✓ Respectful
- ✓ Open and eager to grow, change and learn
- ✓ Dependable, responsible, reliable
- ✓ Flexible and adaptable
- ✓ Desire the help the community
- ✓ Persistent
- ✓ Creative and resourceful
- ✓ Sense of humor
- ✓ Supportive (helping) rather than directive (telling what to do)
- ✓ Emotionally mature
- ✓ A model for trying to live a healthy lifestyle

The list of qualities from the NCHA Study has been expanded with input from Project Reach Out staff in Santa Barbara, Ca.

Challenges and Solutions to Working on a Team

OBJECTIVES

At the end of this unit, participants will be able to:

- Identify and work through challenges associated with working in a multi-disciplinary team

INSTRUCTIONS

1. Explain that working on a multi-disciplinary care team has many advantages, but it can also be challenging.
2. Case studies activity
   - For the next activity, we will discuss some challenges of working in multidisciplinary care teams and brainstorm potential solutions to those challenges.
   - Break participants into five or six groups. Distribute markers, a flip chart sheet, and the case studies handout to the participants. Assign a different case scenario to each group. Ask the participants to choose cooperative learning roles in their groups (facilitator, note taker, reporter, and time keeper).
   - Ask each group to read their case study and answer the discussion questions. Provide 20 minutes for discussion. The recorder will write the solutions on a flip chart sheet.
   - Ask the reporter from each group to summarize the challenge and share their solutions with the larger group.
   - Ask if there are other suggestions for how to best work with multidisciplinary teams in a clinical setting. Write answers on flip chart.
3. Wrap up: Summarize some of the key challenges and solutions the groups identified. Thank participants for their creative strategies and ask about which solutions they will try in their agency.

Related C3 Roles

Cultural mediation among individuals, communities, and health and social service systems; care coordination, case management and system navigation; providing direct service; participating in evaluation and research

Related C3 Skills

Communication skills, service coordination and navigation, professional skills and conduct

Method(s) of Instruction

Small group activity

Estimated time

45 minutes

Key Concepts

Challenges, solutions, team, multidisciplinary team

Materials

- Flip chart
- Markers

Handouts

- Case Studies for Working on a Team

Case Studies for Working on a Team

Case Studies for Working in a Clinic: Scenario 1

Facilitator: _____

Recorder: _____

Reporter: _____

Timekeeper: _____

Instructions: Choose roles for each of the group members (facilitator, recorder, reporter and timekeeper). Read through your scenario and discuss how you, as a CHW, would respond to the situation.

Scenario 1: You are escorting a client to the hospital to visit a client and the doctor and/or nurse wants to know who you are and what your role is.

Related CHW roles:

- Assist client with identifying and removal of barriers to accessing care
- Care coordination and case management
- Client/provider education
- Systems navigation
- Coaching and social support

How would you discuss your role with the doctor and/or nurse?

Case Studies for Working in a Clinic: Scenario 2

Facilitator: _____

Recorder: _____

Reporter: _____

Timekeeper: _____

Instructions: Choose roles for each of the group members (facilitator, recorder, reporter and timekeeper). Read through your scenario and discuss how you, as a CHW, would respond to the situation.

Scenario 2: You are going on a home visit and the outreach nurse on your team reports they've overbooked their schedule—but your client needs wound care. They ask if you would perform this task for the nurse while you're visiting the client.

When you arrive at the client's home there are needles all over the place. You let them know that this is a health hazard and must be removed. The client reports that all of their sharps containers are full and asks you if you can take them to the needle exchange for them, or give them a ride to the needle exchange so they can turn them in and get new ones.

Related CHW roles:

- Providing basic screening and tests
- Providing social supports
- Meeting direct needs
- Providing appropriate health education and information

How would you respond to (a) the nurse's; and (b) the client's requests? Are their requests within the scope of your role?

Case Studies for Working in a Clinic: Scenario 3

Facilitator: _____

Recorder: _____

Reporter: _____

Timekeeper: _____

Instructions: Choose roles for each of the group members (facilitator, recorder, reporter and timekeeper). Read through your scenario and discuss how you, as a CHW, would respond to the situation.

Scenario 3: Your client is being released from a hospital and you need the doctor's approval and signature in order for the patient to be assigned a medical motel voucher for a week so they can recuperate. You can only have a minute or two to speak to the doctor before they see their next client.

Related CHW roles:

- Care coordination
- Case management
- Advocating for individuals

How would you communicate with the doctor about the client?

Case Studies for Working in a Clinic: Scenario 4

Facilitator: _____

Recorder: _____

Reporter: _____

Timekeeper: _____

Instructions: Choose roles for each of the group members (facilitator, recorder, reporter and timekeeper). Read through your scenario and discuss how you, as a CHW, would respond to the situation.

Scenario 4: Your client had been using methamphetamine for a long time and has just recently completed drug treatment and is meeting with their new social worker for the first time. This social worker has replaced the social worker the client was working with prior to going into treatment. The client also suffers from a high level of anxiety and when the client is nervous and/or excited they speak rapidly in broken sentences and have jerky movements. The new social worker speaks with you after their initial meeting and shares concerns about the client's seemingly erratic behavior.

Related CHW roles:

- Cultural mediation among individuals, communities, and health and social service systems
- Care coordination
- Providing direct service
- Advocating for individuals and communities

How can you help the social worker understand the bigger picture of what the client has been going through so that they don't misunderstand or judge the client?

Case Studies for Working in a Clinic: Scenario 5

Facilitator: _____

Recorder: _____

Reporter: _____

Timekeeper: _____

Instructions: Choose roles for each of the group members (facilitator, recorder, reporter and timekeeper). Read through your scenario and discuss how you, as a CHW, would respond to the situation.

Scenario 5: A client came into the clinic several times complaining of shoulder pain and wanting medication for the pain. Because the client has a history of substance use disorder, the client was not sent for an x-ray until their third visit. When the x-ray came back, it turned out that the client had a bad infection and had to be admitted to the hospital. Now they don't want to go back to the clinic.

Related CHW roles:

- Cultural mediation among individuals, communities, and health and social service systems
- Care coordination
- Providing direct service
- Advocating for individuals and communities

How could you work with the doctor and medical team to rebuild trust with the client? How could you help them understand why the client may not be adhering to their HIV medication regimen?

Case Studies for Working in a Clinic: Scenario 6

Facilitator: _____

Recorder: _____

Reporter: _____

Timekeeper: _____

Instructions: Choose roles for each of the group members (facilitator, recorder, reporter and timekeeper). Read through your scenario and discuss how you, as a CHW, would respond to the situation.

Scenario 6: You are attending a doctor visit with a client and their interpreter and you notice that the interpreter is looking at the doctor when interpreting more than at the client. The client is nodding and smiling with furrowed brows.

Related CHW roles:

- Cultural mediation among individuals, communities, and health and social service systems
- Care coordination
- Providing direct service
- Advocating for individuals and communities

How would you work the interpreter, doctor, and client to make sure that the client's needs are being met?

De-Escalation in the Workplace

OBJECTIVES

At the end of this unit, participants will be able to:

- Describe the causes and correlates of aggressive behavior among patients.
- Identify safe options to prevent and manage patient aggression.
- Demonstrate skills in evaluating and assessing efforts of staff in managing aggressive patients and situations.
- Demonstrate adaptive effective options for enhancing therapeutic client interactions (ways to de-escalate a client).

INSTRUCTIONS

1. See individual slides and notes for lecture details.
2. Wrap up. In working with clients and helping them manage their needs and wants, it is important for CHWs to also have time for self-care. Share the hand out self-care assessment. Give participants 10 minutes to review and complete. Ask for volunteers to share how they engage in self-care activities.

Related C3 Roles

Providing coaching and support

Related C3 Skills

Professional skills and conduct

Method(s) of Instruction

Lecture, small group discussion

Facilitator's note: This module should be facilitated by a skilled professional, preferably a facilitator with a licensed clinical degree (MSW, psychology, counseling) with experience in direct service with clients, especially clients who have substance use or mental health disorders.

Estimated time

60 minutes

Key Concepts

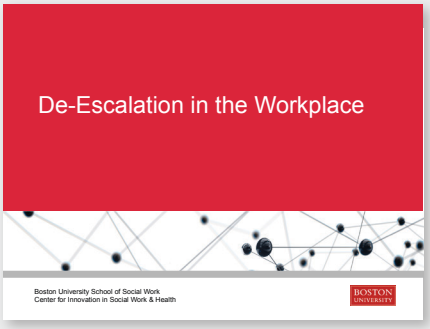
De-escalation, verbal and physical aggression, aggression, de-escalation strategies, action responses.

Materials

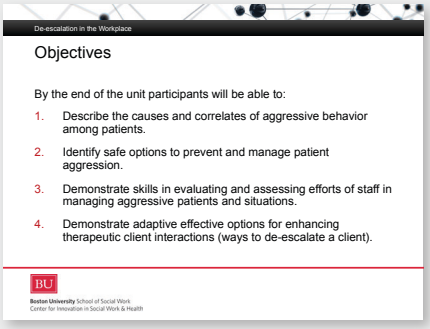
- Computer with internet access and projector
- PowerPoint slides

Handout

- Self-Assessment Tool: Self-Care

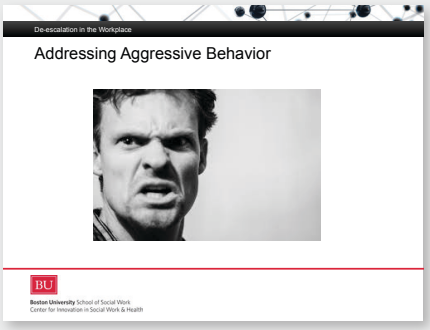


SLIDE 1



SLIDE 2

Review the objectives.

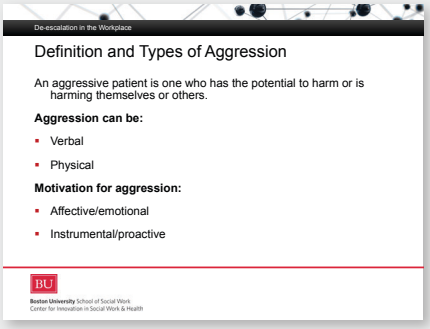


SLIDE 3

From this picture we can see that this man is displaying an aggressive facial expression.

Let's define: What is aggression?

We know it when we see it, but what is it exactly?



SLIDE 4

When we look up the definition of aggression we can find many meanings.

According to Wikipedia, aggression is overt, often harmful, social interaction with the intention of inflicting damage or other unpleasantness upon another individual. It may occur either in retaliation or without provocation.

For the purpose of this session we will define an aggressive patient as one who has the potential to harm or is harming themselves or others.

In humans, aggression can be verbal or physical. I suspect at one time or another many of us has experienced aggression from someone we have been in contact with.

As humans there are many motivations for aggression. Think about the following motivations:

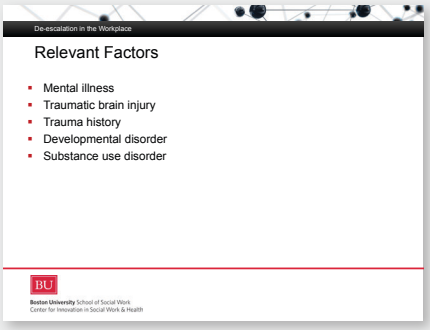
- Affective/emotionally-triggered: when we experience feelings of anger and frustration we are unable to control our affect and lose control.
- Instrumental/provocative: our motivator is to maintain order to achieve a goal or positive outcome in a controlled way.

SLIDE 5

Let's look at this picture, how would you interpret what is going on in this picture?

Clearly she is frustrated by what she is reading or feels like she has lost control and literally pulling her hair out.

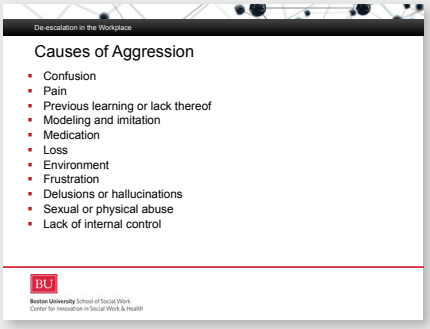
Ask participants if they have ever become so frustrated they thought about engaging in or engaged in aggressive behavior.



SLIDE 6

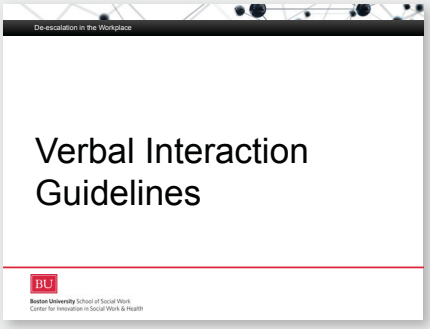
There are many factors that can cause people to become aggressive, especially if people we work with have:

- Mental illness
- Traumatic brain injury
- Trauma history
- Developmental disorder
- Substance use disorder



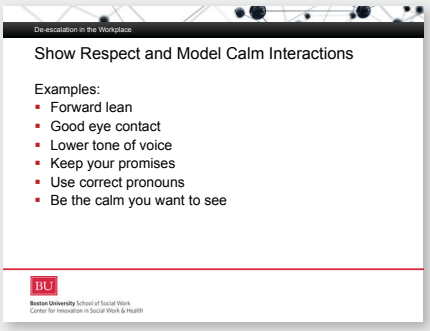
SLIDE 7

Review the slide.



SLIDE 8

We will now learn ways to manage verbally aggressive situations.

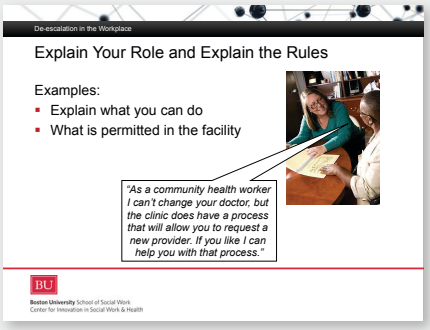


SLIDE 9

To help manage verbally aggressive situations the following are examples of how you can use both non verbal and verbal language to decrease the situation when working with clients. It is helpful to lean forward, make good eye contact, lower your tone of voice, and keep your promises.

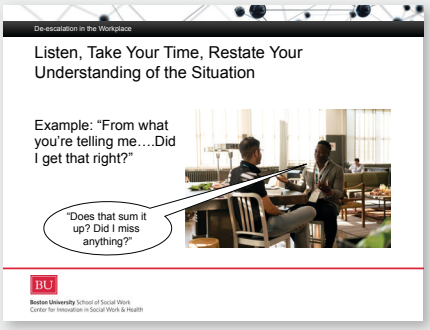
Examples:

- Explain what you can do and what is permitted in the facility.
- Reframe what the client is sharing with you to ensure understanding "Are you saying that . . . ?".
- Remain calm, reassure you patient that you are there to help.
- Reframe what you are hearing: "So the problem is . . . ? You are concerned that . . . ? This is upsetting you because. . . ."
- Ask the client: "How have you handled this before? Was anyone able to help you with you problem before? What will help in this situation? When this happens we usually. . . ."



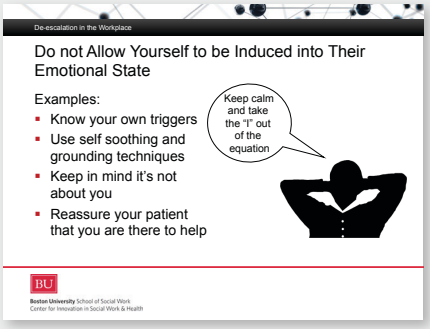
SLIDE 10

Sometimes it is helpful to explain what your role is and how you might be able to help the client. If there are policies you are to follow in the workplace regarding managing an escalating situation, please explain to the client what can and can not happen. Ask for help from your co-workers as needed so you receive help to manage the situation.



SLIDE 11

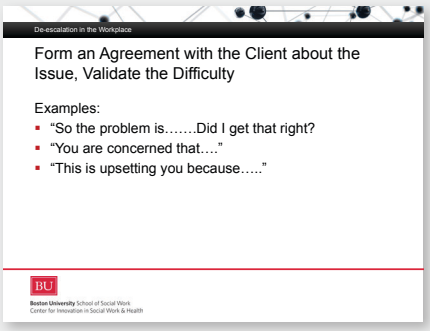
If you are meeting with a client, take the time to listen to what the client is saying to you, and restate what you hear to ensure understanding and guide potential ways to help the client. Clients get frustrated with things they do not understand, so be the one to get it right.



SLIDE 12

Be careful as sometimes we can get caught up in an aggressive situation.

Review the slide.



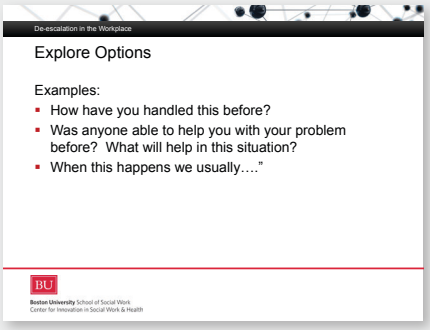
SLIDE 13

At times clients want acknowledgement of the challenges they experience that cause their frustration.

Be sure to ask questions to ensure understanding of the challenge they are experiencing such as:

"You are concerned that. . . ."

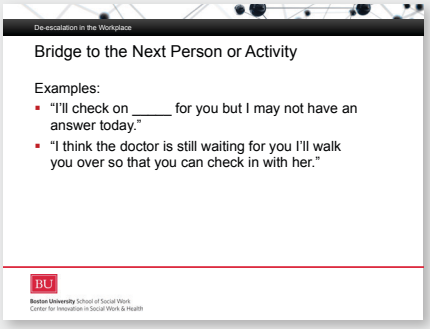
"This is upsetting you because. . . ."



SLIDE 14

Clients are resilient. Many times they have experienced other frustrating situations that lead to their aggressive responses.

Explore options with them to see how they can manage the situation.



SLIDE 15

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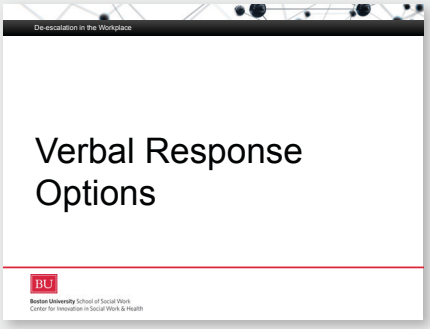
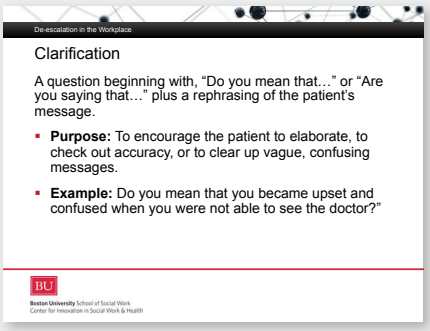


SLIDE 16

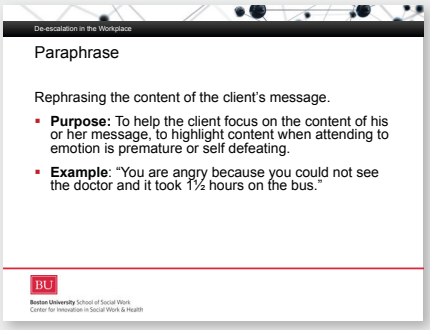
We will now look at strategies to manage a verbally aggressive situation.



SLIDE 17

At times when a client becomes verbally aggressive and you want to de-escalate the situation, there are several verbal responses that can be used, such as clarification.

Review the slide.



