

A GUIDE TO IMPLEMENTING A COMMUNITY HEALTH WORKER (CHW) PROGRAM IN THE CONTEXT OF HIV CARE

Improving HIV Outcomes through the
Integration of CHWs in Care Teams



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INTRODUCTION

Introduction

Community Health Workers (CHWs) are important members of the primary health care workforce who can effectively improve chronic disease outcomes. CHWs are trained laypeople who often share similar socio-economic, cultural, linguistic, and other identities as the people they serve, and have been shown to improve self-management and health outcomes for people living with a variety of chronic conditions, such as asthma, diabetes, and cancer. Evidence suggests that CHWs have a positive impact on people living with multiple chronic conditions,¹ and play a crucial role in helping low-income people living with chronic conditions access preventive services and cost-effective treatment.² CHWs are trusted members of the health care workforce because they often have a deep understanding of the health and social needs of their communities. CHWs are able to promote racial, gender, and health equity by reaching people who have not traditionally had access to adequate health care services, and who are at highest risk for health inequities.

Integrating CHWs into HIV Care

For more than 25 years, the Ryan White HIV/AIDS Program (RWHAP) has provided comprehensive HIV medical care and support services to more than half of the approximately 1.2 million people with HIV in the United States. RWHAP has also provided funding for provider training, including for community health workers (CHWs).³ RWHAP funding is administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB) and is designed as a payer of last resort for states, municipalities, clinics, and community-based organizations. RWHAP funding improves access to and use of HIV care and support services for individuals and communities most affected by the epidemic, including racial/ethnic and sexual minorities, youth, and women. Yet despite many of the successes of the program, there are still communities and individuals who do not have adequate access to HIV care and treatment or have not achieved viral suppression.

¹Kangovi, S., Mitra, N., Grande, D., Huo, H., Smith, R. A., & Long, J. A. (2017). Community health worker support for disadvantaged patients with multiple chronic diseases: a randomized clinical trial. *American journal of public health*, 107(10), 1660-1667.

²Islam, N., Nadkarni, S. K., Zahn, D., Skillman, M., Kwon, S. C., & Trinh-Shevrin, C. (2015). Integrating community health workers within Patient Protection and Affordable Care Act implementation. *Journal of public health management and practice: JPHMP*, 21(1), 42.

³<https://hab.hrsa.gov/about-ryan-white-hiv-aids-program/about-ryan-white-hiv-aids-program>

To the extent possible, HIV/AIDS program activities strive to support the National HIV/AIDS Strategy and focus on addressing the following goals:

- Reduce new HIV infections
- Increase access to care and optimize health outcomes for people with HIV
- Reduce HIV-related health and gender inequities, and address social determinants of health (SDoH)
- Achieve a more coordinated national response to the HIV epidemic

In 2016, HRSA/HAB launched a three-year initiative titled, *Improving Access to Care: Using Community Health Workers (CHWs) to Improve Linkage and Retention in HIV Care*, to provide training, technical assistance, and support to RWHAP recipients to integrate CHWs into their multidisciplinary care team, strengthen their capacity to reach racial and ethnic minority communities, and reduce racial and ethnic inequities in HIV.

In general, many RWHAP recipients have utilized CHWs to carry out community activities in HIV prevention, care, and treatment. These workers may have a variety of titles, including: outreach worker, patient navigator, peer educator, counselor, linkage care coordinator, health system navigator, promotora, and others. RWHAP recipients have integrated these roles in a variety of ways, such as:

- Using outreach workers to find people out of medical care
- Peer counselors/educators to support retention in care or adherence to treatment
- Patient/peer navigators to connect people with HIV to referrals and resources, such as housing, food assistance, substance use treatment, specialty care, or mental health care
- Linkage-to-care coordinators to connect newly diagnosed individuals to HIV medical care

RWHAP recipients have historically encouraged people at risk for and with HIV to be part of the model of care and to help shape service delivery. Many RWHAP recipients have consumer advisory boards to ensure services respond to the social and medical needs of people with HIV, and to advise on the allocation of resources to address unmet needs and improve the quality of care. Despite this history, there are no current standards or guidelines on how to integrate CHWs into care teams to improve access to and retention in HIV care and treatment.

CHW TITLES

peer educator
linkage care
counselor
coordinator
patient navigator
health system navigator
outreach worker
PROMOTORA

How Can CHWs Enhance HIV Care Teams

A CHW can enhance the HIV care team by working in partnership with case managers, nurses, doctors, social workers, and other service providers to address the medical, social, and economic needs of people with HIV. The CHW role across the HIV care continuum may include:



Assisting, educating, and supporting people with HIV to become aware of their status;



Linking and engaging people with HIV into medical care;



Helping people with HIV adhere to treatment; and



Explaining health benefits and other types of available assistance to people with HIV.

This guide incorporates CHW best practices from RWHAP recipients and state and local CHW association standards. For the purposes of this guide, a CHW is defined as the following (emphasis added):

“A Community Health Worker (CHW) 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 CHW 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 CHW 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.”⁴