SLIDE 18

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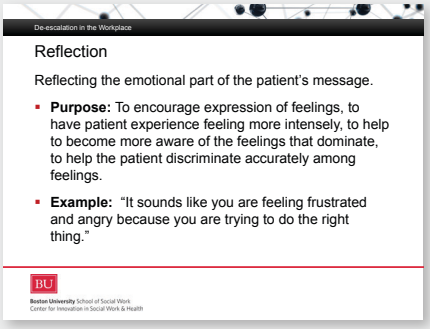

SLIDE 19

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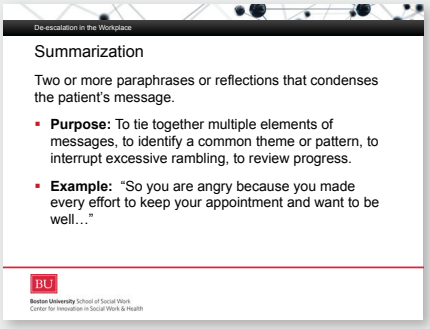

SLIDE 20

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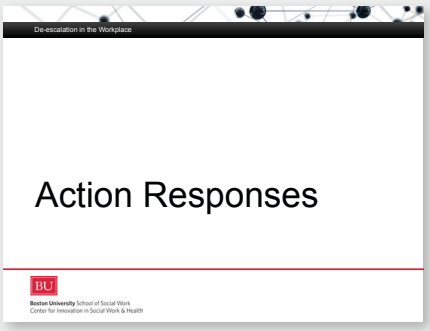
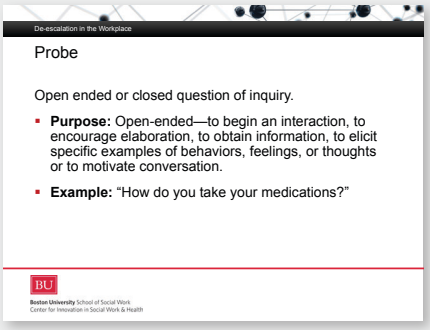


SLIDE 21

Let's take a look at a few additional action responses.



SLIDE 22

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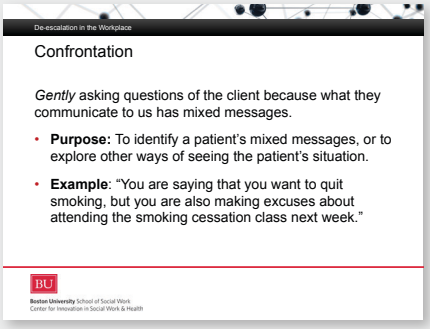
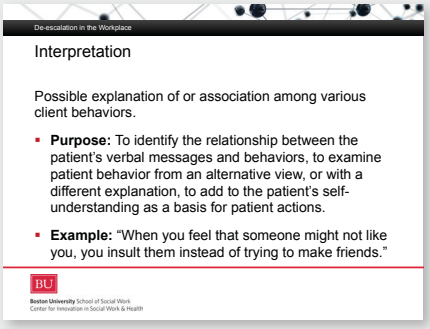


SLIDE 23

We may *gently* ask questions of the client because what they communicate to us has mixed messages.

Review the slide.



SLIDE 24

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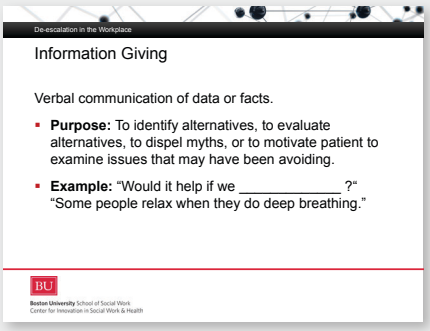

SLIDE 25

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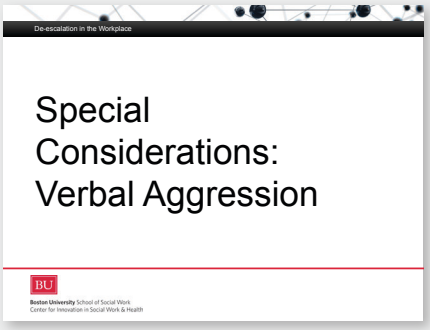
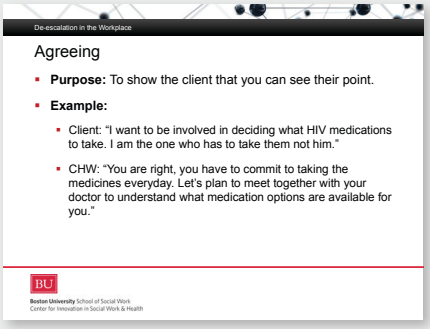


SLIDE 26

Next, we will review some special considerations related to verbal aggression.



SLIDE 27

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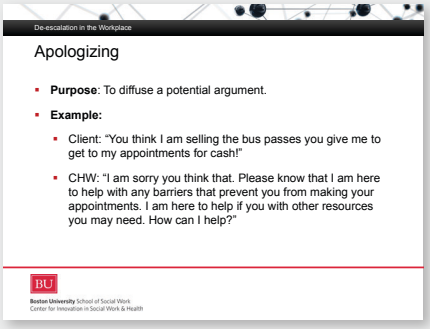
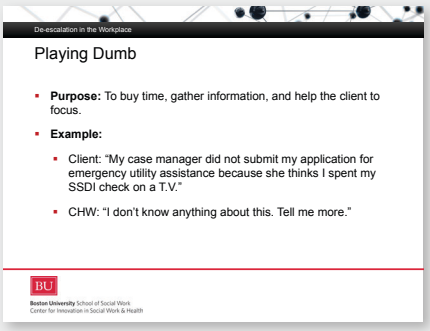


SLIDE 28

Review the slide.



SLIDE 29

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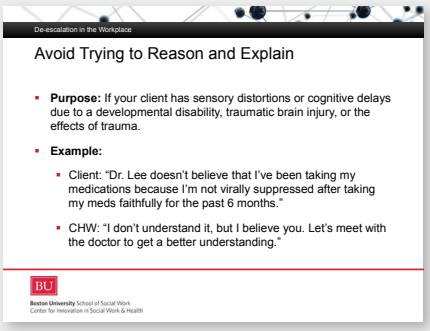
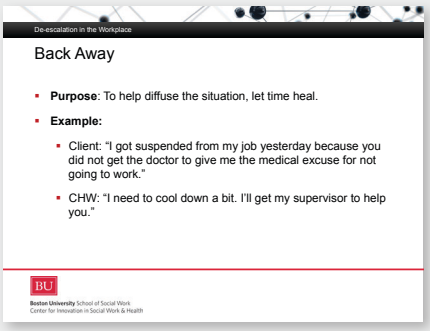


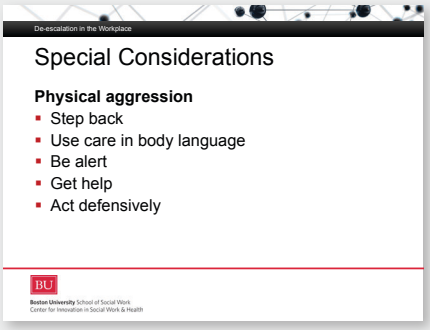
SLIDE 30

Review the slide.



SLIDE 31

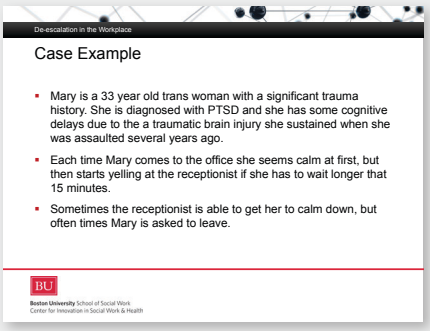
Review the slide.



SLIDE 32

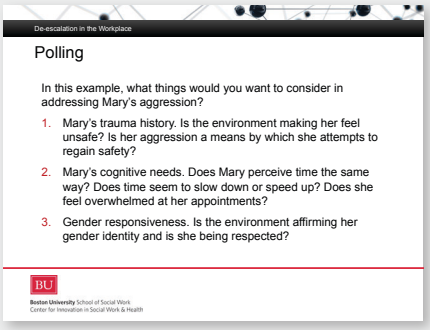
Unfortunately there are some situations where clients do become physically aggressive and our goal is to manage our safety. There are certain strategies to keep yourself safe:

- Step back: Do only what has to be done, such as food, and getting medications. If you try to intervene with normal activities you are increasing the risk to you and your patient.
- Use care in body language: Be sure to approach you patient from the front. Do not turn your back. Give the patient plenty of space. Use a calm tone of voice and reduce the stimuli around the person.
- Be alert: If an aggressive episode has happened it will most likely reoccur. Be prepared.
- Get help: Working in a team is most effective.
- Act defensively: Almost anything can be used as a weapon. Remain alert and aware of possible scenarios in the aggressive episode.



SLIDE 33

Ask for a volunteer to read the case example.



SLIDE 34

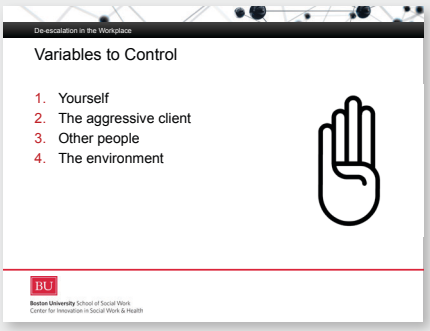
Read the question.

Ask for a volunteer to reach each point.

Ask participants to comment on each point.

SLIDE 35

Let's look at additional ways to manage difficult situations.



SLIDE 36

Four variables to consider when managing a challenging situation are:

Yourself

Emotionally: Maintaining composure as exhibited by tone of voice, rate of speech, use of force and body language.

Physically: In your use of your hands and feet, body posture, and position in relations to others.

The aggressive client

Verbally: Through empathy, redirection, offering alternatives, providing reassurance, or setting a limit.

Physically: Using the least restrictive option necessary to prevent or avoid injury during emergency situations.

Other people

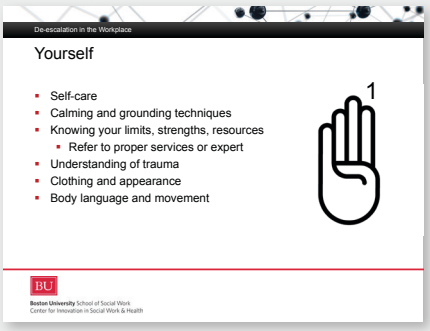
Patients in the area may be scared, frightened, or angry. For their safety and to prevent further escalation, it might be best to have them leave the immediate area.

Staff coming upon the scene after the incident is under way need to be briefed on the on the situation and given directions (calling for help, offering assistance, etc.)

The environment

The environment should be free of dangerous items. Be aware of any object that may be used as a weapon.

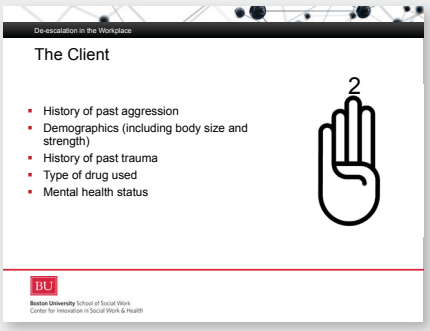
If a patient needs space to wander allow that space. If a patient becomes upset being in a small room, allow them to access larger rooms.



SLIDE 37

Things to consider in managing yourself in the difficult situation:

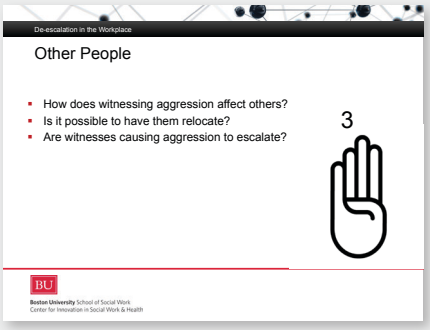
- Self-care
- Calming and grounding techniques
- Knowing your limits, strengths, resources
  - Refer to proper services or experts through supervision, Employee Assistance Programs
- Understanding of trauma
- Clothing and appearance—sometimes how you dress could be triggering to your clients.
- Body language and movement—understand how your body language, your stance, or sudden movements can be triggering to the situation.



SLIDE 38

Things to consider in managing the client in the difficult situation:

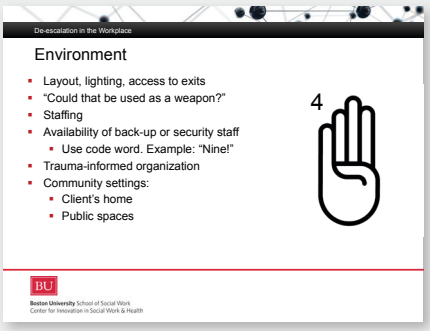
- History of past aggression—do you know if your client has a history of past aggression? If not, read their medical records or collaborate with team members who may have worked with the client previously.
- Demographics (including body size and strength)
- History of past trauma
- Type of drug used
- Mental health status



SLIDE 39

Things to consider in managing other people in the difficult situation:

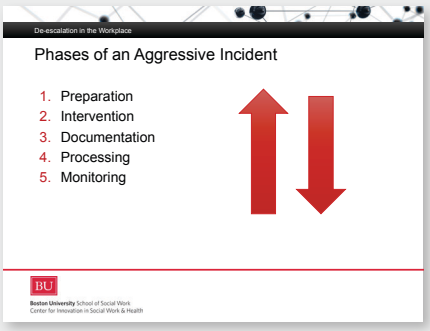
- How does witnessing aggression affect others?
- Is it possible to have them relocate? Maybe it is best to be in an environment that is less triggering for the client or maybe with others who can help you de-escalate the situation.
- Are witnesses causing aggression to escalate? Again this is a situation where the environment you are in with the client can hurt or help the situation you are trying to manage.



SLIDE 40

Things to consider in managing the environment where the difficult situation is being played out:

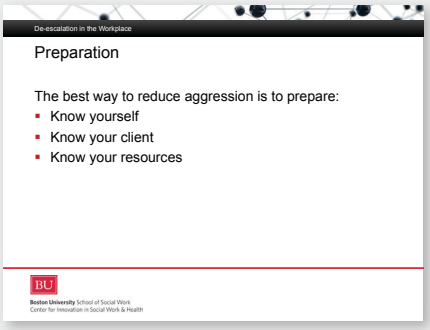
- Layout, lighting, access to exits—review your physical environment.
- Are there materials or items in the space where you think "Could that be used as a weapon?"
- Staff: Are there too many people in the room? Do the people in the room have a position that could be threatening to the client?
  - Availability of back-up or security staff
- Use code word, example "Nine!"
- Trauma informed agency
- Community settings:
  - Client's home
  - Public spaces



SLIDE 41

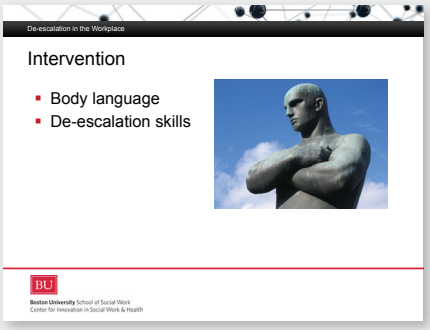
Review the slide.

There are 5 phases to an aggressive incident.



SLIDE 42

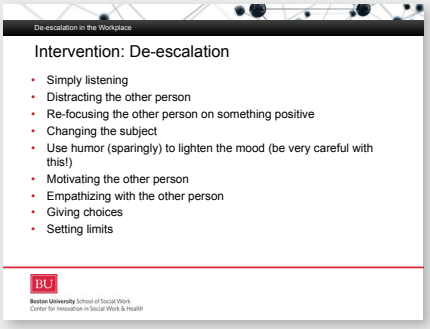
Review the slide.



SLIDE 43

The intervention phase has two parts:

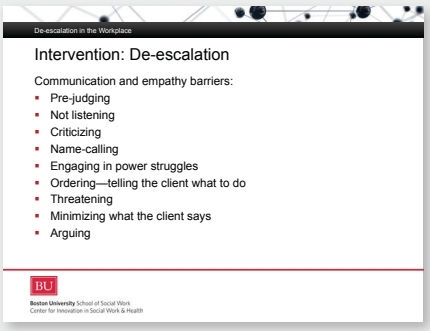
- Body language. From this picture one could say that this figure is closed to whatever others are saying. We see his arms are folded and there is no eye contact as indicated by his closed body language.
- De-escalation could be difficult.



SLIDE 44

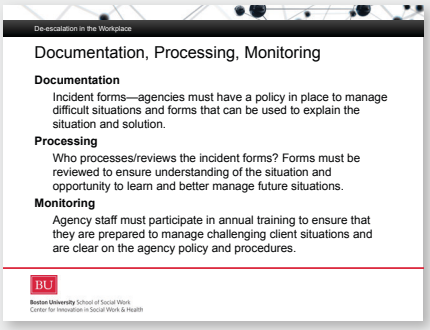
There are certain strategies that can be applied to support de-escalating a heightened situation.

Review the slide.



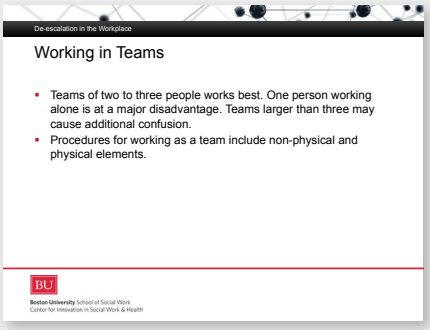
SLIDE 45

On this slide we can see that occasionally we as providers may make choices that do not support de-escalation. We want to ensure that we are communicating in ways that support empathy. Here are some pitfalls to avoid.



SLIDE 46

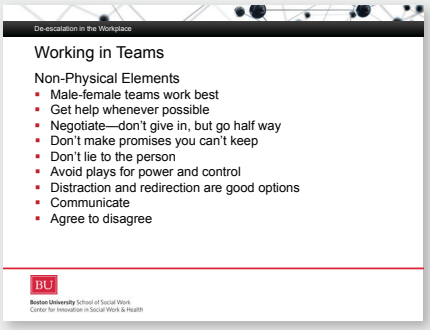
Additional phases of the incident beyond managing the situation include the following.



SLIDE 47

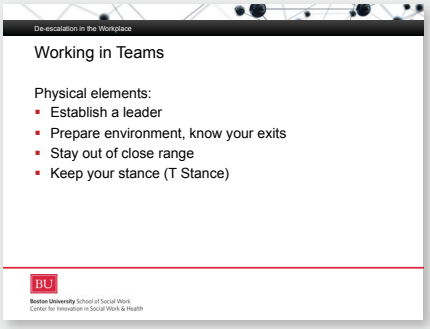
It takes support from our team to help mitigate difficult situations.

If there is potential for a client to become verbally or physically aggressive, it's always best to have teams prepared to manage the situation. At some institutions a designated statement over the telephone/PA system might state: "Mr. Quickly is needed in room 9". . . . this would alert members of the team to respond to a staff person managing a difficult situation. I'm sure many of your institutions have these crisis policies in place. Be familiar with the policy at your institution.



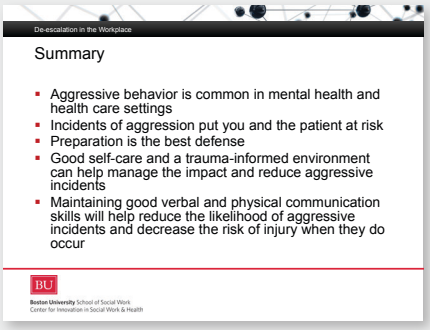
SLIDE 48

Here are some additional considerations for working in teams.



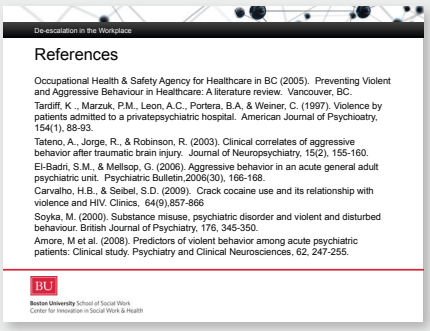
SLIDE 49

If the situation becomes physical in a team consider the following.



SLIDE 50

Review the slide.



SLIDE 51

Self-Assessment Tool: Self-Care*

How often do you do the following?

	Frequently	Sometimes	Rarely	Never	It never occurred to me
Physical Self-Care					
Eat regularly (e.g. breakfast and lunch)					
Eat healthfully					
Exercise, or go to the gym					
Lift weights					
Practice martial arts					
Get regular medical care for prevention					
Get medical care when needed					
Take time off when you are sick					
Get massages or other body work					
Do physical activity that is fun for you					
Take time to be sexual					
Get enough sleep					
Wear clothes you like					
Take vacations					
Take day trips, or mini-vacations					
Get away from stressful technology such as Phones and email					
Other:					
Psychological Self-Care					
Make time for self-reflection					
Go to see a psychotherapist or counselor for yourself					
Write in a journal					
Read literature unrelated to work					
Do something at which you are a beginner					
Take a step to decrease stress in your life					
Notice your inner experience: your dreams, thoughts, imagery, feelings					
Let others know different aspects of you					
Engage your intelligence in a new area: go to a museum, performance, sports or other activity					
Practice receiving from others					
Be curious					
Say no to extra responsibilities sometimes					
Spend time outdoors					
Other:					

	Frequently	Sometimes	Rarely	Never	It never occurred to me
Emotional Self-Care					
Spend time with others whose company you enjoy					
Stay In contact with important people in your life					
Treat yourself kindly (supportive self-talk)					
Feel proud of yourself					
Reread favorite books, rewatch favorite movies					
Identify and seek out comforting activities, objects, people, relationships, places					
Allow yourself to cry					
Find things that make you laugh					
Express your outrage in a constructive way					
Play with children					
Other:					
Spiritual Self-Care					
Make time for prayer, meditation, reflection					
Spend time in nature					
Participate In spiritual gathering, community or group					
Be open to inspiration					
Cherish your optimism and hope					
Be aware of nontangible (nonmaterial) aspects of life					
Identify what is meaningful to you and notice its place in your life					
Sing					
Express gratitude					

	Frequently	Sometimes	Rarely	Never	It never occurred to me
Celebrate milestones with rituals that are meaningful to you					
Remember and memorialize loved ones who have died					
Nurture others					
Have awe-filled experiences					
Contribute to or participate in causes you believe in					
Read inspirational literature					
Listen to inspiring music					
Other:					
Workplace/Professional Self-Care					
Take time to eat lunch					
Take time to chat with co-workers					
Make time to complete tasks					
Identify projects or tasks that are exciting, growth-promising, and rewarding for you					
Set limits with clients and colleagues					
Balance your caseload so no one day is "too much"					
Arrange your workspace so it is comfortable and comforting					
Get regular supervision or consultation					
Negotiate for your needs					
Have a peer support group					
Other:					

***Adapted from Saakvitne, et. al. Transforming the Pain: A Workbook on Vicarious Traumatization, 1996.**

Establishing and Supporting Professional Boundaries

OBJECTIVES

At the end of this unit, participants will be able to:

- Define confidentiality
- Define HIPAA
- State the connection between confidentiality and HIPAA regulations
- Define boundaries
- Name and differentiate the four types of boundaries (emotional, place/time, physical, and personal)
- Identify strategies to manage boundary dilemmas
- Discuss the importance of boundaries in professional relationships

INSTRUCTIONS

1. Prior to the session review the PowerPoint slides and notes.
2. Welcome participants and review session objectives (slide 2).
3. Brainstorm answers to the questions with the group (slides 3–4).
4. Ask participants if they know of any legal reasons why confidentiality is kept and for what reasons. Review slide 5 on the Health Insurance Portability and Accountability Act (HIPAA).
5. Brainstorm ideas of when confidentiality can be broken. Record answers on a flip chart. After the brainstorm session, compare answers with slide 6.
6. Ask participants, "What happens when confidentiality is not respected or breached?" Compare responses to slide 7.
   - Distribute the handout on confidentiality.
7. Review slides on boundaries and types of boundaries.
8. Facilitate activity with the handout "Boundaries in Professional Relationships." See slide 22 for details on guiding a discussion after participants complete the worksheet.
9. Divide participants into pairs. Distribute the "Boundary Scenarios" handout, assigning each pair to a different scenario. Ask them to discuss how they would handle the scenario as CHWs. Save some time to ask participants to share back what was discussed. (30 minutes)
10. Wrap up. Review slide 23 and remind participants that as health care workers supporting patients, we must always be aware of confidentiality and our professional and personal boundaries.

Related C3 Roles

All

Related C3 Skills

Professional skills and conduct

Method(s) of Instruction

Lecture, group discussion, activity

Estimated time

90 minutes

Key Concepts

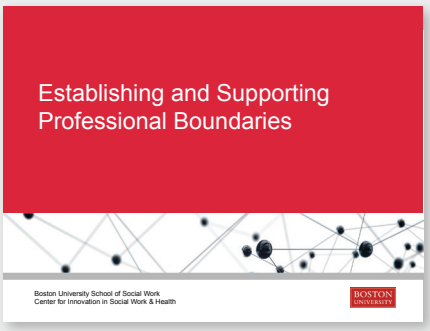
Boundaries, confidentiality, HIPAA regulations

Materials

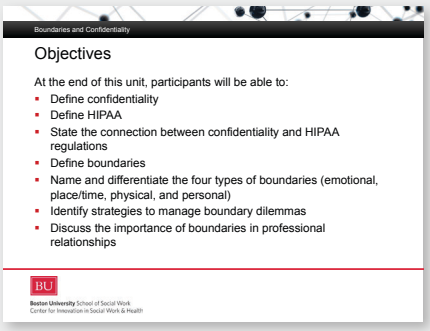
- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers
- Activity Sheet—Boundaries in Professional Relationships

Handouts

- Confidentiality
- Establishing and Maintaining Professional Boundaries
- Boundaries in Professional Relationships
- Boundary Scenarios

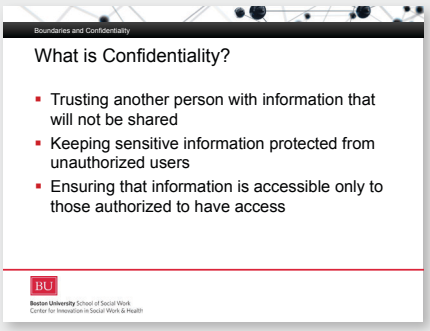


SLIDE 1



SLIDE 2

Review the objectives.

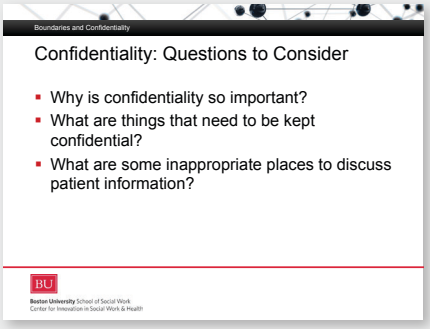


SLIDE 3

Ask, "What is confidentiality?"

Offer the definition of confidentiality on the slide.

Define for participants who is an authorized/unauthorized user: Unauthorized users can vary from one organization to the other, but, generally, unauthorized users are people who are not employees of the organization. In many cases, even among employees, only those working directly with a patient and their supervisors have access to patient files.



SLIDE 4

Ask participants: Why is confidentiality so important? Write responses on a flip chart. Share possible answers:

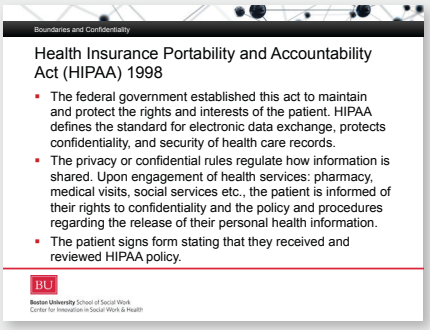
- People need to be able to trust their CHW
- People need to feel safe
- We must respect the dignity of individuals
- If patients don't trust us we may lose them
- It's agency policy
- There are liability issues for the agency

Tell participants that beyond access to records and files, CHWs hold a lot of personal information about patients and have an ethical responsibility to guard that information from unauthorized users. This can be tricky because as people with HIV, CHWs may travel in some of the same circles as their patients, and when patients see them in those circles, they may wonder if the CHWs will guard their information. Any "leaks" will get back to patients and before you know it other patients will know that the CHW can't be trusted. This could render the CHW ineffective and can lead to negative consequences.

Question 2: Quickly brainstorm with group specific things that should be kept confidential. Summarize by stating that everything about the patient is confidential.

Question 3: Conduct another quick brainstorm on inappropriate places to discuss patient information and document on a flip chart. Some suggested areas to share (if not mentioned):

- Clinic and office hallway.
- Email communication with patient's full name.
- Outside of the clinic/agency; for example grocery store, community meeting places
- In places where others can hear what we are talking about.

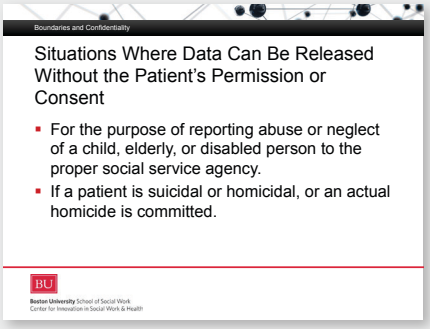


SLIDE 5

Ask, "How many of you have heard the term HIPAA?"

Ask for a volunteer to read the slide.

- The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was enacted by the United States Congress and signed by President Bill Clinton.
- The purpose of this act is to maintain and protect the rights and interest of the patient. HIPAA defines the standard for electronic data exchange, protects confidentiality and security of health care records.
- The privacy or confidential rules regulate how information is shared. Upon engagement of health services: pharmacy, medical visits, social services etc., the patient is informed of their rights to confidentiality and the policy and procedures regarding the release of his personal health information.
- The patient signs a form stating that they received and reviewed HIPAA policy.



SLIDE 6

Ask for a volunteer to read the slide.

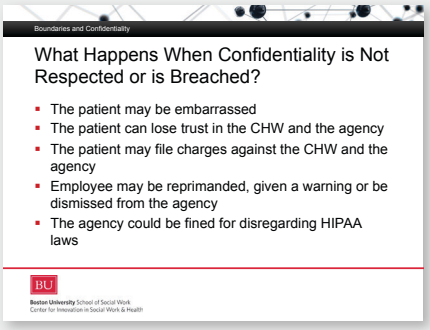
Ask participants to brainstorm about this question: What are examples of situations when data can be released without the patient's permission or consent?

Possible answers to situations when data can be released without the patient's permission or consent:

- For the purpose of reporting abuse, neglect, or domestic violence to the proper social service or protective services agency.
- To prevent serious threat to health and public safety.

Other answers include:

- To the department of public health for health reporting purposes.
- Informing appropriate bureaus during disaster relief.
- Workers' compensation.
- Food and drug administration for expected side effect to drugs of food product defects to enable product recall.
- Correctional institutions.
- To medical examiners, coroners for procurement of organs for certain research purposes.
- Notifying family members or legal guardian involved in the patient's care if a person is missing (example Amber or Silver alerts on television/radio).



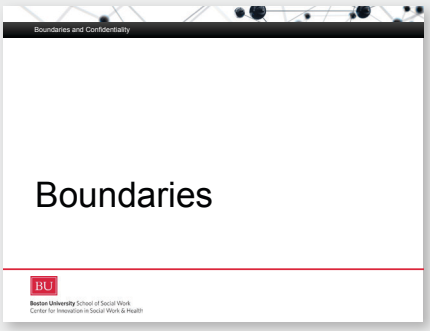
SLIDE 7

Ask, "What happens when confidentiality is not respected or is breached?"

It is important for us to follow these HIPAA laws. If for some reason we do not follow this law and confidentiality is breached certain situations arise.

Review the slide.

Say, "Let's now transition to talking about professional boundaries."



SLIDE 8

Ask, "What are boundaries and why are they important?" Brainstorm and note responses flip chart.

Each type of boundary (physical, time, place, emotional and personal) could be on its own sheet or you can just list them all together. Encourage participants to think in terms of all types of boundaries.

Possible responses: for patients to feel safe, for staff to feel safe, for supervisors to feel safe, to prevent CHW burnout, to prevent misinformation, to prevent liability, to keep patients engaged with the organization.

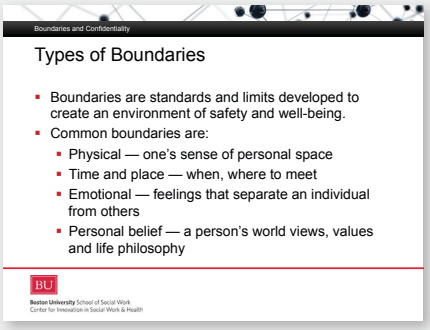
Share with participants that some boundaries are non-negotiable, as established by professional codes and agency policy, while others are more personal, and may be different from person to person or situation to situation.

CHW related boundaries have always been a concern for service providers.

We tend to be more concerned about CHW boundaries than with other employees.

Ask, "Why do you think this is so?" Take a few responses.

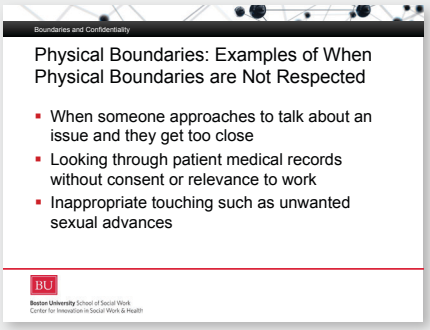
Possible responses: Higher level of intimacy, lack of experience in the workplace, wanting to be all things to patients, not knowing the limits of their roles.



SLIDE 9

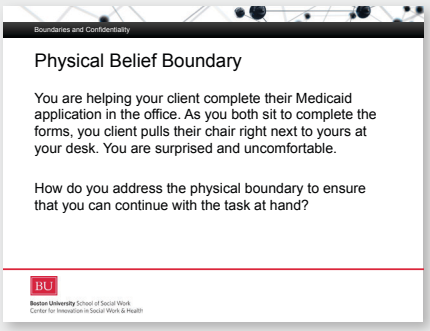
Review the slide.

As we just defined, boundaries are standards and limits developed to create an environment of safety and well-being.



SLIDE 10

Review the slide.



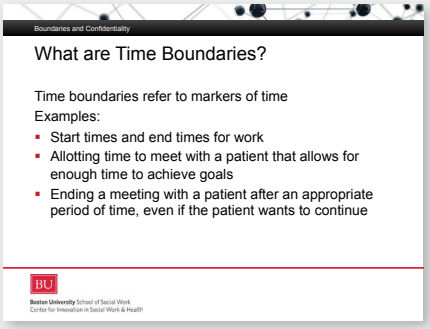
SLIDE 11

Ask for a volunteer to read the scenario.

Ask, "How do you address the physical boundary to ensure that you can continue with the task at hand?"

Possible answers:

- Shift your chair away and share that it is important to have some personal space between each other
- Explain to your client that you are most comfortable working when there is space between you both, that way you will not bump into each other as you complete forms.
- If you are using a computer to complete the form online, share the screen so that your client can see it and it will allow for some personal space in between. In addition, chairs will not have to be moved closer together to see the screen.

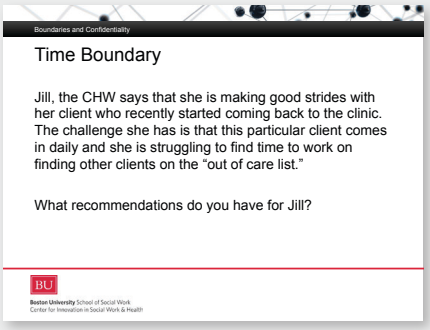


SLIDE 12

The next type of boundary we want to review is time boundaries which refer to markers of time.

Review the examples on the slide.

CHWs modeling appropriate time boundaries can help clients set boundaries with others in their lives. It can also build a sense of trust between the CHW and the client.



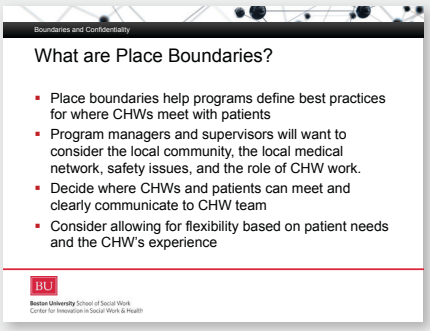
SLIDE 13

Ask a volunteer to read the slide.

Ask, "What recommendations do you have for Jill?"

Possible answers:

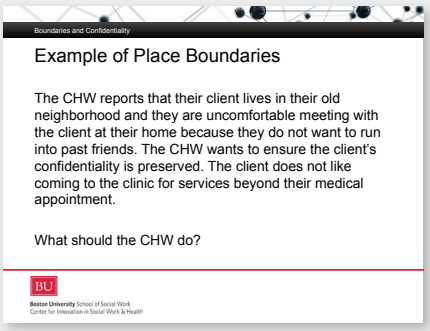
- Provide times that the client could check in with her, like 30-minute sessions on particular days.
- Jill can provide positive feedback about the client re-engaging with the clinic, then explain that she has other clients to work with and must be available to other clients as well.
- Jill can connect her client with other people on the team who can help them with getting their needs met.
- Jill can not respond to the client when they show up to be seen unexpectedly.



SLIDE 14

Review the slide.

CHWs are familiar with the community so they know where safe places may be for their patients. It is important for CHWs to inform coworkers about when and where they are meeting with their patients as part of the safety protocol at the agency.



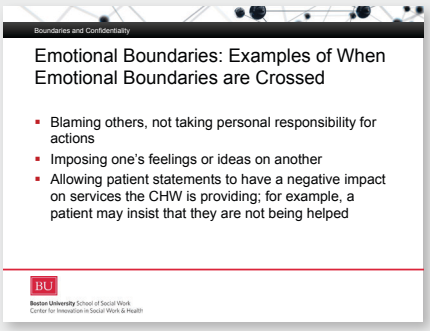
SLIDE 15

Ask for a volunteer to read the scenario.

Ask, "What should the CHW do?"

Possible answers:

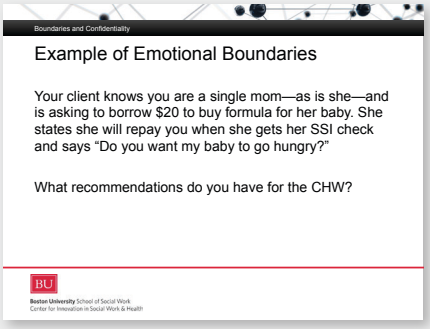
- The CHW can explain to the client that they used to live in the neighborhood and are concerned that may run into old friends who may inquire about why they are in the neighborhood.
- The CHW can acknowledge that the client does not like coming to the clinic and suggest some other places in the community where they can meet that will maintain confidentiality.



SLIDE 16

Review the slide.

Another type of boundary is emotional boundaries.



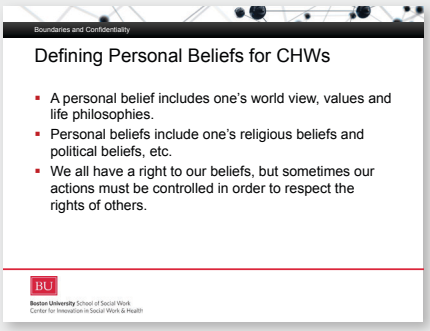
SLIDE 17

Ask for a volunteer to read the scenario.