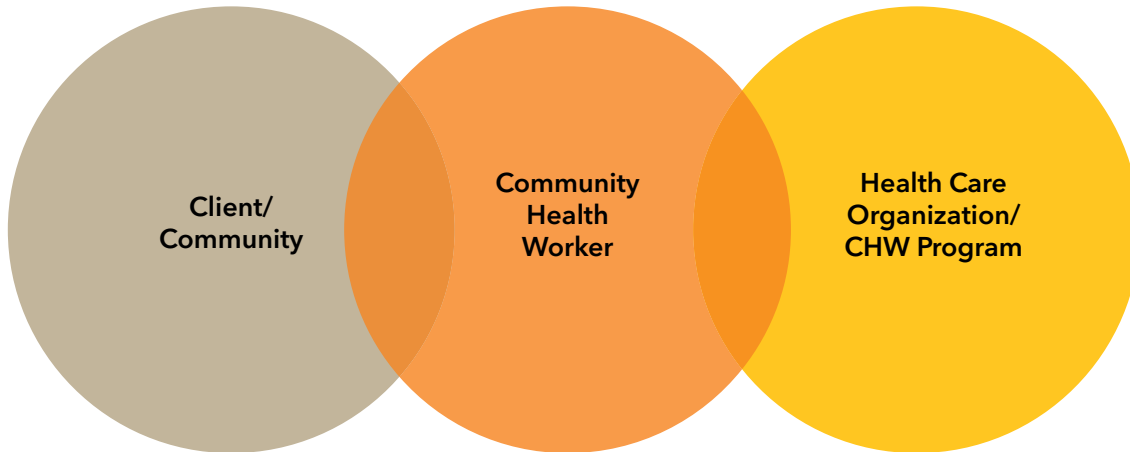
CHWs are often referred to as a bridge between the individual and the community where they live, and the health care system. As such, their work is often “bi-directional” as shown in Figure 1 (page 4).^{5,3} CHWs have a role in improving the health of clients and the community, and they also influence the program and the clinical setting in which they function. In the HIV context, CHWs serve as a bridge for the client between HIV clinics, support services agencies (e.g., housing and food), and public health departments. **CHWs are professional staff who also serve as a bridge between clients and members**

⁴ American Public Health Association. n.d. Community Health Workers. Available at: <https://www.apha.org/apha-communities/member-sections/community-health-workers>

⁵ Gutierrez Kapheim M and Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute, January 2014, 19-20.

of the care team. They are an important member of the health care workforce in addressing racial, gender and other inequities and ensuring health care access for all.

Figure 1. Relationships between Clients/Communities, CHWs, and Health Care Organizations



Reasons for Hiring and Recruiting CHWs

There are many reasons for using CHWs in health care settings. CHWs are recognized as important members of the public health and health care workforces.⁶ CHWs' unique ability to connect with the community can facilitate a patient-centered approach to improve health outcomes and lower costs.⁷ CHW jobs can also improve employment opportunities for underserved communities and increase economic vitality in those communities. Other reasons for hiring and recruiting CHWs include:

- **Bridging the gap** between clients and their providers
- **Developing relationships** with clients and encouraging them to share information they might not otherwise share with their providers
- Ability to spend more **one-on-one time with clients**
- **Address social determinants of health** such as housing, food, transportation, employment, and other support services

⁶ Patient Protection and Affordable Care Act of 2010, PL 111-148 secs. 5101, 5102, 5113, 5403, and 3509; American Public Health Association. Support for community health workers to increase health access and to reduce health inequities. Policy no. 20091. Washington, DC: American Public Health Association; 2009. Available at: https://www.apha.org/~media/files/pdf/topics/aca/prevention_aca_final.ashx

⁷ Berwick, DM, Nolan, TW, and Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*, 27(3): 759-769.

According to one national *Community Health Workers Workforce Study*,⁸ employers hire CHWs because of the:

- Belief that CHWs are **effective**
- Belief that using CHWs is **cost effective**
- Evidence that CHWs are able to **organize communities** in developing comprehensive health action plans
- Evidence that programs addressing **racial and health disparities** are more effective when using one-on-one outreach by CHWs.

Organizations employing CHWs view them as being effective in improving health services⁹ as a result of factors such as:

- **Connecting with hard-to-reach populations** that other health workers may have avoided
- **Coaching clients** in ways that are culturally appropriate to facilitate positive behavior change
- **Developing trusting** and caring relationships with clients
- **Communicating with clients** to provide or collect information
- **Motivating clients** by using motivational interviewing and other behavior change techniques
- **Addressing client needs**, especially around social determinants of health (SDoH)

Purpose of the Guide

This implementation guide outlines key steps for RWHAP recipients to implement or enhance their use of CHWs as part of the care team to improve outcomes along the HIV care continuum: linkage, engagement, and retention in care, adherence to treatment and, ultimately, viral suppression for people with HIV. The guide was piloted in 10 RWHAP recipient sites from across the United States from 2017-2019, and then adapted and revised to incorporate the lessons learned and best practices from these sites. The guide focuses on how to integrate CHWs as part of an organization's workforce and adapts the existing service delivery model to better engage and retain people with HIV in care, and support treatment adherence. The focus of the pilot project was on racial and ethnic minority populations and areas of the U.S. where viral suppression rates are low. The information, examples, and resources in this guide are drawn from HIV and non-HIV health programs in which CHWs work and can be used in a variety of geographic and organizational settings (e.g., small rural clinics, large outpatient hospital centers, and health departments). The guide describes steps that RWHAP recipients and other populations served by community health centers, hospitals, and other health care providers can take to address the medical and social services needs of diverse populations, including individuals newly diagnosed with HIV, immigrants, racial/ethnic minorities, or people with multiple comorbidities.

⁸ Community Health Worker National Workforce Study. US Dept. of Health and Human Services. Health Resources and Services Administration. Bureau of Health Professions. Washington, D.C. March 2007, p. ix.

⁹ Community Health Worker National Workforce Study. US Dept. of Health and Human Services. Health Resources and Services Administration. Bureau of Health Professions. Washington, D.C. March 2007, p. ix.