Ask, "What recommendations do you have for the CHW?"

Possible answers:

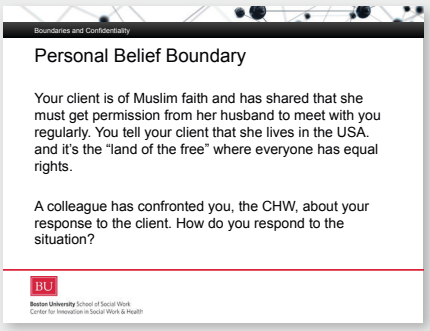
- The CHW can remind the client that she cannot loan money to her because it goes against the agency policy.
- The CHW can suggest community resources where the client can get formula for her baby and help her in getting the resource.



SLIDE 18

Review the slide.

Personal beliefs include one's religious beliefs, political beliefs, etc. We all have a right to our beliefs, but sometimes our actions must be controlled in order to respect the rights of others.



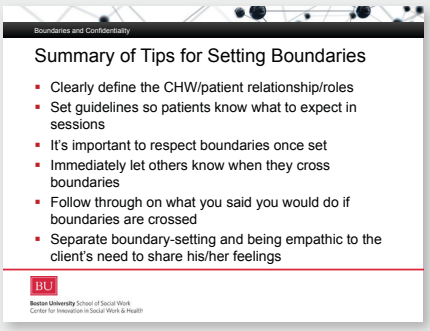
SLIDE 19

Ask for a volunteer to read the scenario.

Ask: "A colleague has confronted you, the CHW, about your response to the client. How do you respond to the situation?"

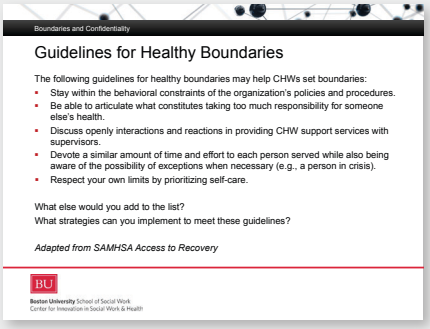
Possible answers:

- You thank your colleague for bringing this to your attention as you did not realize your statement could have negative results with your client's religious beliefs.
- You ask for help on how to apologize to your client because you recognize you were disrespecting their belief boundary.



SLIDE 20

Review the slide.



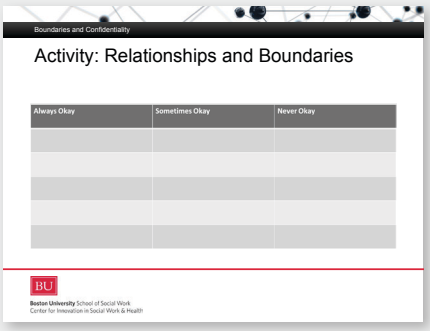
SLIDE 21

Here are some tips from SAMHSA about healthy boundaries.

Ask participants:

- What else would you add to the list?
- What strategies can you implement to meet these guidelines?

Distribute the handout Establishing and Maintaining Boundaries. Ask for volunteers to read it aloud.



SLIDE 22

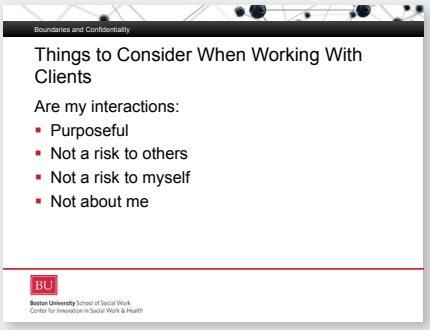
We are now going to do an individual exercise that will help you test/assess your own boundaries

Distribute the handout Boundaries in Professional Relationships and spend a few minutes answering the questions.

Debrief/discussion:

- Ask for volunteers to share how they answered the questions.
- Were there any gray areas?
- Are there boundaries they felt strongly about or boundaries they just couldn't answer at all?

Key Point: It is important for members of the team to understand their own boundaries.



SLIDE 23

As we wrap up this module, here are some key things to consider when you are working with clients.

If you answer no to any of these considerations, then seek support from your administrative or clinical supervisor. The relationship between the client and CHW is one of privilege as clients invite us to be part of their lives and CHWs in return want to support them in the best possible way to keep them engaged in care and services.

Confidentiality

Situations when HIPAA data can be released without client's permission or consent:

- ✓ Reporting abuse, neglect, or domestic violence
- ✓ Prevent serious threat to health and public safety
- ✓ Reporting to Department of Public Health for health purposes
- ✓ Inform appropriate bureau during disaster relief
- ✓ Workers compensation
- ✓ Food and Drug Administration for expected side effects to drugs or food product defects to enable product recall
- ✓ Correctional institution
- ✓ Funeral directors, medical examiners, coroners, procurement of organ, for certain research purposes
- ✓ Notify family members, legal guardian involved in the client's care for notifying them of a person's location

Consequences of breaking confidentiality include:

- ✓ Employee reprimand, warning, or dismissal
- ✓ Client/patient may be embarrassed
- ✓ Client will lose trust in CHW and agency
- ✓ Client may file charges against CHW and agency
- ✓ Agency could be fined criminal penalties for disregarding HIPAA

Establishing and Maintaining Professional Boundaries

Establishing and maintaining appropriate professional boundaries allows Community Health Workers (CHWs) to better protect the welfare of clients, themselves, employers, and the community.

Examples of professional boundary issues are:

- A CHW's self-disclosure of personal information to a client
- Physical contact with a client
- Romantic or sexual involvement with a client
- Managing dual or multiple relationships with clients

A **dual or multiple relationship** exists when you have another type of relationship or connection with someone who is also a client. For example, a client may be a former coworker, or a member of your church, synagogue, or mosque.

CHWs confront potential boundary dilemmas frequently, including offers of gifts from clients, requests from clients to borrow money, or invitations to develop a romantic relationship. Whether it is lending a client $1.50 for bus fare, giving a client a ride in your car to an appointment, being invited to become the godmother to the client's daughter, or seeing a client at your neighborhood grocery store or school, it is sometimes difficult to know what to do.

Professional boundaries are defined as *limitations or ethical guidelines that a professional establishes within working relationships*. Boundaries may be fluid and flexible depending on the situation.

Establishing professional boundaries can assist both the CHW and the client to clearly define their working relationship. Identifying what you can or cannot do for the client is an important part of building trust in your relationship. Your clients should know what to expect from your behavior at the outset of the relationship. The moment a CHW deviates from a strictly professional role, it is known as **boundary crossing**.

Not every boundary crossing is unethical. Because CHWs often work in the same community where they live, it is difficult to avoid dual relationships with clients. In fact, those relationships may be part of what makes the CHW a "trusted member of the community." CHWs must stay aware of their influential position with respect to clients, however, and avoid exploiting the trust of clients. Understand that some dual relationships can impair professional judgment or increase the risk of harm to clients. The guiding principle here should be: What is in the best interest of the client? If it could be harmful for a client to work with a CHW with whom the client has a dual relationship, then the CHW should refer that client to a colleague.

Here are some questions you can ask yourself if a boundary dilemma arises:

- Who benefits from the boundary crossing?
- Is the boundary crossing necessary?
- Did the client receive informed consent about the potential risks involved in the boundary crossing?
- How will the boundary crossing affect the relationship?
- Am I being objective?
- Is there a cultural context to consider in this situation?

When in doubt, seek support from colleagues, your supervisor, or the code of ethics in your workplace.

Source: Berthold et al (Eds.), 2009, *Foundations for Community Health Workers*

Boundaries in Professional Relationships

Decide whether **for you** each of these situations in clearly Always Okay or Never Okay. If there are times when it might or might not be okay, depending on circumstances, check Sometimes Okay. Then make a note as to **when** or under **what circumstances** would make that behavior okay. Discuss your answers with others.

Behavior	Always Okay	Never Okay	Sometimes Okay (When?)
1. Keep your attraction to your client secret from supervisor/team			
2. Keep client's attraction to you secret from supervisor/team			
3. Keep boundary concerns secret from supervisor/team			
4. Bend the rules for an individual client			
5. Share religious/spiritual beliefs with client			
6. Advocate for a client despite your team/agency's opposing view			
7. Share after-hours social time with a client			
8. Bring a client to your home for any reason			
9. Share a meal with a client			
10. Engage in common interests with a client			
11. Spend time alone with client in their apartment			
12. Lend money to a client			
13. Lend personal items to a client			
14. Accept a loan of money from a client			
15. Accept a loan of personal items from a client			
16. Give a gift to a client			
17. Accept a gift from a client			
18. Call a client after work hours			
19. Accept a call from a client after work hours			
20. Accept a call from a client at your home			
21. Invite clients to a party at your home			
22. See a former client as a friend			
23. Date a former client			
24. Accept a hug from a client			
25. Initiate a hug with a client			
26. Accept a massage from a client			
27. Initiate a massage with a client			
28. Take a client to your church			
29. Take a client to your self-help meeting			
30. Ride in a client's vehicle			
31. Encourage your client to disclose to his/her partner(s)			
32. Encourage your client to disclose to his/her family members			
33. Disclose your own HIV status and your life story to your client			

Boundary Scenarios

Role Confusion

Joe has received primary care and case management services from the clinic, which has supported his goal of increasing his knowledge of HIV and how to manage his health. Joe is now ready to give back to others who are struggling with the disease. He participated in training to become a CHW and was hired part-time at the clinic as a CHW. He must now manage his dual role: patient and CHW. During a recent supervision meeting, Joe shared with his colleagues that he is struggling with wanting to attend the support group he has gone to for the past three years that helped him with his sobriety.

What are the boundary issues presented in this scenario and what would you do?

A Prior Relationship

Brad is a CHW at the clinic. One day he sees his friend Steve come into the clinic for his first appointment. Brad is surprised to see Steve, as they have never talked about their HIV status. Brad is now concerned that his confidentiality will be compromised because they share the same social circles.

As the CHW in this scenario, what would you do?

Immigration Status

Ramon Torres, a 38-year-old male from Guatemala, is a client who was arrested and convicted for DUI in 2015. He was required to complete inpatient treatment and take a defensive driving course, all which he successfully completed.

Ramon has been coming to the clinic since 2014, but has had trouble with adherence and attending his doctor's appointments. Once he was released from jail, he was assigned a navigator who supported Ramon as he began inpatient drug treatment, and attending medical and legal appointments. Ramon began to thrive once sober, and his viral load was suppressed and undetectable at last visit.

Immigration and Customs Enforcement (ICE) recently began inquiring about clients, and even taking some into custody who had prior convictions. This scares Ramon, and he now refuses to come back to the clinic for fear of been detained by ICE.

As a CHW/navigator, how would you help this patient?

If you were approached by an ICE officer and they asked you if Ramon Torres is a client at your clinic, how would you respond?

Domestic Violence

A CHW has been working with a married, heterosexual female who has two young children. The client lives in subsidized housing and stays at home with her children, while her husband works. The client isn't able to make it to the clinic or other services very frequently, but childcare has been the only barrier identified.

The client's housing case manager had been exchanging emails with the client, who said she was scared of her husband. The housing case manager was unable to do a home visit, so the CHW agreed to go and uses her personal vehicle to drive 30 miles to visit the client.

Upon arrival the CHW is able to confirm domestic violence is occurring, and the client is unable to leave the home. The CHW calls local domestic violence hotlines, but is unable to reach a staff member via phone. The CHW calls the housing agency, who immediately provides a hotel voucher. The client's husband is not home, but often comes home unannounced. The client is not expecting to flee her home with her two children, and doesn't have any belongings packed so the CHW assists the client with packing belongings for herself and her children – using a suitcase owned by the CHW that she had in the back of her personal vehicle.

Motel arrangements are made, but client has no debit or credit cards, no cash, and does not have her food stamp card, as her husband keeps it. En route to the DHS office to secure benefits, both of the client's children are crying, as they have not had any meals since breakfast. The CHW uses their personal debit card to purchase food for the children. The client decides she is too overwhelmed to go to the DHS office with the children, since she doesn't have a stroller, and gets anxiety when leaving the house. She is also tearful and traumatized from the day's events. By this time, it is late in the afternoon, so CHW drives the client to the motel room and assists with unpacking her items from the car. The CHW agrees to go back to the motel the next morning. The client's children have left food and packaging strewn throughout the CHW's car.

The CHW arrives at the motel the following day and two unknown men answer the door, who tell the CHW that the client is in bed. It turns out that the client's husband found out what motel she was in, and showed up in the middle of the night. He was arrested, but let out early that morning. The CHW enters the motel room, and finds out that the client's husband has been circling the area surrounding the motel. The husband was found with drugs in his possession, so is likely under the influence. The CHW calls 911 and requests a police escort. Instead of taking the client to apply for benefits as previously discussed, the police say they should go directly to a domestic violence center and file a restraining order.

The CHW ends up being confined in the motel room with the client, her two kids, and two men for 2.5 hours while waiting for the police. The CHW purchased food for the family again, as several hours passed while the police were on the scene.

What are the boundary issues presented in this scenario and what would you do?

Domestic Violence

Mike, a new client to the clinic, is a 32-year-old man who tells his CHW that he escaped his apartment after being held captive and beaten all weekend by his partner Will.

Will is a 30-year-old man who has been a client at the clinic for several years, and the CHW has known Will from the community before coming to work at the clinic. The CHW is a board member of a local non-profit of which both Will and Mike are volunteers. The CHW reported a conflict of interest to their supervisor, but it was determined it would still be okay to work with Mike.

The two clients are in an on-going domestic violence situation. The CHW does a home visit, and although Mike had filed a restraining order against Will, Will is at Mike's apartment. Will is high on meth and talks about hearing voices. Mike says that Will understands that they are no longer in a relationship and is temporarily staying at his house because he lost his apartment and has nowhere to go. The CHW asks if Mike understands that this is in violation of the restraining order that is designed to protect him from future physical violence. The CHW is able to convince Will to leave the house and takes him back to the clinic to problem solve about the housing situation.

In their role as a community organizer, the CHW has multiple relationships with both clients outside of the CHW role, as the CHW attends social functions and meetings with both clients in the community. In one of these settings, mutual friends are discussing concerns about the abuse in the presence of the CHW, who reports that they cannot discuss the abuse. The friends are trying to develop a strategy to assist Will with his substance use and housing situation.

Two weeks later Mike is in a counseling session at the clinic and tells his therapist that he is afraid to return home because Will is there and was threatening him. Will continued to stay at the apartment until he was arrested. The CHW has been asked to testify at the trial, however, is requesting dismissal due to the dual relationships.

What are the boundary issues presented in this scenario and what would you do?

Prioritizing and Organizing Your Time

OBJECTIVES

At the end of this unit, participants will be able to:

- Organize time and tasks in order to manage the multiple demands of a Community Health Worker

INSTRUCTIONS

1. Before the session, prepare two flip chart sheets: 1) Importance of Organizational Skills, and 2) Challenges and Solutions for Time Management. Review PowerPoint slides and handouts.
2. Welcome participants and review session objectives (slide 2). Explain to participants that managing time is important for everyone, but it is especially important for CHWs.
3. Discussion: Ask, "Why are organizational skills important for CHWs?"
   - Solicit responses and write them on the flip chart.
   - CHWs must balance many competing demands on their time. They get demands from community members, from co-workers, from supervisors, from family members, etc. They may feel they don't have much control over their time.
4. Review tips for time management (slide 3).
5. Prioritizing Tasks Activity
   - Distribute the handout "Time Management Activity Sheet."
   - Review slide 4 for detailed instructions. Ask participants to work on the time management activity first on their own and then share with a partner.
   - Ask, "What are your challenges for time management?" Write answers on the flip chart.
   - Ask, "What are some solutions that you have for these challenges?" Write answers on the flip chart.
6. Share the information on time management apps and the time log handout.
7. Wrap up. Summarize by stating that everyone struggles with time management. As a CHW, coming up with a time management strategy that works for you will promote a productive and trusting relationship with your care team and your clients. It can also prevent you from feeling overwhelmed by your work and developing burnout.

Related C3 Roles

All

Related C3 Skills

Professional skills and conduct

Method(s) of Instruction

Large group brainstorm, individual activity, pair activity

Estimated time

60 minutes

Key Concepts

Time management, prioritization, organization

Materials

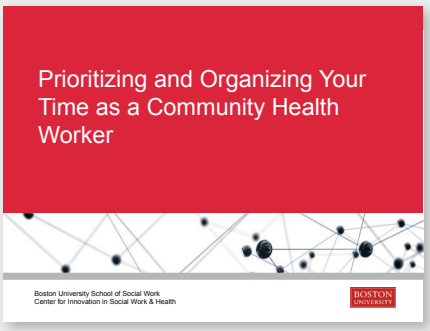
- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Handouts

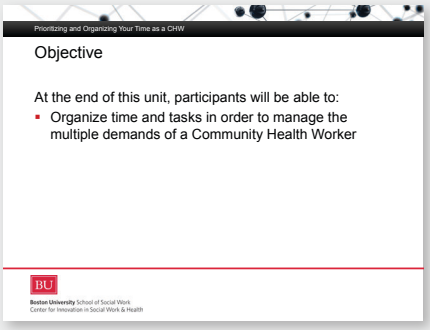
- Time Management Activity Sheet
- Time Log

Resources

Information on time management apps, *https://techigem.com/time-management-apps/*

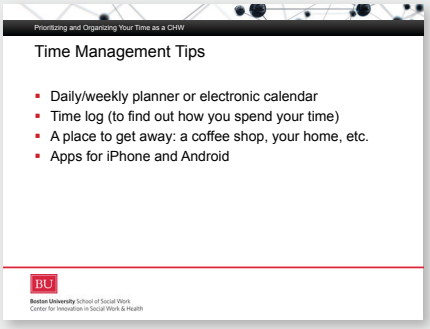


SLIDE 1



SLIDE 2

Review the slide.

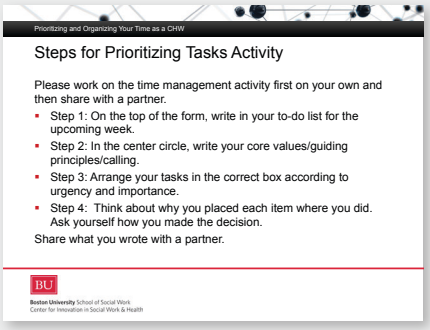


SLIDE 3

Here are some tips and tools to help you manage your time more efficiently.

Review the slide.

Ask participants, "Are there other tips that you use to manage your time?"



SLIDE 4

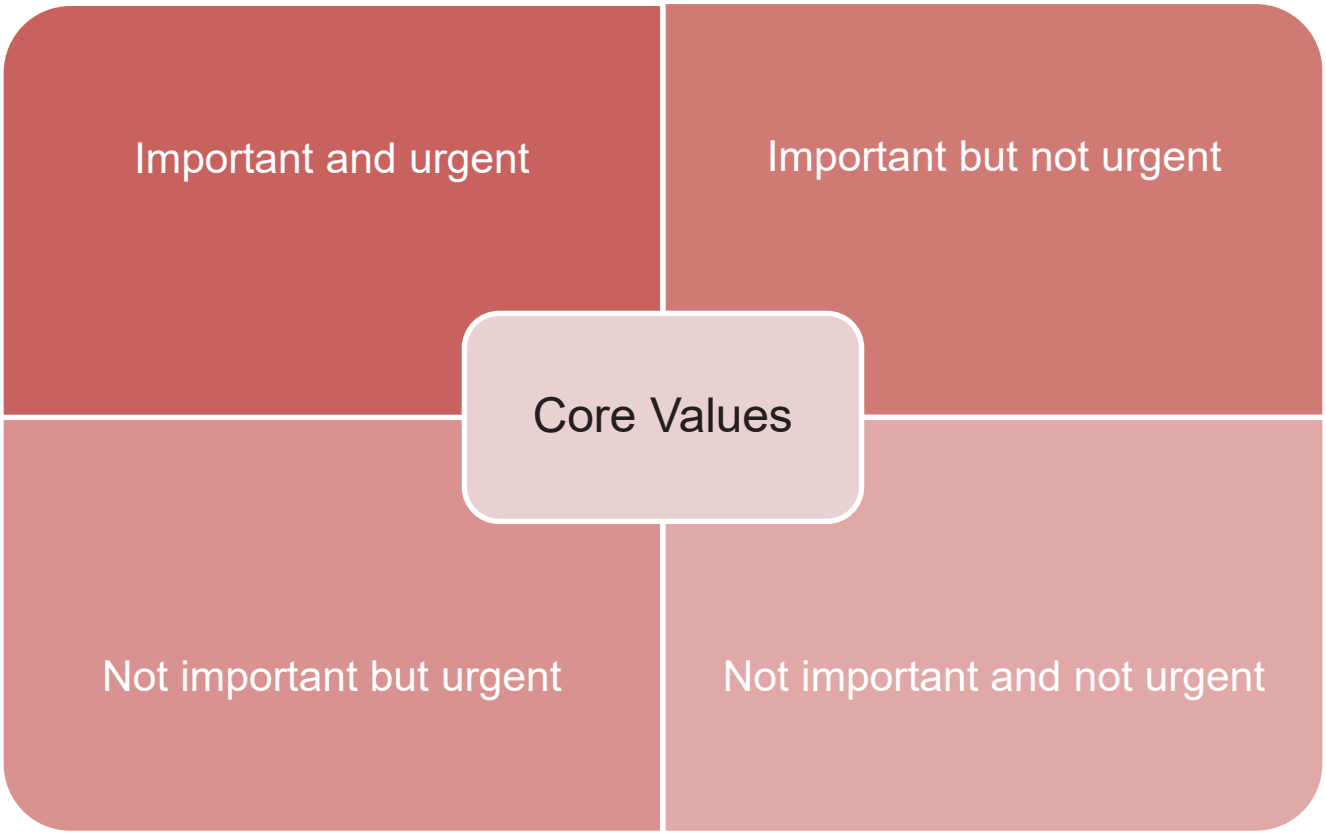
We are now going to work on an activity to help us prioritize tasks.

Review the instructions on the slide.

Time Management Activity Sheet

To Do List:

1.	6.
2.	7.
3.	8
4.	9.
5.	10.



Time Log

DATE	ACTIVITY	FROM	TO	TOTAL TIME

Professional Development

OBJECTIVES

At the end of this unit, participants will be able to:

- Have awareness of professional boundaries and challenges with disclosure of personal information in the workplace
- Understand the balance of giving and receiving feedback in a professional manner
- Develop strategies to support individual short- and long-term professional and life goals

INSTRUCTIONS

1. Before the session, review the notes from the PowerPoint slides
2. Welcome participants and review the objectives.
3. Review PowerPoint slides. See notes for detailed information for conversation facilitation throughout.
4. Wrap up. Share additional resources for ongoing planning and opportunities for CHW professional growth. Encourage participants to talk with their supervisors about professional development opportunities in their community. Encourage them to join CHW and other associations to develop their skills and professional opportunities.

Related C3 Roles

Cultural mediation among individuals, communities and health and social service systems

Related C3 Skills

Education and facilitation skills, capacity building skills, advocacy skills

Method(s) of Instruction

Lecture

Estimated time

60 minutes

Key Concepts

CHW professional development, development planning, personal and professional boundaries, CHW professional growth

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

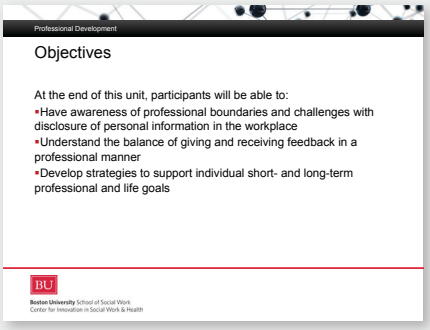
Resources

Boundaries at work: *https://study.com/academy/practice/quiz-worksheet-maintaining-boundaries-at-work.jpg*

Communication etiquette: *https://www.glassdoor.com/blog/dos-and-donts-business-email-etiquette/*

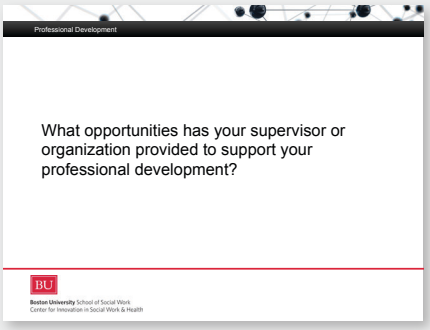
Improving Public Speaking: Toastmasters International: *https://www.toastmasters.org/*

SLIDE 1



SLIDE 2

Review the objectives.



SLIDE 3

Ask participants: What opportunities has your supervisor or organization provided to support your professional development?

Note the responses on the flip chart.

Define professional development: "The process of improving and increasing capabilities of staff through access to education and training opportunities in the workplace, through outside organization, or through watching others perform the job. Professional development helps build and maintain morale of staff members, and is thought to attract higher quality staff to an organization. Also called staff development." (Source: http://www.businessdictionary.com/definition/professional-development.html)

Give examples of professional development:

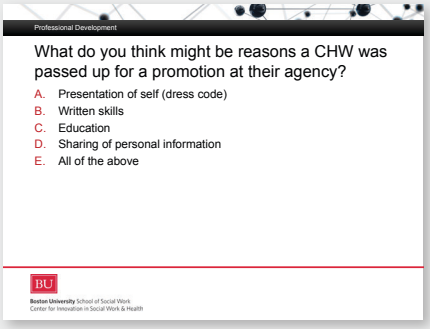
- Trainings at the agency
- Community meetings
- Advocacy events

CHW certification process is an example of professional development in that the organizations have invested time and resources to send you to the learning/training sessions.

Although a training might be focused on the role of a Community Health Worker, many skills are transferable.

For example, the skill of identifying community resources and building relationships with community partners is not a skill relegated to the role of a CHW; it is a useful skill that can be applied any many different professional positions.

Ask participants for examples of how their agency provides professional development.



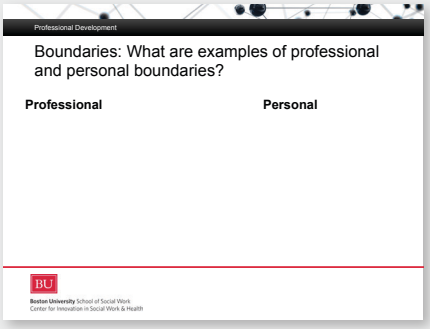
SLIDE 4

Ask participants, "What do you think might be reasons a CHW was passed up for a promotion at their agency?" (The answer is E)

Briefly discuss why participants chose their response.

Give examples for each response.

1. Presentation of self (dress code).
   Perhaps the CHW's team was selected to do a presentation for the board of directors and potential funders during a formal dinner event and the CHW dressed in jeans and a t-shirt.
2. Written skills.
   Certain roles require a specific level of literacy skills. Maybe the CHW was challenged with grammar or conveying complete thoughts through writing and was put on a disciplinary plan for poor documentation in patient charts or monthly reports.
3. Education.
   Maybe the CHW's educational experience doesn't correspond with the job requirements (certification or degree).
4. Sharing of personal information.
   Perhaps the CHW spent time sharing personal information (not related to the job) that can be intrusive to colleagues or overheard by others. This can lead to the CHW being seen as less than professional.



SLIDE 5

Share with participants: As we continue to explore the topic of professional development, we will note several layers that can facilitate or hinder people who are engaged in this professional growth process. Next, we will address the familiar subject of boundaries

Ask participants, "What are some of the professional and personal boundaries that might impact a person's professional growth or upward mobility?"

Write the responses on flip chart paper or a whiteboard if available.

Share a few from the list below that may not have been mentioned.

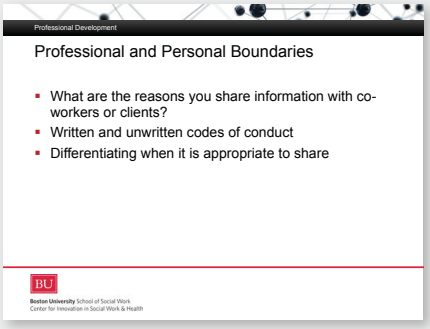
Examples of professional boundaries:

- Loud cellphone ring in the workplace or loud conversations that are intrusive to colleagues
- Showing up tardy regularly due to the relaxed culture of the agency
- Using your colleague's office supplies without permission
- Volunteering a colleague for tasks when they are not present to speak for themselves

Examples of personal boundaries:

- Repeatedly touching your colleague (on the shoulder or something) when you excitedly share a story
- Using the organization's office supplies and equipment to make promotional flyers for a personal event
- Repeatedly asking a colleague to pay for your lunch or give you a ride home because . . . (fill in the blank)
- Sharing intimate details about yourself to your colleague
- Asking your colleague to introduce you to their friends

These are examples of breaking professional and personal boundaries that often occur in the workplace. Now let's look at some things that can help.



SLIDE 6

Tell participants: We all have relationships of varying degrees with colleagues. We spend a significant amount of our life with our colleagues, it's important, therefore, to make distinctions that will enable us to honor appropriate professional and personal boundaries and ensure that our relationships do not hinder our professional growth goals.

Ask participants, "Why do we share what we share AND when is it appropriate to share what we share?"

Note responses on the flip chart.

One tool that is helpful for guidance is the organization's *written* and *unwritten* codes of conduct. Many situations are clearly stated. When it's not clear, err on the side of caution using common sense and learned lessons.

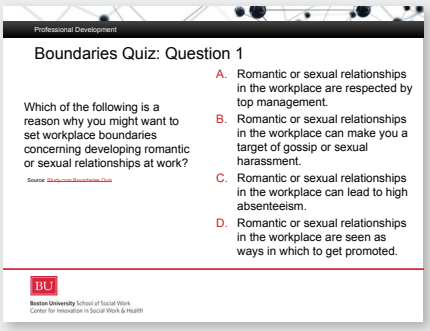
Ask participants, "What are some of the written codes of conduct in your agency? What are some of the unwritten codes of conduct?"

Note responses on the flip chart.

Discuss with participants examples of when it is appropriate to share information: types of services that are helpful to a client, sharing one's HIV status if it is useful, etc. Consider power dynamics in relationships (subordinate to superior).

Ask participants, "Think about what and how you share with a supervisor or colleague and how it might effect their perception of you and your professional development." For example, conduct outside of work at holiday parties, etc.

Note responses on the flip chart.



SLIDE 7

Tell participants: Let's see how you would respond in the following scenarios.

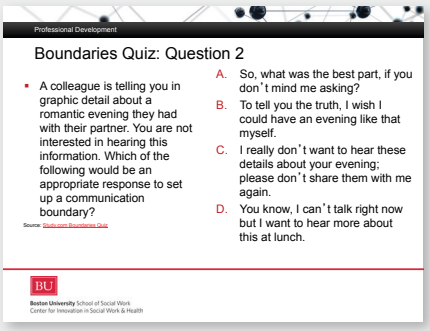
Ask for a volunteer to read the question on the slide.

Ask participants for a show of hands for each answer, A–D.

The correct answer is B.

Facilitate a brief discussion about the quiz.

Source: https://study.com/academy/practice/quiz-worksheet-maintaining-boundaries-at-work.jpg



SLIDE 8

Ask for a volunteer to read the scenario.

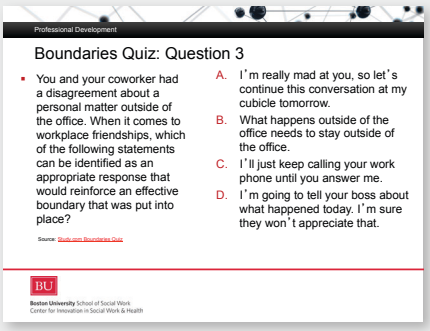
Ask participants for a show of hands for each answer, A–D.

Ask participants to justify their selection.

In this scenario, C would be the best choice because you are not comfortable with this information.

If there is time, brainstorm some other appropriate ways to respond, and write them on the flip chart.

Source: https://study.com/academy/practice/quiz-worksheet-maintaining-boundaries-at-work.jpg



SLIDE 9

Ask for a volunteer to reach the scenario.

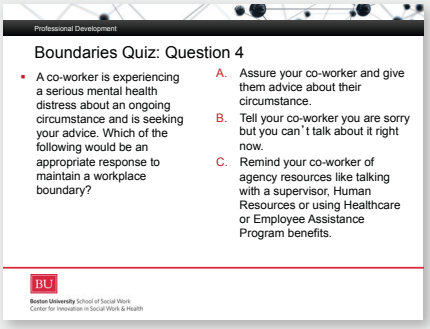
Ask participants for a show of hands for each answer, A–D.

Ask participants to justify their selection.

In this scenario, B would be the best choice because you are not comfortable with this information.

If there is time, brainstorm some other appropriate ways to respond, and write them on the flip chart.

Source: https://study.com/academy/practice/quiz-worksheet-maintaining-boundaries-at-work.jpg



SLIDE 10

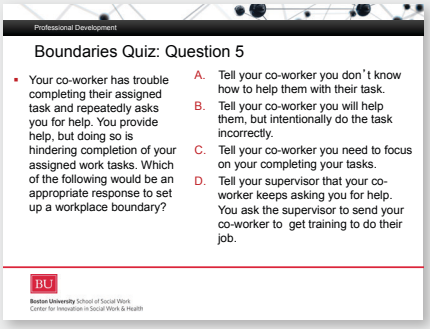
Ask for a volunteer to reach the scenario.

Ask participants for a show of hands for each answer, A–D.

Ask participants to justify their selection.

In this scenario, C would be the best choice to demonstrate compassion for the situation while still maintaining boundaries.

If there is time, brainstorm some other appropriate ways to respond, and write them on the flip chart.



SLIDE 11

Ask for a volunteer to reach the scenario.

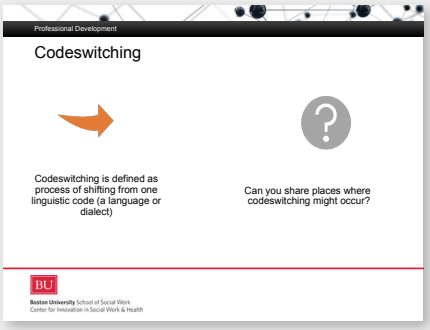
Ask participants for a show of hands for each answer, A–D.

Ask participants to justify their selection.

In this scenario, C would be the best choice as you cannot take on your coworker's tasks or be responsible for their performance.

If there is time, brainstorm some other appropriate ways to respond, and write them on the flip chart.

Thank participants for their participation. Tell participants that we have addressed the first objective to increase awareness of professional boundaries and challenges with disclosure of personal information in the workplace, all with the purpose of keeping in mind how to position one's self for the greatest professional success. Now we will look at some things to consider regarding communication.



SLIDE 12

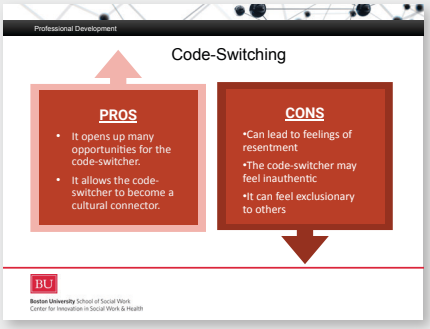
Tell participants: We wear multiple hats, sometimes simultaneously. One example is facilitating communication with a provider and a client in a session. Having the skill to effectively communicate with both seamlessly can be called codeswitching.

Additional examples:

- Dressing and talking differently based on who you are working with.
- Interacting with people differently based on the environment.
- Speaking in a language that the client would understand.
- Dressing differently depending on the situation, for example, wearing jeans if teaching someone how to clean their apartment versus business casual attire in an office.

Ask participants, "Can you share places where codeswitching might occur?"

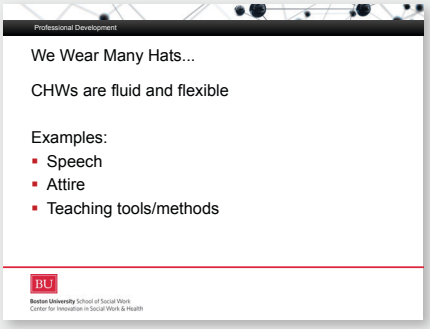
Note responses on the flip chart.



SLIDE 13

Review the slide.

There are pros and cons to this style of communicating. Code-switching for many people is an effective communication strategy, but it can have some drawbacks.



SLIDE 14

Tell participants: Code-switching punctuates the fact that as a CHW, we wear many hats. Wearing multiple hats has cultivated skills that are desirable for expanding professional growth opportunities. They are worthy of noting here.

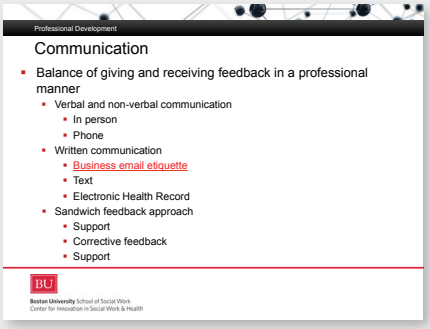
For example, being fluid and flexible (examples speech, attire, teaching tools/methods)

Demonstrating flexibility in how we communicate and present ourselves to foster best outcomes with clients and co-workers/providers (e.g., We often mirror cultural norms)

We use appropriate teaching tools and methods to communicate information in the ways that are most easily understood.

Ask participants if they think of ways they are flexible in each one of these areas:

- Speech?
- How they dress?
- Teaching tools?
- With clients?
- With other members of the care team?



SLIDE 15

Tell participants: How we communicate is an important element of professional development. Let's review some of the types of communication and etiquette for professional development.

Be mindful of how you communicate with people (language and tone) weather it's in person, or over the phone, or email.

Email: Resource for etiquette: Resource for email etiquette

https://www.glassdoor.com/blog/dos-and-donts-business-email-etiquette/

Keep in mind what is not appropriate for professional correspondence vs. a personal relationship (e.g. emojis, casual salutations, text lingo).

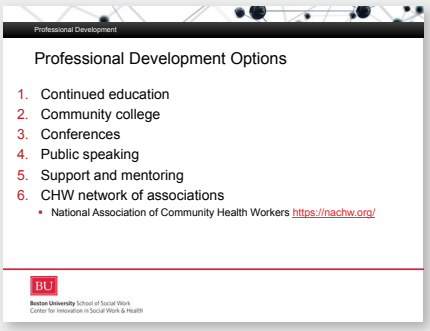
Think about the time, for example sending a text in the early evening to remind someone to take medication that night vs. a more vague text late at night to ask how they are doing—it can be misinterpreted.

Electronic Health Record: Be careful of how you document a client's health record as it is a legal record that can be subpoenaed.

Describe the three steps of the sandwich feedback approach:

- Give support
- Provide corrective feedback
- Give support again

Example: When a client has breached a boundary. Your comment shows a sensitive and open side to your personality. However, it's important that we maintain a professional relationship.