Intended Audience

This guide is intended for any RWHAP grant recipient, and others who are interested in integrating CHWs into their clinical practice or strengthening their current use of CHWs. Specific audiences for this guide include:

- Program supervisors and managers who want to improve linkage and retention in care and quality of services for people with HIV who may be out of care, new to care, or at risk of falling out of care
- Physicians, nurse practitioners, and other clinicians who want to support client engagement, adherence to treatment, and use of referrals to other medical and social services
- Program and policy directors who want to enhance systems of care and capacity of the HIV workforce to improve health outcomes for vulnerable communities and individuals affected by the HIV epidemic
- CHWs and other program staff such as case managers who are already at work in the organization
- State, county, and local CHW organizations and health departments who want to invest resources in programs to reach people who are difficult to engage in care, and who are most impacted by HIV and other comorbidities

“I believe community health workers bring a unique passion and perspective to the healthcare team that enhances our goal of providing comprehensive, knowledgeable, and compassionate care.”



SECTION 1

Setting up Systems for CHW Workforce to Deliver HIV Care and Treatment

- Asking Key Questions
- Involving Stakeholders
- Securing Buy-in
- Leveraging Data
- Developing Logic Models
- Conducting Needs Assessments
- Meeting with Human Resources

Section 1

Setting up Systems for CHW Workforce to Deliver HIV Care and Treatment

This section describes the systems that need to be in place within an organization to support a CHW as part of the care team, and makes recommendations for how to clearly define the CHW role. The traditional HIV care team clinic structure—consisting of health care providers, nurses, medical case managers and/or social workers—may not be sufficient to address all client needs and promote achievement of viral suppression. Additional staff members are needed to go beyond the clinic walls to reach out and engage people who are not aware of their status, who have fallen out of care due to other competing psychosocial needs (e.g., homelessness, substance use, mental health, or mistrust of the health care system), or who are busy and may feel healthy, so do not prioritize a need to seek HIV care and treatment. CHWs, who may include outreach workers and/or navigators, are members of the health care workforce who can reduce the burden and stress of large caseloads and enhance the traditional RWHAP care team to meet the needs of people with HIV.

Be prepared to address how CHWs will enhance services and the plan to financially support CHWs within the organization. As CHW program planning and implementation progresses, develop talking points (e.g., an elevator speech) to promote the effort, communicate the role of the CHW, and make the case for support from internal and external partners. Creating a robust framework for your CHW program can ensure the program continues during staffing changes and unexpected circumstances. The program framework should promote inclusivity in the hiring process and reflect the diversity of the community to be served.

Staff members such as outreach workers, peers, or patient navigators assist people with HIV to engage in care and adhere to treatment. Unlike physicians and other healthcare providers, there is currently no common standard of practice for CHWs. However, there have been efforts at the national level to develop standards for the role of CHWs. In 2014, The Community Health Worker Core Consensus (C3) Project was launched to establish national training and practice guidelines on CHW Scope of Practice and Core Competencies. These guidelines are for use in community and clinical settings at local, state, and national levels and across health conditions. The C3 Project developed a list of 10 core CHW roles. (See [Appendix A](#).) Although the C3 Project was not focused specifically on HIV care, the roles and skills it reported are a good framework for developing the CHW's role. This list can also be used to help develop the specific tasks and responsibilities the CHW will provide within the broader HIV care team. (See [Appendix B](#).)



Lessons from the Field

Legacy Community Health in Houston, TX had a history of using patient navigators on their medical team to assist with linking and retaining people with HIV in services. However, in reviewing their clinic data they found that they often lost patients in a short time period—within a 72-hour window—due to demands on navigator time. A new CHW (called a linkage coordinator) became responsible for working closely with newly identified HIV-positive patients, as well as those currently in or lost to care. The linkage coordinator also proved instrumental in helping clients renew their RWHAP certification so clients could continue to receive services at the clinic.

Preparing Organizational Systems and Engaging Stakeholders

Identify the CHW Role in the Context of Organizational Goals and Structures

Organizations need to first identify the role of the CHW within the broader care team and then create a new, or adapt an existing, organizational infrastructure in order to support and empower the CHW in their work. Thinking about existing services and the service delivery model is an essential element in planning a new CHW program. After doing this, you can then determine how CHW services will best complement current services and improve patient outcomes. During this step you can:

- Involve existing staff to identify and prioritize the service gaps that CHWs might help fill.
- Clarify how CHWs will help meet the needs of the agency or program and how they will contribute to fulfilling the agency mission.
- Involve representatives from the care team (including case managers) and programs in the preliminary planning and decision-making stage. This involvement will help create a strong foundation for CHW services as the program develops.
- Develop a flow chart to show how CHW activities fit with other programs and services. The McGregor Clinic in Fort Myers, FL worked together as a team to create a work flow with care team members to establish which clients the CHW could help support and how the CHW's tasks would complement other care team members tasks.
- Identify any specific populations that the CHW program will serve.



Checklist of Major Steps for Including CHWs in Medical Team Prior to Hiring

- ✓ Determine the goal of CHW involvement: What do you want to achieve by including a CHW as part of the medical team?
- ✓ Identify the role of the CHW
- ✓ Examine and revise staffing plan for the HIV clinic, including a designated CHW supervisor
- ✓ Share with all team members for buy-in and support
- ✓ Set up a plan for orientation with all team members so the CHW and the team members can discuss how they can work together