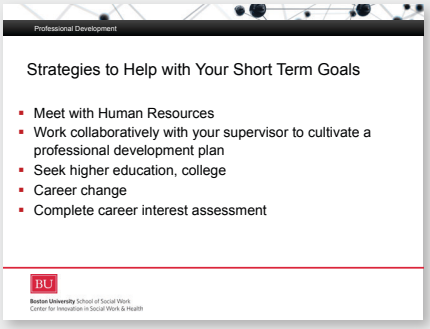
SLIDE 16

Tell participants-the final aspect to consider in professional development is to look for opportunities to grow our skills.

This could be through:

- Attending courses or a program at colleges/universities
- Participating in certificate programs
- Sign up for public speaking training such as Toastmasters club (https://www.toastmasters.org/)

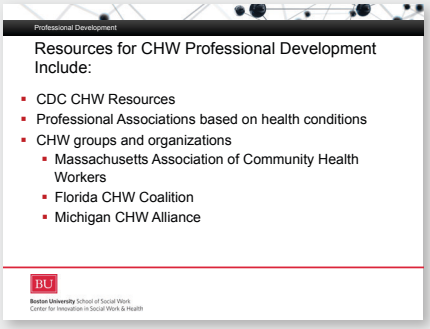
Visit the website for the National Association of Community Health Workers to become part of a network and learn about opportunities.



SLIDE 17

Ask participants, "What is your plan for professional development?"

Review the strategies on the slide, and write others on the flip chart.



SLIDE 18

Share additional resources to help CHWs connect with people who are doing similar work or to learn about job opportunities and ways to grow professionally.

Community Assessment and Community-Based Participatory Research (CBPR)

OBJECTIVES

At the end of this unit, participants will be able to:

- Explain the organic relationship between principles, methods, and outcomes in Community-Based Participatory Research (CBPR), using the "Tree of CBPR" metaphor
- Identify project design and implementation methods that foster an environment of equity and participation
- Identify how CPBR principles could be used in their work as CHWs
- Know how to involve the community in assessing a program/intervention's impact on clients, organizations, and the community

INSTRUCTIONS

1. Before the session, distribute the Pre-session: Practice CBPR Assessment handout and ask participants to complete it in advance of the session. Give participants at least 1 week prior to the session to complete the assessment.
2. Review PowerPoint and handouts. Arrange chairs in a circle to encourage participation and sharing.
3. Welcome participants and review the objectives (slide 2). Let participants know that we will reference their completed CBPR assessment throughout the session.
4. Review CBPR definition and how it is different from other types of research, facilitating discussion (slides 3–5).
5. Introduce the CBPR tree metaphor (slide 6). Distribute the From the Roots to the Fruits handout.
6. Review CBPR principles, and how they align with popular education and cultural humility principles, and facilitate discussion (slides 7–10).
7. The trunk: Discuss the role of the environment in CBPR, inviting participants to answer questions based on the assessment they conducted (slides 11–12).
8. The branches: Discuss how information was gathered during the assessment (slide 13).
9. The fruits: Discuss impact, referencing questions from the assessment (slide 14).
10. Wrap up. Ask, "How might you share back with your team or co-workers what you learned from your assessment and from this webinar about CBPR? How might you incorporate CBPR principles and practices into the work of the clinic?" (slide 15)

Related C3 Roles

Implementing individual and community assessments; participating in evaluation and research; providing culturally appropriate health education and information; building individual and community capacity

Related C3 Skills

Capacity building skills; evaluation and research skills; individual and community assessment skills; education and facilitation skills; knowledge base

Method(s) of Instruction

Pre-work activity; group discussion

Facilitator's note: A trainer experienced in research or Commuinty-Based Participatory Research (CBPR) should facilitate this session.

Estimated time

90 minutes

Key Concepts

Community-based participatory research, CBPR, community assessment

Materials

- Computer with internet connection and projector
- Power Point slides

Handouts

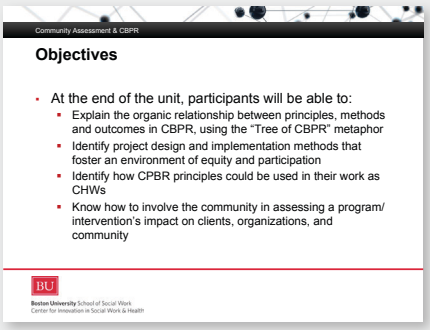
- Pre-session: Practice CBPR Assessment
- From the Roots to the Fruits: Using CBPR in Diverse Communities

Resources

WK Kellogg Foundation: ***https://www.wkkf.org/news-and-media/article/2009/01/an-effective-approach-to-understanding-communities***

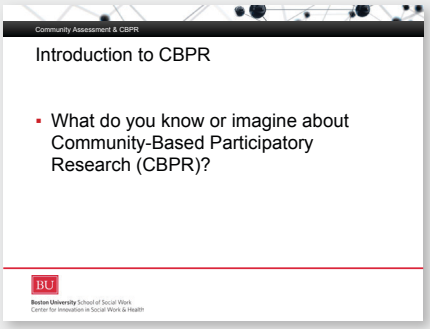
Wallerstein, N., & Duran, B. (2010). Community-based participatory research contributions to intervention research: the intersection of science and practice to improve health equity. *American Journal of Public Health,100*(S1), S40–S46.

SLIDE 1



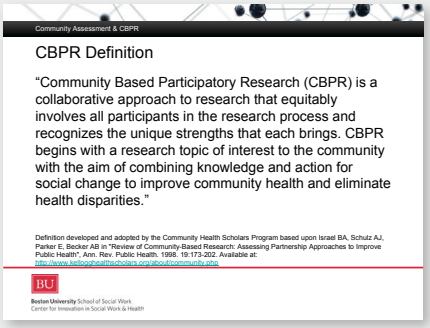
SLIDE 2

Review the objectives.



SLIDE 3

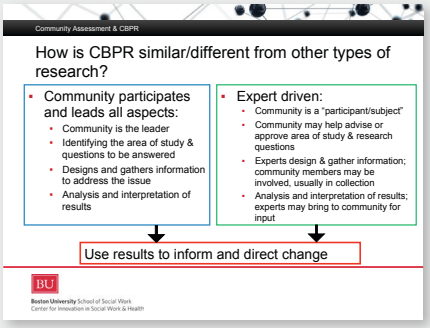
Ask for a volunteer to read the question on the slide and facilitate a group discussion around participants responses.



SLIDE 4

Ask for a volunteer to read the definition.

After the definition is read, ask, "What words/phrases stand out to you from this definition?"

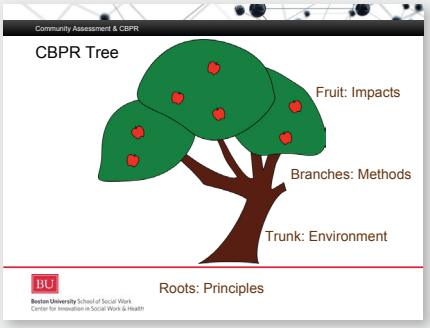


SLIDE 5

Ask for a volunteer to read the slide.

Ask, "From your understanding and experience, how is CBPR similar/different from other types of research? When you think of conventional research or evaluation, what comes to mind? Have you personally participated in a research study? What did you do? Were you a participant? Did you ever participate in a survey or focus group? What was the experience like? Is research conducted in your work setting? Who conducts the research? What differences do you notice?

CBPR and other types of research (clinical research, intervention research, implementation research, and program evaluation all have the ultimate goal of producing results to inform change. However, most research tends to be expert driven. CBPR is driven by the community it. Ask, "Is there one you identify more in your experience and in your work setting?"

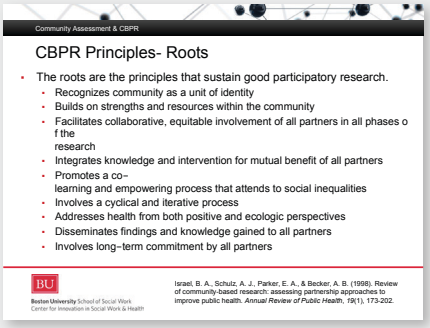


SLIDE 6

We will use a metaphor of a tree to help us understand the different components of Community Based Participatory Research (CPBR).

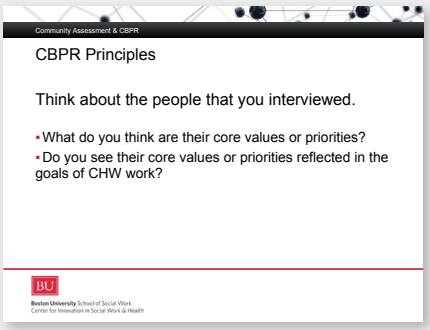
- The roots of our tree are the principles of CBPR.
- The trunk of our tree consists of the ways in which we embody these principles, or put the principles into action, throughout a project (i.e., the "how").
- The branches of the tree are methods of collecting data and conducting an intervention in CBPR projects (i.e., the "what").
- The fruits are the outcomes or the applications of CBPR projects.

We will go over each section of the tree in more depth, starting with the roots, or principles.



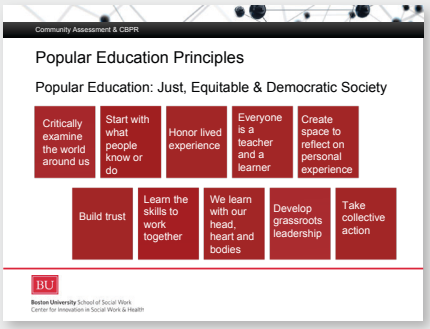
SLIDE 7

Ask for a volunteer to read through the list of CBPR principles.



SLIDE 8

Ask the participants the questions on the slide.



SLIDE 9

Inform participants that we are using two frameworks to think about Community Assessment and Community Based Participatory Research.

One framework is Popular Education, which is focused on principles such as starting with what people know, honoring lived experience, and creating spaces where everyone can learn from each other and critically reflect on their personal experiences.

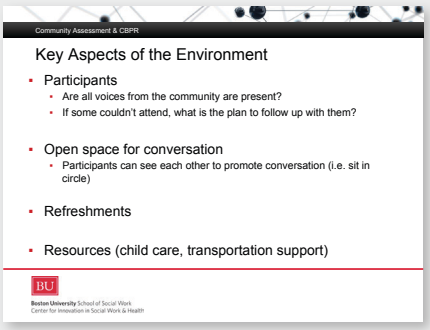
SLIDE 10

The other framework is cultural humility.

SLIDE 11

In order to put the principles into practice and to facilitate participatory data collection, we need to create a climate of equity and participation when we are designing and implementing our CBPR projects. The things that characterize how we work to create that climate form the trunk of our tree.

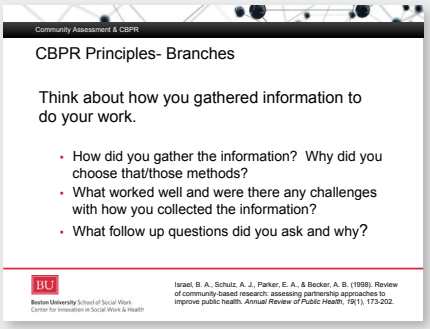
Invite participants to answer the questions based on the assessment that they conducted.



SLIDE 12

Review the slide with participants.

Ask if participants have any additional ideas (e.g. incentives?)



SLIDE 13

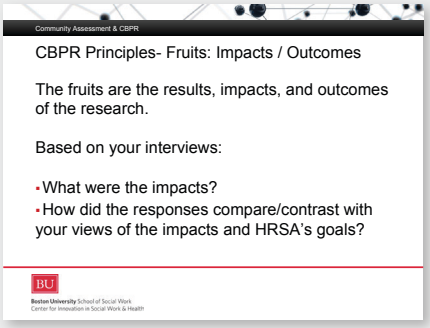
We are going to move on to the branches of our tree. Just as branches grow from the trunk of a tree, participatory data collection and evaluation grow out of a solid foundation of participation and equity.

And just as we hope you were able to see how the principles, or roots, of CBPR can be put into practice in the design of the project (the trunk), we'd like to demonstrate how those principles extend throughout the branches, and what this looks like in practice.

The branches refer to the evaluation/data collection methods, which may be the first thing people think of when they hear the phrase "Methods of CBPR."

Invite participants to answer the questions based on the assessment that they conducted.

Ask if participants have any additional ideas.



SLIDE 14

We have finally arrived at the fruits of our tree. A healthy tree should yield fruit, and a healthy CBPR project should yield positive impacts for our communities.

There are many impacts of CBPR that we would hope to see from our efforts.

Invite participants to answer the questions on the slide based on the assessment that they conducted.

Ask if participants have any additional ideas.

SLIDE 15

Group discussion:

- Did you share the results of what you did?
- How might you share back with your team or co-workers what you learned from your assessment and from this unit about CBPR?
- How might you incorporate CBPR principles and practices into the work of the clinic?

Pre-session: Practice CBPR Assessment

In preparation for the CBPR unit, please complete the following activity. You will be asked to share aspects of the assessment during the unit so that we can learn from one another.

Assessment instructions: Conduct a short assessment about the role of CHWs in the HIV Care Continuum. The main question is, "From your perspective, what are the impacts of having a CHW as part of the healthcare team?" You may ask follow up questions if you like.

Who to interview: You can meet with your healthcare team, a community partner, or a client to gather information. Please reach out to at least one person.

How to do the assessment: You can do the assessment on your own or in teams with other CHWs, with your supervisor, etc. Choose a way of collecting information that you think will work best for the person/people you are interviewing (e.g. in-person, phone call, email, etc.).

Reflection: After your conversation, please respond to the following questions. We will ask you to share your answers during the CBPR unit.

1. Where did the meeting take place?

2. Who did you invite? Who attended? Did you invite anyone who didn't attend? Who would you have liked to invite?

3. Were there any challenges in setting up the meeting (e.g. transportation or childcare needs, finding a convenient time, finding a comfortable space)?

4. What (if any) follow up questions did you ask and why?

5. How did you collect the information? Why did you choose that method? What worked well and were there any challenges with how you collected the information?

6. How did the responses compare/contrast with your views of the impacts and HRSA's goals?

From the Roots to the Fruits: Using CBPR in Diverse Communities

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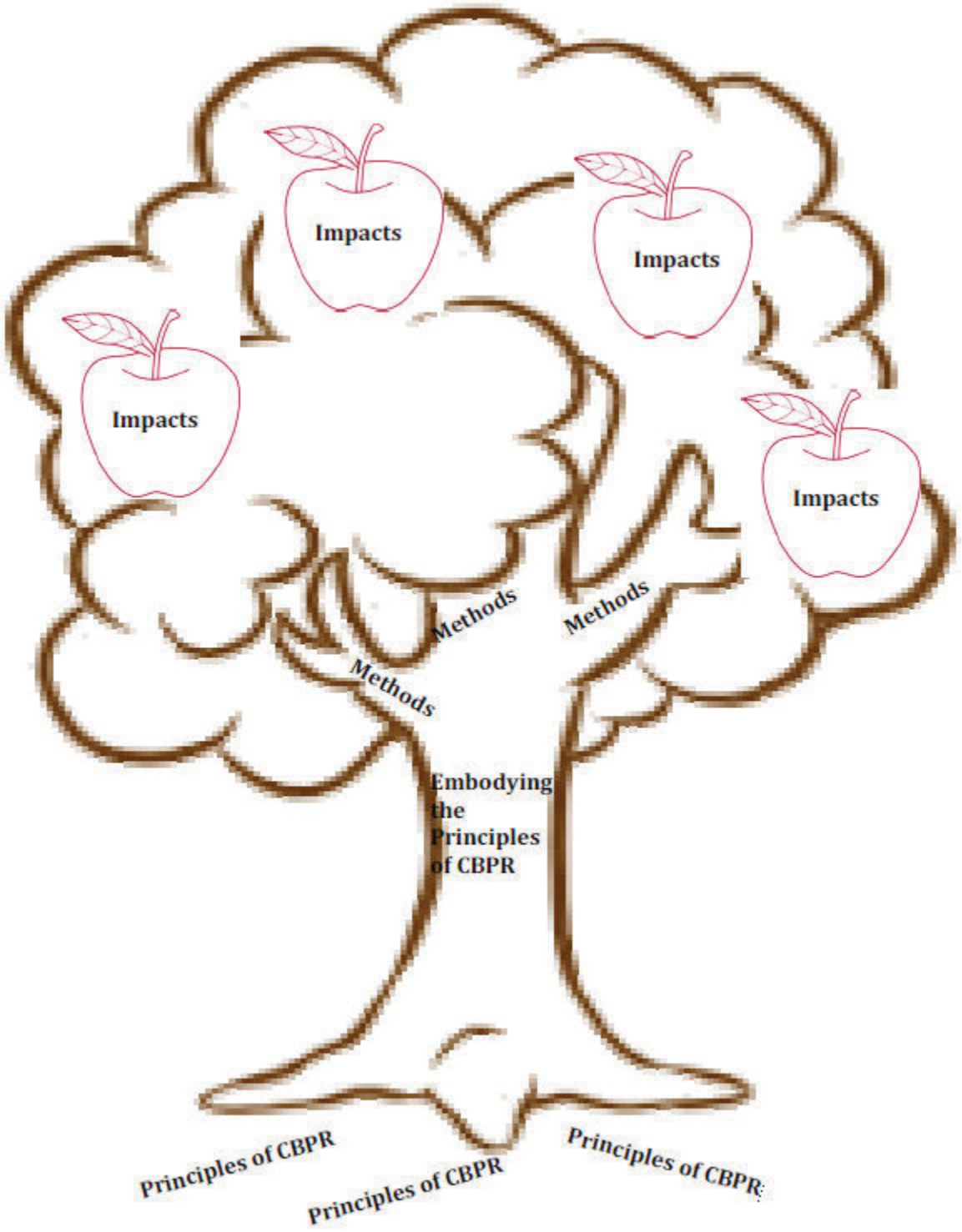


ROOTS: The roots are the principles that sustain good participatory research.

- Recognizes community as a unit of identity
- Builds on strengths and resources within the community
- Facilitates collaborative, equitable involvement of all partners in all phases of the research
- Integrates knowledge and intervention for mutual benefit of all partners
- Promotes a co-learning and empowering process that attends to social inequalities
- Involves a cyclical and iterative process
- Addresses health from both positive and ecologic perspectives
- Disseminates findings and knowledge gained to all partners
- Involves long-term commitment by all partners

(Israel B., 1998)

TRUNK: The trunk of our tree consists of how we embody the principles of CBPR, creating a climate of equity and participation when we are designing and implementing our CBPR projects. The methods we use to design and implement CBPR projects may differ from project to project, depending on the community with whom we are working and the topic, and may include:

- Shared facilitation of meetings
- Food
- Opportunity to receive academic credit when participating
- Integrating and using two or more languages for all project activities
- Starting meetings with prayer

BRANCHES: The branches of the CBPR tree are the methods we use to design a program or collect data (for research or evaluation), and again, will look different from project to project. Just as branches grow from the trunk of a tree, participatory data collection methods grow out of a solid foundation of participation and equality.

FRUITS: Finally, the fruits of CBPR refer to our intended or actual outcomes of CBPR projects. Just as a tree yields fruit, a healthy CBPR project should yield outcomes for communities. The potential impacts of a successful CBPR project are countless, and may include:

- Increased awareness among non-community members
- Community identifies and solves problems
- Increased knowledge
- Community empowerment
- Social justice
- Better health

Credit: Community Capacitation Center, 2016.

Background and Information about the Training

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand what they will be trained on throughout the five-day training
- Understand the background and goals of the project.