Key Questions to Ask

- How will CHWs complement the roles and responsibilities of other team members, such as case managers? Do you have a matrix that identifies who does what within the clinical team? A matrix with key work responsibilities for all role groups may be a useful tool for clarifying expectations. The Southwest Louisiana AIDS Council (SLAC) developed a policy and procedure for how CHWs and team members can work together. (See [Appendix H](#).)
- What is the current caseload for case managers and health care providers? What's an appropriate CHW caseload size given the work assignment and client characteristics? Will the CHW maintain contact with less active or inactive clients?
- How will clients transition on and off the CHW's caseload?
- What tasks can CHWs do to support the work of case managers in addressing client needs?
- What can case managers and other members of the care team do to support the work of CHWs?
- How many CHWs can be hired to work with the HIV care team?
- Who will supervise the CHWs?
- Who will provide backup and coverage for the CHWs when they are not available due to illness, training, and/or vacation? What are the expectations for staff coverage?
- How will CHWs be oriented to their role and to the organization? It is critical that CHWs are able to explain their role and how they fit into the organization to colleagues, clients, and community partners. (See [Section 3](#).)
- What is your organization's staffing structure? For example, if your organization is a federally qualified health center (FQHC) with CHWs working with clients with other chronic diseases, where will the RWHAP HIV CHW be housed—in a medical department or other department?
- How will the CHW interact with and support the medical case manager(s)?
- How will the CHW be integrated as a member of the care team?
- How will you integrate the CHWs into quality management activities? (See [Section 6](#).)
- How will the CHW document their work with clients/patients and share with the care team?
- How can the CHW best be used to engage hard-to-reach populations?
- Are there specific populations that your organization wants to reach and should that be the focus of the CHW's work?
- How will your CHWs and supervisor be trained?
- Are there state certification program available in your area for CHWs? (See [Section 7](#).)

These are critical questions to answer to create a productive and supportive environment for the CHW and staff. (See [Appendix C](#).)

Table 1. Who Should be Involved in Setting up Systems for a CHW Workforce?

Whether the CHWs are new to your organization, or you are strengthening the capacity of an existing program, this table includes a list of potential stakeholders to involve.	
Internal Partners	External Partners
<ul style="list-style-type: none"> ● Medical and social service providers, including: <ul style="list-style-type: none"> » Health care providers (e.g., nurses, nurse practitioners, certified medical assistants, (CMAs), physician assistants, physicians) » Behavioral health staff » Other support services staff (e.g., benefits counselors, outreach workers, etc.) » CHWs on staff » Case managers » Program supervisors » Administrative directors 	<ul style="list-style-type: none"> ● Hospitals, medical specialists, and social service agencies from outside your organization
<ul style="list-style-type: none"> ● Your organization’s board of directors/executive directors 	<ul style="list-style-type: none"> ● Statewide/organizational consumer advisory boards
<ul style="list-style-type: none"> ● Human Resource departments and department heads with whom the CHW may interact (e.g., nutrition, primary care) 	<ul style="list-style-type: none"> ● RWHAP Planning Councils & Advisory Councils
<ul style="list-style-type: none"> ● Supervisors/department heads where CHWs will be assigned 	<ul style="list-style-type: none"> ● State and regional CHW organizations
<ul style="list-style-type: none"> ● Funders/donors 	<ul style="list-style-type: none"> ● City and State departments of public health

Gather Information to Inform Decisions about Specific CHW Tasks, Supervision Structure, and Target Populations

Use RWHAP enrollment and outcome data to inform the CHW program planning process. Every RWHAP is required to submit annual reporting and quality management data to HRSA/HAB about its services, called the Ryan White HIV/AIDS Program Services Report (RSR). If you are a community health center, consider using information from your Uniform Data System (UDS) which you are required to report to the Bureau of Primary Health Care or other quality management system to help you identify key gaps that a CHW could address in your programs and services. Review the program data to identify linkage, retention, and viral suppression rates for your clinic and identify client groups (e.g., young men, women of color, immigrants, etc.) experiencing lower than expected viral suppression or retention rates compared to your overall clinic populations (i.e., health inequities). These groups could be populations

that would benefit by engaging with a CHW. Also, engage with your local and state health department leaders and review HIV epidemiological reports to identify at-risk populations for HIV or those who may be lost to care.

In addition to using data, gather information from existing team members (health care providers, nursing/medical assistants, social workers, case managers, other providers, and public health departments) about how CHWs are, or could be used in HIV or other health conditions. Ask about roles and responsibilities, tasks performed, and what works well and what could be improved. This information can be helpful in moving the planning process forward.

Caseload size is a critical factor for the success of a CHW program. While there is currently no consensus on the “right” caseload for a CHW, across the field caseloads for CHWs are typically much lower than for case managers, nurses, and medical providers since the CHW is often working outside the clinic and addressing more intense needs. Things to consider when establishing a caseload:

- Needs of the client, or intensity of needs (high vs. low); a caseload should contain a mix of high, medium, and low need clients
- The number of “active” clients compared to clients that the CHW is monitoring lightly or in the process of transitioning to standard care (e.g., inactive but open case); a caseload can be larger if some clients are “inactive,” for example waiting for social security paperwork to be processed
- What is the appropriate caseload size to prevent burnout? The CHW may be working with a population that have many complex needs including addiction, homelessness, and mental health disorders which may justify a lower caseload compared to other staff. The supervisor and CHW should be engaged in determining what is a manageable number of clients.



Lessons from the Field: CHW Caseload

There is no ideal caseload size; it will depend on client need/acuity. Experience from other RWHAP recipients have found caseloads could vary from 20-40 clients at one time depending on acuity and tasks of the CHW on the care team. Since most CHWs work with a mix of clients that need a range of services, from less intensive (e.g., connecting to basic resources or medical care) to more intensive (e.g., housing, substance use treatment, and mental health services) discussing with a supervisor to establish the appropriate size is best to avoid burnout. We encourage you to consider 1) the role and skill of the CHW when determining the maximum amount of people included on the CHW's caseload; 2) the composition of the caseload in terms of the acuity and comorbidities of clients to be served; and 3) to involve the CHW in the process of determining the case load. They will know best!

Create Buy-in from Existing Organizational HIV Team Members & Key stakeholders

There are a number of activities that can help secure buy-in and ensure a smooth onboarding and integration process for new CHWs. These include the following:

- **Hold Meetings with Key Staff.** Once data are compiled, hold meetings with the individuals providing medical and social services to people with HIV in order to solicit their feedback on the CHW role and how it can be integrated into their work to provide better quality of care. Regular/ongoing updates and discussions with all staff will help to resolve confusion about roles and duties. Share work flow and organization charts as they are developed and be prepared to adjust these charts to reflect staff input over time. Remind staff that there will be changes as the new CHW program is implemented.
- **Leverage Key Staff to Secure Senior Leadership Buy-in.** In order to engage senior leaders and key decision makers within the organization, ask key medical and social support staff to announce the approach and their vision of how it will benefit the program and clients. Their authority can help you secure more buy-in from staff members at the organization. Senior leadership and program managers need to demonstrate support for the CHW program and be able to articulate the importance of CHWs to the organization.
- **Share CHW Role with Broader Clinic Staff.** Share the CHW roles and proposed work with clinicians, case managers, support staff, and program directors to identify how a CHW can help client populations that may need additional outreach or support. Determine what tasks a CHW would perform to enhance the quality of HIV care and also what tasks will NOT be performed by the CHW. Remind staff that CHWs have specific duties that may or may not include ad hoc and one-time assignments. There may be a tendency for care team members to “dump” work on the CHW; a clear role description will help prevent this problem. Have a clear process for the clinic team to bring ideas about the CHW’s work to the CHW supervisor.

Establish Internal Systems and Infrastructure to support the CHWs

In addition to securing buy-in, creating internal systems and infrastructure within the agency to support the CHW role is important to ensure a smooth onboarding process for new CHWs. These activities include the following:

- **Draft Job Description.** Draft and share a job description so other staff members are clear about the CHW’s tasks and responsibilities. Job descriptions support clarity of roles. (See [Appendix D](#) and [Section 2](#).)
- **Identify Office Space.** Identify a space for the CHW to sit and potential materials and resources they will need to carry out their duties. (See [Section 4](#).)
- **Assign a CHW Mentor and Supervisors.** Assign someone to serve as an onsite buddy/mentor who will help the CHWs become familiar with the clinic’s culture and practices from a staff point of view. The mentor can accompany the CHW to their first round of internal staff and team meetings, as well as community meetings. Finally, identify who will have the responsibility to provide administrative and clinical supervision on a regular schedule to the CHW. (See [Section 5](#).)

- **Schedule Time for New CHWs to Shadow Others.**

Organize a detailed tour of the facilities. Provide an opportunity for CHWs to shadow others in the clinic; this will help them to understand the roles of team members and how they fit together into the care team. Identify key community partners and arrange for the CHW to spend time with these agencies and shadow partner staff as appropriate. Also arrange for supervisory staff to shadow the CHW from time to time.

Franklin Primary Health Center in Alabama had their CHWs meet with medical case managers, behavioral health team members and the primary care team prior to seeing clients so they could understand each other roles and become familiar with clinic services.

- **Introduce CHW to Community Partners.** The supervisor or other appropriate staff should schedule time for the CHW to meet with key community partners, with an emphasis on those agencies/program with whom there are frequent interagency referrals. Southern Nevada Health District works closely with community partners and found it useful to create a release of information in order to work with outside agencies. Having CHWs meet with community partners will also create buy-in with those partners. (See [Appendix H](#).)
- **Develop Processes to Share Client Information.** Develop a detailed communication and staffing plan across teams and departments. For example, as an integrated member of the care team, CHWs should participate in staff meetings to receive up-to-date information about the organization and attend team meetings and case conferences about clients to keep other members up to date about client needs and barriers. (See [Section 4](#).)
- **Create a Program Logic Model.** Draft a logic model with the care team to guide the program and outline the activities of each CHW and staff member to achieve the specific outcomes of the program. (See [Figure 3. Sample Logic Model](#).) Work together to identify indicators and processes to track the activities of CHWs and create data collection tools to obtain client feedback and assess the impact of services. This can help monitor the progress of activities and identify potential gaps that need to be addressed in services in order to achieve viral suppression. (See [Section 6](#).)
- **Leverage Electronic Record Systems to Improve Communication and Transparency.** Set up systems to collect information and communication across team members. CHWs, like other staff members, should have access to electronic record systems, such as medical and case management records with appropriate training and supervision. Since so much information is recorded in the system about client contact, last medical visits, and case notes about medical and service needs, the CHW can use electronic records to keep other team members informed about the successes and challenges clients may be facing that may affect full engagement in care. (See [Section 6](#).)

Plan and Conduct Meetings with Community Partners and Stakeholders

One of the CHW's roles is to increase the organization's capacity to serve people with HIV in the community. To begin this process, set up a series of stakeholder meetings with staff in community partner organizations to identify gaps in services and needs, and assets and resources that may be critical and affect a person's ability to stay in care and adhere to HIV treatment. Not all members of the care team will have time to make connections to the resources in the community (such as food, clothing, housing, transportation, legal services, employment, etc.) to address these needs. Planning with community partners and stakeholders can help partners support and buy-in to the program. Meeting with community partners helps ensure that you are considering their priorities and identifying assets and resources outside the clinic walls that can be leveraged for CHW and client success.

In addition to checking with your regular partner organizations, familiarize yourself with other community needs assessments that are conducted by hospitals in your area and other community development corporations or foundations, such as the United Way. Often, federal law requires that these organizations conduct periodic needs assessments in the community. These assessments can provide your organization with valuable information about what is happening in the community. Local Ryan White Planning Councils and advisory councils that serve people with HIV are also great resources.

During the planning process, create Memoranda of Understanding (MOU) with key partners about how they will work with the CHW. Establishing an MOU can help to clarify expectations, roles, and responsibilities for each agency and their respective staff.