INSTRUCTIONS

1. Prior to the session, make copies of the handouts on gender pronouns. Write on a flip cart sheet a schedule with topics to be presented, along with the date and the facilitators. Prepare two flip chart sheets with the headings: Group Agreements and Question Garden.
2. Welcome participants. Review goals on PowerPoint slides and distribute handouts on Gender Pronouns. Give people a few minutes to review. Provide information about bathrooms and meals, and explain that people should feel free to move about as they need.
3. Ask participants to introduce themselves, including their name, gender pronouns and where they live/work.
4. Explain that we will be using popular education principles throughout the training. Popular education is both a philosophy and methodology that has been used to train CHWs all over the world and is recognized as a best practice for training CHWs. We will share more about the principles and methods of popular education later.
5. Introduce the question garden. Explain that if there is a question that we don't know the answer to, we can write it on the question garden, do some research, and then share the information with the group.
6. Brainstorm with participants about group agreements/ground rules on a flip chart sheet. Ask, "What agreements do we want to set as a group to ensure we all learn from this training and feel comfortable and respected?" Suggested topics:
   - Make space, take space (explain further as needed).
   - Once the facilitator says, "I will call on x and then on y and then we are moving on," please allow the facilitator to move on.
   - Please put cell phones on vibrate and put them away. Refrain from using phones unless it is an emergency.

(continued)

Related C3 Roles

All

Related C3 Skills

All

Method(s) of Instruction

Brief presentation, brainstorming

Facilitators note: This is an example of how to introduce the training program. You may want to adapt to fit the needs of your program.

Estimated time

20 minutes

Key Concepts

N/A

Materials

- Computer internet access and projector
- Flip chart
- Markers

Handouts

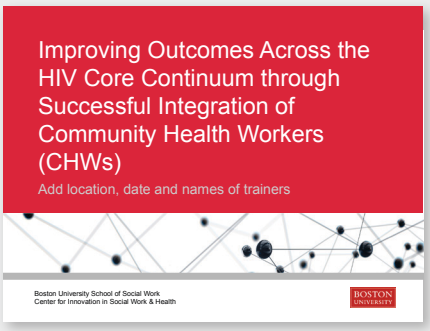
- Introducing Gender Pronouns
- Navigating Gender Pronouns #1
- Navigating Gender Pronouns #2

Background and Information about the Training

INSTRUCTIONS (continued)

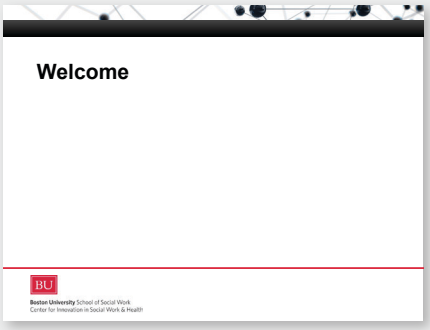
- Because we will be addressing highly charged topics (like injustice and oppression), you may feel some strong emotions. Popular education makes space for emotions. If you need to process with a facilitator during a break, we will be available.
- If you take offense at something someone says, speak to the person individually during a break. Please try to do so in a way that does not cause further offense.
- Listen to understand, not to respond.

7. Wrap up. Ask, "Does anyone have questions before we proceed?"



SLIDE 1

Facilitator's note: Add location, date and name of trainers.



SLIDE 2

Welcome participants to the training.

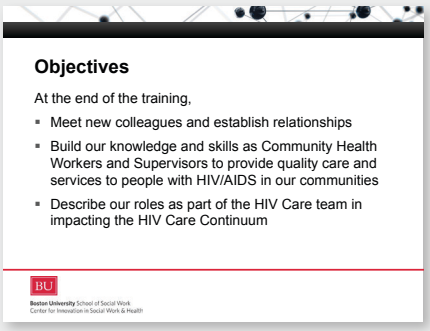
Facilitators should introduce themselves, including their gender pronouns and their connection to this work.

We want to create space that is welcoming for all. One way that judgement and bias come up is that we are taught to call people by gender pronouns like "he" or "she" based on the way they look. This assumption isn't helpful for anyone, and in particular impacts our transgender community members. We believe it's part of basic respect to call people by the name and pronoun they ask for, so we'll ask everyone to share their name and the gender pronoun you use when introducing yourself. This might be "she," "he," "they," or another gender pronoun. Please pay attention to what people ask to be called, even if it's new for you.

If you'd rather not to share that part of your identity, feel free to leave that out. But if this is your first time being asked to share your pronouns, we invite you to participate.

Ask participants to introduce themselves, including their name, gender pronouns and where they live/work. Explain that we will have an Icebreaker activity to get to know each other better in a few minutes.

Select an Icebreaker for participants to get to know each other.



SLIDE 3

Review the objectives.

Introducing Gender Pronouns

Introducing Gender Pronouns in Group Meetings

- People rarely get defensive or frustrated if you explain up front what a pronoun is and why you're asking. If someone does get upset, you can say " we try not to make assumptions about which pronouns people use based on how they are seen" or "this is something we do at our organization to make sure we're being respectful of everyone."

- If someone makes a joke or pushes back about why this is important, here's a few things you can do:

    - Engage in conversation. Ask them if they've heard about the organization's work to be trans-affirming; if they haven't heard about it, offer to them a bit and listen to what they have to say.
    - Respond to their comment by saying "we do this in all meetings because some of our clients, volunteers, and staff are trans, and we want it to be a place of respect for everyone."
    - If they are in a place of defensiveness, you can simply say "it's just something we ask everyone to share here so that we can all be respected"

- It's normal for people to feel challenged by learning pronouns that are new to them or using pronouns that are different than the way they perceive someone. At the same time, using respectful pronouns is a critical way of showing basic respect. So if you notice someone getting someone else's pronoun wrong, make sure you refer to that person with the right pronoun as an example "yes, she did make a great point" or simply say "oh, I think that person goes by (he/she/they/etc.)" and move on. If someone is using someone else's pronouns incorrectly, check in with the person being mispronounced, and ask them how they'd like you to handle it (correct it in the larger group, take the other person aside afterwards, ignore it, etc).

- It's okay for some people not to share their pronouns or to not want their pronouns corrected if someone messes up. There are many reasons why they may feel uncomfortable – they may be questioning their own pronouns, or as a trans person they may be tired of being the only one to have a pronoun different than what's expected. For trans people, it can be emotionally exhausting to constantly correct others who get their pronouns wrong. Whatever the reason may be, don't worry about forcing anyone to share. Do be aware that it's important for cisgender people (people who identify with the gender they are expected to) to take the practice of using pronouns seriously.

How to continue these practices

- In staff meetings, practice using the full introduction so you can get comfortable with it – this may feel unnecessary if you all know each other already but it will go a long way in building your comfort with how to introduce pronouns in other groups.

- Once your staff and/ or client group regularly uses pronouns in introductions, make sure you do a brief explanation and reminder each time someone new joins the group or meeting.

- Get creative! Your group can use nametags, name tents, fun introductions (name, pronoun, and

- unexpected talent) and other ways to make the practice fit unto what you're already doing.

- Remember that every one of your meetings, groups, and other shared space is a chance to make your organization a more welcoming place for transgender people. When mistakes happen or people have questions, these are opportunities to help cisgender (or non-transgender) people understand the importance of trans affirming spaces.

Resource developed by tash shatz with adaptions from materials by Basic Rights Oregon, Nash Jones, and Neola Young.

Navigating Gender Pronouns #1

What are the different kinds of gender pronouns?

Gendered Pronouns	She/Her/Hers/Herself
	He/Him/His/Himself
Gender Neutral Pronouns	They/Them/Their/Theirs/Themself
	Ze/Hir/Hirs/Hirself (pronounced "zee" and "here")
	Plus many others!!

Why do pronouns matter?

- Pronouns are a big part of many languages, and a common way that many of us refer to one another in conversation. **Using someone's pronouns correctly is an important part of showing basic respect, just like using someone's correct name**. For example, it would be disrespectful to call your friend Tom by "Thomas" or to refer to your client Brittany as "Brad."
- It's normal to feel challenged by adjusting when someone changes pronouns, learning pronouns that are new to you, or using pronouns that are different than the way you perceive someone. While it may require you to stretch outside of your comfort zone, using respectful pronouns is a critical way that you can begin to reexamine assumptions about gender that particularly harm trans communities.

How do you find out what pronouns someone uses?

- The commonly practiced method can lead to making mistakes. We can't tell what pronoun someone uses based on how they look/how we are reading their gender expression.
- Ask them!
    - If you are eventually going to use a person's pronouns in conversation, you should find out which pronouns the person uses!
    - If you're going to ask some people, ask all people! Don't isolate only people you read as gender nonconforming.
    - The question can sound like, "I use he/him pronouns, what pronouns do you use?" (Share your own even if you never get referred to with the wrong pronouns!)
    - If someone is confused by the question, they may not know what a pronoun is! Sharing your own can help give them an example, or you could phrase your question more specifically (e.g. "How do you like to be referred to by others? Some people use she or he or they…")
    - If someone gets upset or defensive, they likely do not understand why you are asking. You might take a moment in advance to explain why you're asking: "I'm working on not making assumptions about which pronoun people use based on how I see them," or "This is something we do at our organization/agency to make sure we're being respectful of everyone."

Resource developed by Nash Jones, tash shatz, and Neola Young
Portland, OR 2015-2016

When do you ask about pronouns?

- When you're meeting someone new! Pairing the pronoun question up with the name question can help to know when you might ask.
- If you are a provider, you can add a question about pronouns on your intake form along with other identifying information. If not on your intake form, you can ask during an intake interview. See above for example language.
- You can add pronouns to the list of what folks should share in a meeting when you would usually go around and share names and departments.

Isn't asking for pronouns outing* someone? (*To "out" someone is to disclose their identity without their consent)

- Actually, pronouns are not private. Pronouns are social! You and others will use pronouns for someone regardless of whether space is created for them to share the ones they actually use. If you ask everyone, you won't be targeting anyone in particular or isolating them.

Resource developed by Nash Jones, tash shatz, and Neola Young
Portland, OR 2015-2016

Navigating Gender Pronouns #2

- It is true that some people use different pronouns in different spaces and not respecting this could out them. Find out if a client, colleague, or friend only uses their pronouns in some spaces and uses different pronouns in others. (e.g. a student who uses one pronoun at school and another at home for safety reasons.)

What if I haven't had the opportunity to find out what pronouns someone uses? This might also come up because you have incredibly limited interactions with clients/students/colleagues, which do not often warrant a pronoun conversation.

- Use gender neutral language! Here are some examples:
  - "A client/student/customer up front is wondering where to go to turn the paperwork in…"
  - "I don't know what pronouns that person uses" or "I liked what that person said about…"
  - "There's someone here I don't recognize; have you met them? Over there with the glasses…"

What do I do if I accidentally use the wrong pronouns for someone? How should I react?

- Acknowledge your mistake. This can sound like simply changing to the correct pronoun mid-sentence. (e.g. "I was telling her…um, him to come by in the afternoon.")
- Move on quickly. Do not sit in the moment stewing over the mistake (e.g. "Oh shoot! I've been so good at getting it right lately! It's tough, I mean I knew him before he was a him!"). Get back to whatever you were talking about as soon as you've changed to the right pronoun.
- Center the needs of the person who was mispronounced, not your own. Your needs are probably to be assured you are still a good person/ally or affirmed in the work you've been doing to respect that person's identity ("I've been trying! I've been getting better!"). Do not look to be taken care of by the mispronounced person (e.g. "Cut me some slack" or otherwise putting them in the position to say, "it's ok"); take care of them in that moment by correcting yourself and moving on. If you need to process what happened, do it later, on your own time, with someone other than that person.

How do you use gender neutral pronouns in a sentence?

They	"They are bringing their friend with them because they don't like being by themself." -"Whose is this?" "It's theirs"
Ze/Hir	"Ze is bringing hir friend with hir because ze doesn't like being by hirself." "Whose is this?" -"It's hirs"

Who uses gender neutral pronouns?

- ~~Only young people.~~ People of any age use gender neutral pronouns! Age and pronouns do not correlate in any particular way.
- ~~Only people of certain genders.~~ Gender neutral pronouns are used by people who hold a variety of different gender identities.

Resource developed by Nash Jones, tash shatz, and Neola Young
Portland, OR 2015-2016

Other best practices to remember:

- **Say "gender pronoun" rather than "preferred pronoun."** Pronouns are often not simply a preference (such as "I prefer chocolate ice cream to vanilla, but I'll take whatever") but a key part of respecting one another.
- **Talk about specific pronouns such as she, he, they, etc. rather than saying "female pronouns" or "male pronouns."** Though gendered pronouns are culturally associated with gender identities (e.g. men use "he" and women use "she"), this does not apply to everyone. For example, some people who use "she" do not identify as women but may use "she/her" pronouns for safety reasons or in different situations.

If you've never had your pronouns questioned, be mindful of how you share your pronouns. For example, if you say "I don't care" or "you can use any pronoun for me," make sure that you understand the impact of being called pronouns different than what you are used to being called.

Resource developed by Nash Jones, tash shatz, and Neola Young
Portland, OR 2015-2016

Introduction to Social Determinants of Health

OBJECTIVES

At the end of this unit, participants will be able to:

- Define social determinants of health for our clients
- Identify how these social determinants contribute to risk factors for HIV

INSTRUCTIONS

1. Prior to the session, prepare a flip chart sheet with the question: "What determines our health?" and three bullet points:
   - Biological
   - Genetic
   - Social
2. Explain that in order for us to discuss the role of CHWs as part of the care team, we will start with a discussion about what factors shape and determine how healthy we are (slide 3).
3. Share handouts about SDOH and review slide 3.
4. Wrap up. CHWs can help address these social determinants by bridging the gap between the community and clinic, and helping a person with HIV address social needs, which can help them live a longer life. In this training we are going to learn about the role of CHWs as part of the care team to support people with HIV, and how we can help them live longer, healthier lives.

Related C3 Roles

Knowledge base

Related C3 Skills

All

Method(s) of Instruction

Group discussion

Estimated time

15 minutes

Key Concepts

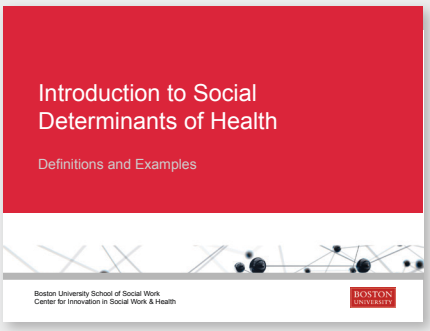
Social determinants of health, SDOH

Materials

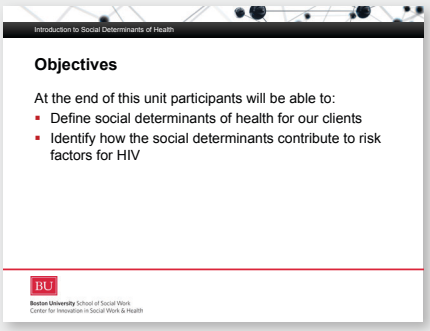
- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Handouts

- Examples of Social Determinants of Health
- Social Determinants of Health

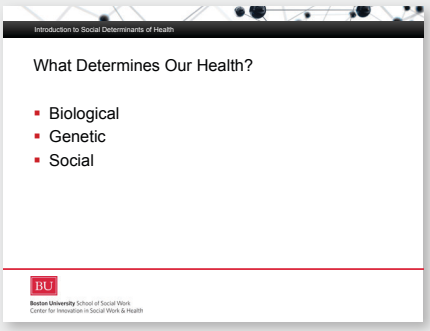


SLIDE 1



SLIDE 2

Review the objectives.



SLIDE 3

Explain that in order for us to discuss the role of CHWs as part of the care team, we will start with a discussion about what factors shape and determine how healthy we are.

Ask participants: "What determines our health?" Ask them to share examples based on the 3 bullets. Record responses on flip chart sheet.

Potential responses:

- Biological determinants = parasites, bacteria, and viruses.
- Genetic determinants = characteristics we inherit from our parents like having high cholesterol.
- Social determinants: social and structural conditions that affect the health of groups.

Break participants into pairs. Ask them to name three to five social determinants of health (SDOH) with their partner.

Ask for volunteers to share social determinants and write them on a flip chart sheet.

Potential examples:

- Poverty
- Housing
- Transportation
- Access to health care
- Access to food
- Neighborhood conditions

SLIDE 4

Share handouts about SDOH and review the slide.

Ask, "How might these social determinants affect risk for HIV?"

Potential examples:

- People who don't have access to health services or resources to purchase condoms may have unprotected sex and spread HIV.
- People who don't have access to health care may not get the treatment they need if they are with HIV.
- People who don't have access to HIV health education may not know how to protect themselves against HIV.
- People may not be aware that HIV is chronic condition with medications available that can help them live a long life with HIV.
- People with HIV who don't have housing may not have a place to store medications to treat their HIV.
- People with HIV who don't have sufficient food may not be able to take their medications properly to effectively treat their HIV.

Examples of Social Determinants of Health

- **Economic Stability**
  - Poverty
  - Employment
  - Food Insecurity
  - Housing Instability
- **Education**
  - High School Graduation
  - Enrollment in Higher Education
  - Language and Literacy
  - Early Childhood Education and Development
- **Social and Community Context**
  - Social Cohesion
  - Civic Participation
  - Discrimination
  - Incarceration
- **Health and Health Care**
  - Access to Health Care
  - Access to Primary Care
  - Health Literacy
- **Neighborhood and Built Environment**
  - Access to Foods that Support Healthy Eating Patterns
  - Quality of Housing
  - Crime and Violence
  - Environmental Conditions

Source: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

What are the Social Determinants of Health?

The social determinants of health are the conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.

Responding to increasing concern about these persisting and widening inequities, WHO established the Commission on Social Determinants of Health (CSDH) in 2005 to provide advice on how to reduce them. The Commission's final report was launched in August 2008, and contained three overarching recommendations:

1. Improve daily living conditions

2. Tackle the inequitable distribution of power, money, and resources

3. Measure and understand the problem and assess the impact of action

Examples of social determinants of health include:

- Income
- Social class
- Race/ethnicity
- Education
- Employment
- Housing
- Environmental conditions
- Respect and dignity

Source: http://www.who.int/social_determinants/en/

Intimate Partner Violence and HIV

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand cultural context and intersectionality
- Understand the basics of intimate partner violence (IPV)
- Understand the intersection of IPV and HIV
- Build on community knowledge about the different forms of power/control and IPV as it pertains to survivors with HIV
- Use tools and skills to support survivors

INSTRUCTIONS

1. Before the session begins, review the slides, handouts, and resources. Participants should receive and read the Safety Planning Guide resource before the session begins.
2. Welcome participants and review objectives and agenda (slide 2). Review slides on the code of care and limitations, acknowledging that triggering content will be discussed (slides 3–4).
3. Review slides on intersectionality (slides 5–6).
4. Review definitions of intimate partner violence and facilitate discussion as described (slides 7–12).
5. Review slides on power and control, and how it intersects with HIV. Distribute handout about domestic and sexual violence and facilitate discussion as described (slides 13–15).
6. Discuss safety planning (slide 16).
7. Distribute case scenarios handout. Display scenarios on slides and facilitate discussion as described (slides 17–22).
8. Wrap up. Ask, "What can supervisors do to support CHWs in working with clients with HIV who have experienced IPV? Name one important thing to keep in mind that you learned today about the intersection of HIV and IPV?" Ask participants to relevant brainstorm resources in their area. Share resources (slides 23–24).

Related C3 Roles

Providing culturally appropriate health education and information; providing coaching and social support; advocating for individuals and communities

Related C3 Skills

Interpersonal and relationship-building skills; capacity building skills

Method(s) of Instruction

Interactive presentation, case studies

Facilitator's note: This session should be conducted by an experienced IPV trainer. If needed, contact an IPV agency in your area to adapt and conduct this training session.