Key Tips: Developing a Needs Assessment

- Tasks or work the CHW could support in the community or within the organization
- Point of contact in partner organization for the CHW
- Specific services provided by partner organizations that are relevant for the CHW's role in their work with clients
- Confidential private space available for a CHW to meet with clients at the partner agencies, if a CHW will spend time at a partner agency
- Ways to communicate, make, and document internal and external referrals to connect clients with CHWs and for CHWs to refer clients for services

See [Building Blocks to Peer Program Success](#)

Consult with Human Resources to Create a CHW Recruitment and Retention Strategy

Prior to recruiting and hiring for the position, meet with your Human Resources department to foster organizational buy-in—a critical step for integrating the CHW into the organization. Here are recommendations to prepare for and guide your work with Human Resources (HR).

- **Do Your Homework.** Based on recommendations from the staff and partners, establish if the position will be part or full-time, identify roles and tasks, and outline the job description and qualifications, department assigned, and supervision structure.
- **Develop a Title.** Work with staff and Human Resources to come up with a standard title for the CHW position. We recommend using “Community Health Worker.”
- **Create a Compensation Package.** Establish a competitive salary, benefits, and compensation package rate based on local and regional guidelines.
- **Research Unions.** Find out if this position will be part of a union and determine if other approvals may be necessary for the job description and establishing a salary and benefits package. Whether the job is part of a union may have implications for other job qualifications (e.g., history of incarceration, educational attainment). (See [Appendix D](#).)
- **Develop a Job Description.** Draft and receive approval for language in the job description to be posted. In drafting the job description think about the level of experience and education that you would like the CHWs to have as well as potential opportunities for growth within the organization. Keep in mind the definition of a CHW in developing the job description. Include the geographic area to be served and any transportation requirements. Southern Nevada Health District Las Vegas, NV, McGregor Clinic Ft. Meyers, FL, and Legacy Community Health, Houston, TX worked closely with their HR departments and leadership to develop a job description that fit their clinics’ needs. (See [Appendix D](#).)
- **Promote Recruitment.** Establish a recruitment team and hiring process within the agency. Consider recruiting from within your organization as strong internal candidates bring organizational knowledge to the work and may require less onboarding. Other team members can help identify potential candidates through formal partners in the community or informal networks for qualified candidates from the community. Spread the word through Client Advisory Boards, Ryan White Planning Councils and other HIV specific groups.
- **Develop an Inclusive Interview and Hiring Process.** Determine who should be involved in the interview and hiring decision processes. Involving team members who will be working with the CHW will help to assure a good fit within the team. It may also be advantageous to include community partners in the interview process. (See [Section 2](#).)

If your organization has a unionized workforce, filling CHW vacancies and retaining existing CHWs can present unique challenges. Depending on the organizational/union contract, existing workers in the same job classification as the CHW may unexpectedly, and without your control, transfer or bump into the position. This can jeopardize one of the most essential and unique qualities that the CHW addresses—community membership or close affiliation. Some ways to address this include requiring HIV specific “knowledge skills or abilities” (KSA) for certain positions or having hiring exams.

- **Determine Fit.** In the context of other similar roles such as peer or patient navigators, determine how the CHW will fit in the organization. (See [Appendix D](#).) Sharing information about the organizational culture to potential candidates will help to assure a better fit.
- **Develop an Orientation (Onboarding) Plan.** Identify and establish a CHW orientation plan so the CHW is familiar with the agency policies and procedures and feels part of the agency and team from the start. Include organization charts and work flows as part of the orientation plan. Include a discussion and handouts about other team members' roles and responsibilities—with attention to situations where there may be overlap of duties. Include orientation with key staff from other departments so the CHW understands how agency departments work collaboratively. Inform the CHW of trainings offered that will enhance their ability to perform the job. The plan should include a clear timeline for each activity. (See [Section 3](#).)
- **Identify Opportunities.** Discuss opportunities for CHWs to be involved in regional or state associations that could provide further training and skills development and lead to credentialing. (See [Section 7](#).)



Lessons from the Field: Creating a New CHW Title

If a CHW is a new position in your organization, be prepared to spend some time working with your Human Resources (HR) Department to identify the proper job title. At East Carolina University Adult Specialty Care Clinic, the administration wanted the job title to reflect the work of the CHW while keeping CHW in the title. This clinic decided on a job title of, "Support Specialist-Community Health Worker" for their associates. They felt this communicated the role of the CHW while also including CHW in the title.

A university hospital system in Oregon wanted to create a "Peer Community Health Worker" position, but no such position existed, and Human Resources resisted. A senior physician at the HIV clinic worked with HR to create a "Treatment Adherence Specialist" with the job description including the role and tasks of a CHW in keeping with the CHW Core Consensus (C3) Project. While job titles are often constrained by the organization, the primary roles should be in line with the C3 CHW roles. (See [Appendix A](#).)



SECTION 2

CHW Recruiting and Hiring

- Recruiting CHWs
- Assessing Qualifications
- Interviewing and Hiring CHWs
- CHWs as Peers
- Understanding Benefits
- Educational Opportunities for CHWs
- Retaining CHWs

Section 2

CHW Recruiting and Hiring

This section describes issues related to the recruitment and hiring of Community Health Workers (CHWs) in HIV care. CHWs may be employees of the organization and part of a care team that offers direct health care services to people with HIV. There are also models where CHWs are employed by a community-based organization and placed in a health care facility to work with the care team and clients. In both approaches, CHWs cannot be successful unless they are fully integrated into the care team.

Recruitment and hiring are key elements of a CHW program. It is critical that the organization/employer consider and explicitly express the reasons for hiring CHWs, and the intended impact they expect the CHWs to make on clinic operations and client outcomes. A clear definition of the CHW role is key.

Steps for Recruiting and Hiring CHWs

Work with Human Resources Department to Establish Job Descriptions, Salary, and Benefits

As a first step, educate the Human Resources staff about the CHW and, together, design a job description that works for your organization. For larger institutions, such as hospitals and university-affiliated medical centers, a CHW may be a new role and it can take time to receive organizational approval for the job description. (See Section 1 "Lessons From the Field: Creating a New CHW Title.")



Clear Delineation of CHW Roles

It is important for the organization to think through how CHWs can most effectively be used in the health care setting; the work of CHWs should play to their individual strengths and they should complement and not duplicate the work done by other staff members, such as medical case managers. For example, a medical case manager or housing case manager may be responsible for filing paperwork for a client to obtain health insurance or food stamps, but a CHW may play a role in helping a client complete the forms and having appropriate supporting documents in place. Having a clear vision for the CHW will help organizations create an effective plan for recruitment, training, and integration of CHWs into the clinic. Some of these issues are addressed in more detail in other sections of this guide.

Work with your Human Resources Department to Develop the Job Description, Salary, Benefits Package, and Opportunities for Career Advancement

According to published reports,¹⁰ the salary and wages of CHWs vary, but most employers offer health insurance and standard benefit packages for CHWs.¹¹ CHWs, like other team members, are paid members of the care team. To the extent possible, providing a competitive wage and standard benefits package is desirable for CHW positions. The minimum suggested benefits are health insurance, dental insurance, paid time off (i.e., vacation, personal, and sick leave), and a retirement plan (e.g., 401K or 403B). In order to address professional growth and career opportunities, employer organizations should strongly consider offering professional development benefits, such as tuition assistance and time off/support for continuing education. (See [Section 5](#).)

Other information to share with Human Resources includes the potential that some ideal candidates may have a criminal record history; you may want to explore ways the department and agency can be more flexible with such candidates.



Lessons from the Field

Southwest Louisiana AIDS Council (SLAC) recruited from within their organization to hire a CHW whose role was to support linkage and retention in care. The candidate previously worked in HIV testing so they had experience with HIV testing, counseling, and education. Supporting linkage to care and retention was a next natural step for the individual in working with a care team. In this case, the CHW also worked with the organization to identify, hire, and train the appropriate person to fill the HIV testing role.

At East Carolina University, the CHW is a “community health worker/support specialist.” They provide support services, which is different from the medical case manager. East Carolina University wanted to maintain the word “community” in the job title to make it clear that this was not a clinic-based only position; the employee would need to go into the community. Unlike a medical case manager, clients are assigned to work short term with a community health worker/support specialist for approximately six months, then are reevaluated if additional intensive support is needed.

Understand the Impact on a CHW Candidate’s Supplemental Income and Health Benefits

If your organization would like to employ CHWs who are receiving public benefits, which may be the case with peer CHWs (i.e., people with HIV serving as CHWs), gather information from the Social Security Administration website about how a salaried position could impact a candidate’s benefits, if applicable.

¹⁰ Bureau of Labor Statistics. Health Educators and Community Health Workers. Accessed on April 21, 2019, <https://www.bls.gov/ooh/community-and-social-service/health-educators.htm>

¹¹ Community Health Worker National Workforce Study. US Dept. of Health and Human Services. Health Resources and Services Administration. Bureau of Health Professions. Washington, D.C. March 2007, p. ix.

Some CHW candidates may be receiving supplemental security income (SSI) or social security disability insurance (SSDI), Medicaid, housing subsidies, or food and nutritional benefits (e.g., SNAP, WIC). Taking on a paid position could reduce the candidate's benefits. This information should be available to all candidates to facilitate an efficient and transparent hiring process. Additionally, encourage candidates to seek out this information independently to ensure their understanding as you support staff retention for the care team and agency.

Assess CHW Qualifications against Program Goals and Objectives

CHWs are members of the community they serve, and the close connection they have to the community is integral to their success. Through their connections, they may have the ability to recruit hard-to-reach populations or facilitate linkages between the health care setting and community organizations. They also carry knowledge of the community that is valuable for tailoring programs and services to the community's needs. Therefore, having a formal degree, such as a bachelor's degree, should NOT be a requirement for hiring. In HIV care specifically, having shared experience is an important element, and being able to connect and work in the community that one is serving is essential. Being a member of the community might mean a variety of things. It could mean that an individual is living with HIV; it could also mean that they have lived experience with substance use, homelessness, or incarceration. The box presents sample qualifications for consideration when hiring a CHW. (More details on skills and qualities to consider are listed in [Appendix A](#) and [Appendix B](#).)

CHWs are members of the community they serve, and the close connection CHWs have to the community is integral to their success as a CHW.



Sample CHW Qualifications

- A desire to help individuals and the community
- An ability to communicate with people
- An outgoing personality
- The respect of community members
- Living in the community with plans to stay there
- Having a reputation as a leader in the community
- Adaptability
- Able to build effective relationships across groups by age, gender, race/ethnicity, sexual orientation, religion, immigration, incarceration history, and socioeconomic status
- Language capacity
- Basic computer skills or a willingness to learn
- Personal readiness, especially for people with HIV who wish to serve as CHWs
 - » A critical role of the CHW is to navigate services. A peer CHW will also share their HIV experience in a professional manner; sharing personal strategies is an important function and can be valuable for a client to find resources to meet their needs



Lessons from the Field: Reducing CHW Turnover + Improving Job Retention

To reduce CHW turnover and encourage retention, organizations need to support career development and education opportunities. Career development and training can be included in the CHW job description and supported by your organization. Suggestions include:

- Developing leadership roles in Ryan White Planning Councils or Consumer Advisory Boards/committees that will support personal growth. At the McGregor Clinic in Ft Myers, FL, the supervisor connected their new CHW to the FL state CHW coalition from the start. Through this connection, the CHW has been able to receive mentoring, connect with colleagues working across the state, participate in advocacy at the state level, and develop leadership skills and experience, all of which can improve job satisfaction and retention.
- Encouraging CHWs to learn and attend national conferences to allow for networking and identification—and implementation—of new program ideas. CHWs participated in multiple conferences throughout the pilot project, such as the Unity conference, the National Ryan White conference on HIV Care and Treatment, and the National Latinx Conference on HIV/HCV/SUD. At the 2019 Unity conference, CHWs from the Jacques Initiative, the McGregor Clinic, and Legacy Community Health presented their experiences with implementing a CHW program, including challenges and solutions that their sites faced. Supervisors' support of these opportunities helped CHWs spread the benefits of having CHWs in healthcare teams, in addition to helping build their own professional development and networks.
- Developing skills, such as planning or leading client groups, helping complete program reports, and inclusion in organizational committees, such as quality management or cultural diversity, supports personal development.