Estimated time

90–120 minutes

Key Concepts

Intimate partner violence, IPV, domestic violence, DV, HIV

Materials

- Computer with internet access and projector
- PowerPoint slides

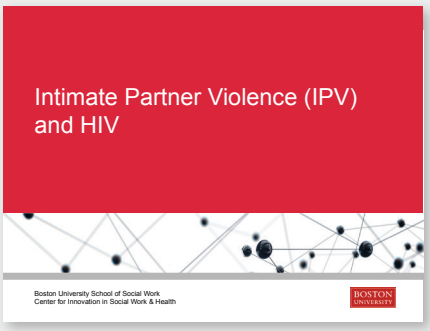
Handouts

- HIV Power and Control Wheel
- HIV and IPV Case Scenarios

Resources

DV & HIV/AIDS Toolkit: *https://nnedv.org/resources-library/dv-hivaids-toolkit/*

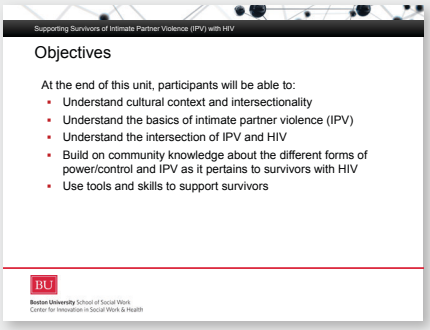
Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals Who Are Experiencing Intimate Partner Violence: *https://safehousingpartnerships.org/sites/default/files/2017-01/safety-planning-tool.pdf*



SLIDE 1

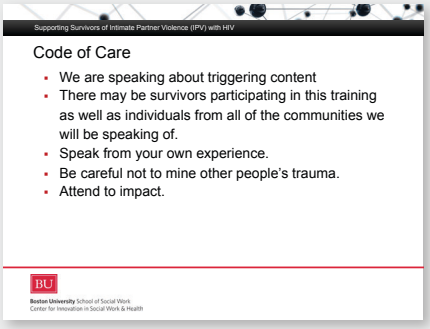
These slides were authored by:

Alexxis Woods, Healthier Relationships Advocate
Kiera Hansen, MSW, Community Based Services Manager
Bradley Angle, Portland, OR



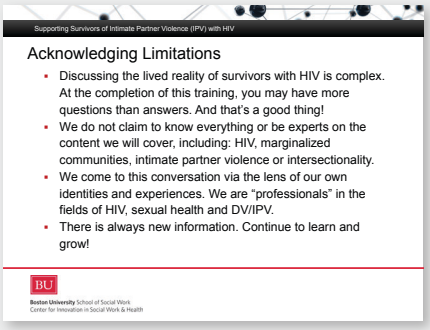
SLIDE 2

Read the slide and answer participant questions, if any.



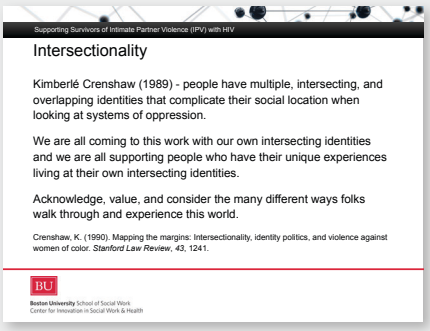
SLIDE 3

Review the slide and answer participant questions, if any.



SLIDE 4

Review the slide and answer participant questions, if any.

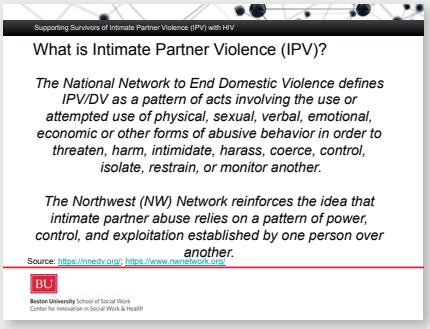


SLIDE 5

Review the slide and answer participant questions, if any.

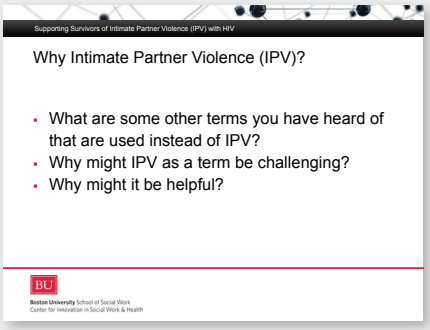
SLIDE 6

Review the slide and answer participant questions, if any.



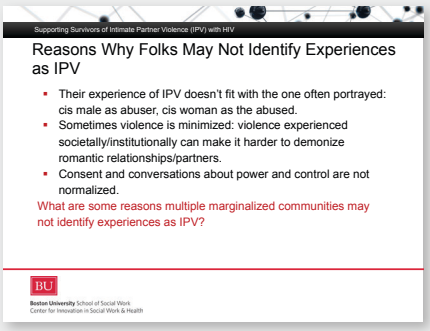
SLIDE 7

Review the slide and answer participant questions, if any.



SLIDE 8

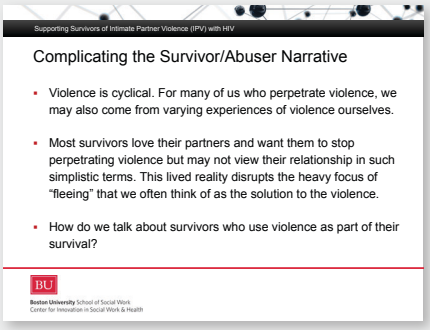
Ask questions and take a few minutes to get feedback from participants.



SLIDE 9

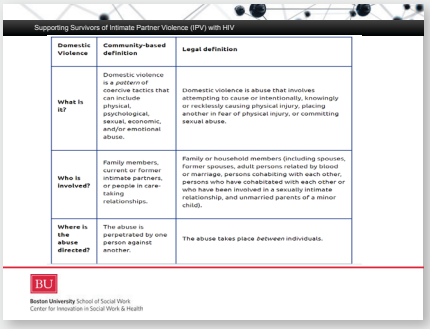
Review the slide.

Ask the question and take a few minutes to get feedback from participants.



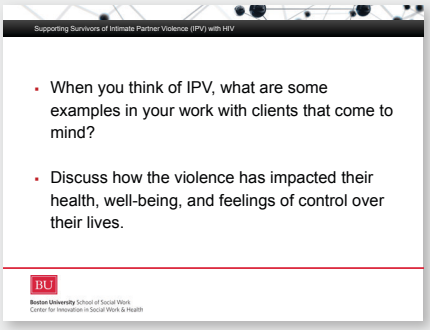
SLIDE 10

Review the slide and answer participant questions, if any.



SLIDE 11

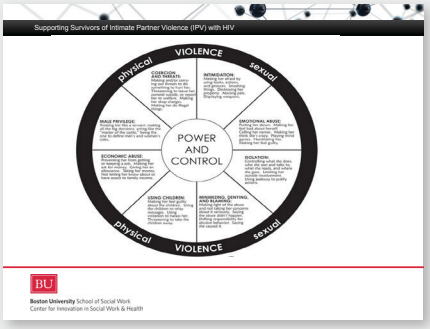
Review the slide.



SLIDE 12

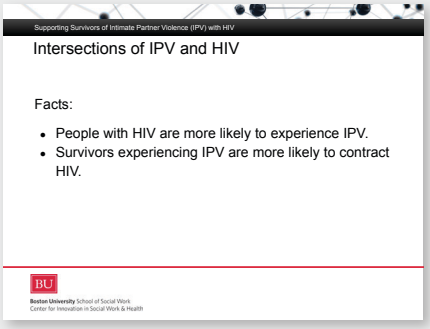
Ask the questions and facilitate a discussion.

Remind people to not disclose client's names and to keep confidentiality in mind so private information is not shared inadvertently with the group.



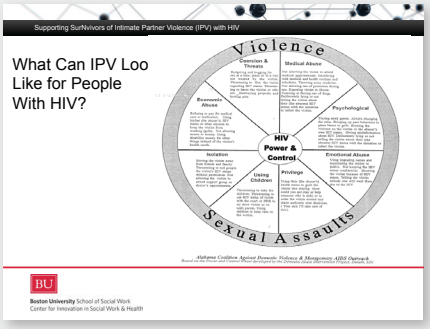
SLIDE 13

Review the slide, or ask volunteers to each read aloud a section of the figure (e.g., Isolation).



SLIDE 14

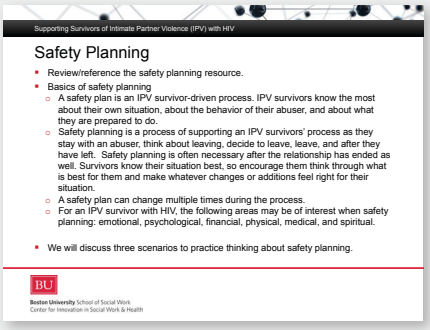
Share the hand out on domestic violence and sexual assault. Ask the attendees who is left out of these stats? How does this intersect to make risk different?



SLIDE 15

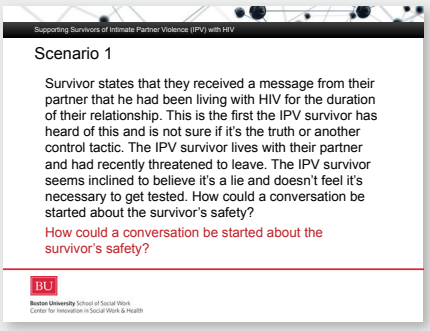
Review the slide.

Distribute the HIV Power and Control Wheel handout.



SLIDE 16

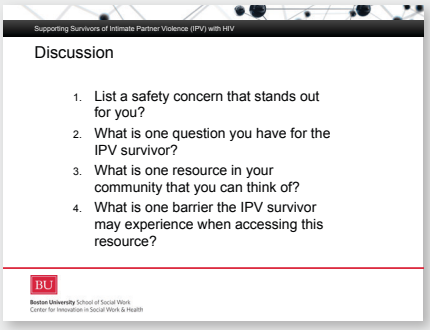
Review the slide and answer participant questions, if any.



SLIDE 17

Ask a volunteer to read the slide.

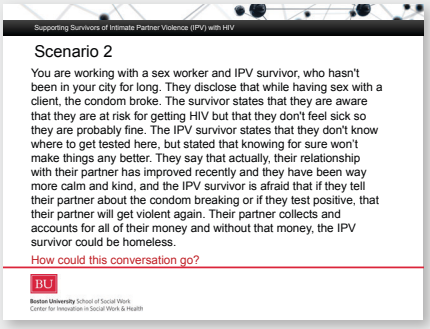
Facilitate a group discussion around the question on the slide and the questions on the next slide.



SLIDE 18

Ask for a volunteer to read each question.

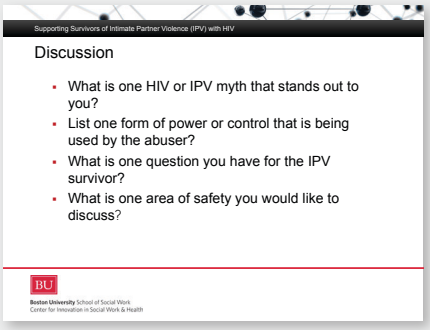
Facilitate a group discussion.



SLIDE 19

Ask a volunteer to read the slide.

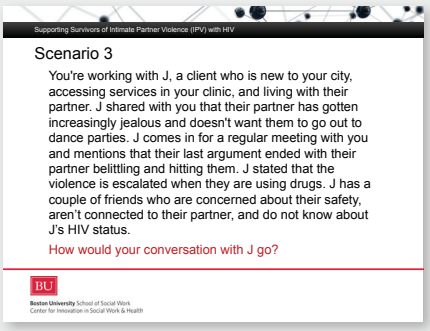
Facilitate a group discussion around the question on the slide and the questions on the next slide.



SLIDE 20

Ask for a volunteer to read each question.

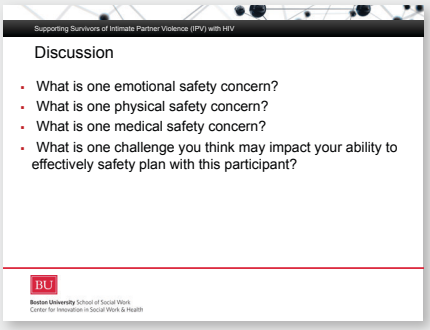
Facilitate a group discussion.



SLIDE 21

Ask a volunteer to read the slide.

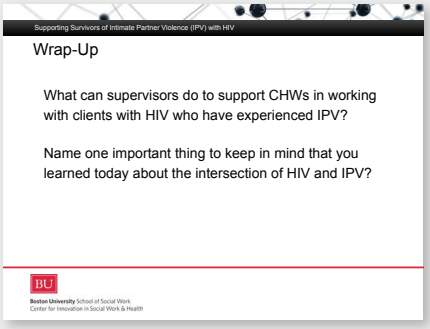
Facilitate a group discussion around the question on the slide and the questions on the next slide.



SLIDE 22

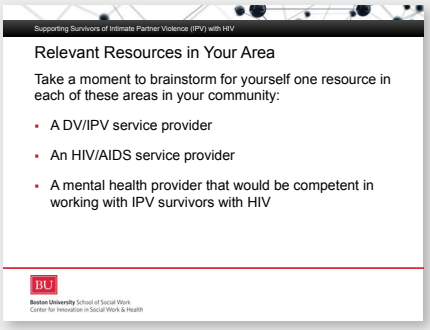
Ask for a volunteer to read each question.

Facilitate a group discussion.



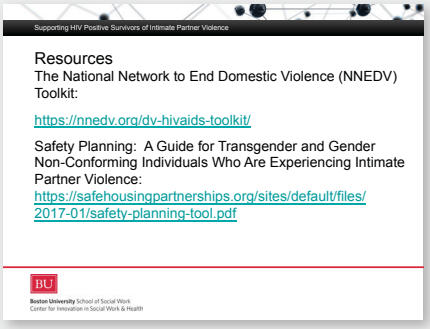
SLIDE 23

Read each question and allow participants to respond.



SLIDE 24

Review the slide and allow time for participants to jot down some answers for themselves.



SLIDE 25

Share the resources on the slide with participants.

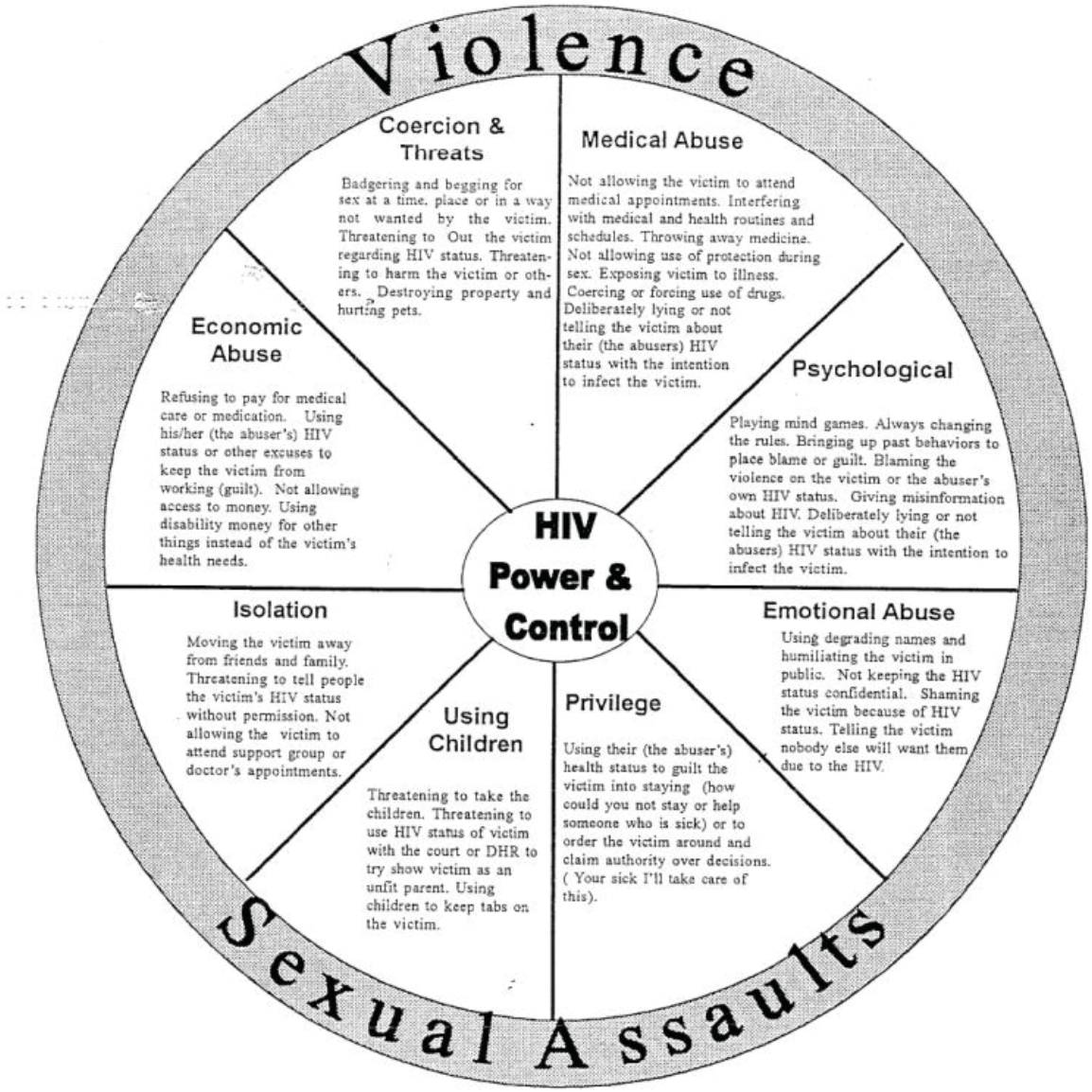
HIV and IPV Case Scenarios

Scenario 1: Survivor states that they received a message from their partner that he had been living with HIV for the duration of their relationship. This is the first the IPV survivor has heard of this and is not sure if it's the truth or another control tactic. The IPV survivor lives with their partner and had recently threatened to leave. The IPV survivor seems inclined to believe it's a lie and doesn't feel it's necessary to get tested. How could a conversation be started about the survivor's safety?

Scenario 2: You are working with a sex worker and IPV survivor, who hasn't been in your city for long. They disclose that while having sex with a client, the condom broke. The survivor states that they are aware that they are at risk for getting HIV but that they don't feel sick so they are probably fine. The IPV survivor states that they don't know where to get tested here, but stated that knowing for sure won't make things any better. They say that actually, their relationship with their partner has improved recently and they have been way more calm and kind, and the IPV survivor is afraid that if they tell their partner about the condom breaking or if they test positive, that their partner will get violent again. Their partner collects and accounts for all of their money and without that money, the IPV survivor could be homeless. How could this conversation go?

Scenario 3: You're working with J, a client who is new to your city, accessing services in your clinic, and living with their partner. J shared with you that their partner has gotten increasingly jealous and doesn't want them to go out to dance parties. J comes in for a regular meeting with you and mentions that their last argument ended with their partner belittling and hitting them. J stated that the violence is escalated when they are using drugs. J has a couple of friends who are concerned about their safety, aren't connected to their partner, and do not know about J's HIV status. How would your conversation with J go?

HIV Power and Control Wheel



Alabama Coalition Against Domestic Violence & Montgomery AIDS Outreach
Based on the Power and Control Wheel developed by the Domestic Abuse Intervention Project, Duluth, MN.