Develop CHW Retention Strategies, Including Career and Educational Opportunities

Retention of CHWs is a key factor in the implementation of a CHW program. In developing the position, work with your Human Resources Department and Business Office to establish a position that can be sustained fiscally, provides opportunities for growth in the organization, and develops skills that can be applied in other health care and community settings.

In general, high turnover has been reported in the CHW field mostly because salaries are on grant cycles.¹² One study of the CHW workforce reported that poor job retention of CHWs was a larger

¹² Scott G and Wilson R. Community health worker advancement: A research summary. Boston, MA: Skillworks. April 2006. www.skill-works.org/Downloads/chwressumm.pdf; Community Health Worker National Workforce Study. US Dept. of Health and Human Services. Health Resources and Services Administration. Bureau of Health Professions. Washington, D.C. March 2007.

problem for employers than finding highly qualified candidates.¹³ Concerns about CHW employment include low wages, job instability, lack of occupational identity, lack of recognition by other health professionals, lack of integration into the health workforce, and lack of a career ladder or trajectory.¹⁴ Programs in health care settings specifically may have high CHW turnover due to the stress of the work, lack of job security, competing issues in the lives of CHWs, and/or low pay and benefits.¹⁵

When CHW turnover is high, valuable institutional knowledge is lost to organizations that are interested in nurturing and growing relationships with communities, building a positive reputation in the community, and establishing strong partnerships with organizations external to the health care setting in areas such as housing and child care.¹⁶ Poor retention can also disrupt the function of programs in the health care setting. One way to encourage retention of CHW staff and growth for the CHW and organization is to ensure there is an appropriate support and supervision structure. (See [Section 5](#).)

People join organizations, but they leave supervisors.



CHW Retention Case Scenario

Field-based work is stressful. The clinic at the Multnomah County Health Department lost a highly effective and compassionate navigator due to the stress of the work. She had worked at the clinic for about a year. During this time, one of her clients had struggled with domestic violence. One day the client walked in, badly beaten. His jaw was broken and he had soiled his pants—it was horrible. He asked the front desk to get his navigator. The navigator met with the client in a triage room near the lobby. Within a short time, she was joined by the team nurse. The navigator was naturally highly distressed and upset by this traumatic situation. The clinic staff were unsure of how to best support this navigator. After the experience, she did not want to continue working as a patient navigator, and transferred into a different position. This event led to formalizing situation debriefs in the clinic and to providing Intimate Partner Violence (IPV) training to the entire staff.

¹³ Scott G and Wilson R. Community health worker advancement: A research summary. Boston, MA: Skillworks. April 2006. www.skillworks.org/Downloads/chwressumm.pdf.

¹⁴ Gutierrez Kapheim M and Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute, January 2014; Community Health Worker National Workforce Study. US Dept. of Health and Human Services. Health Resources and Services Administration. Bureau of Health Professions. Washington, D.C. March 2007.

¹⁵ Gutierrez Kapheim M and Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute, January 2014; Community Health Workers: Essential to improving health in Massachusetts. Division of Primary Care and Health Access. Bureau of Family and Community Health. Center for Community Health. Massachusetts Department of Public Health. March 2005. www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/comm-health-workers-narrative.pdf.

¹⁶ Gutierrez Kapheim M and Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute, January 2014; Community Health Workers: Essential to improving health in Massachusetts. Division of Primary Care and Health Access. Bureau of Family and Community Health. Center for Community Health. Massachusetts Department of Public Health. March 2005. www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/comm-health-workers-narrative.pdf.

As previously described, considering the impact of a unionized workforce can be critical in retaining CHWs. Programs should check with their Human Resources department or Classification and Compensation departments to see what precautions they can take to ensure people they hire primarily due to community affiliation are not in jeopardy of being bumped by union members. For example, you may consider knowledge, skills, or abilities (KSA) related to working in bathhouses frequented by men who have sex with men (MSM) for a CHW who will do outreach in a bathhouse. Additional retention strategies include: adequate supervision, creating a venue for peer support, cultivating an empowering work environment, availability of employee benefits (e.g., sick time), flexible work schedules, and participation in Ryan White Planning Council, Consumer Advisory Council, and agency specific committees that focus on staff retention and education.

Career advancement is limited for CHWs at the present time in most organizations. Some CHWs move up in the organization by becoming an administrative supervisor or case manager. Sometimes, career advancement may result in the CHW leaving the position to return to school and work in social work, nursing, or public health. This may be beneficial to the organization because the CHW can return as a supervisor or leader in another capacity and, thus, train and support the next generation of CHWs for the organization. Organizations can also provide support and growth for CHWs by encouraging attendance at conferences to learn new knowledge and skills and linking the CHW to certification programs. (See [Appendix E](#).)



Lessons from the Field

At the McGregor clinic in Fort Myers, FL, their CHW worked 50% on the prevention team and 50% in the clinic. This way, the CHW could build various leadership skills in two key areas of the field. Their CHW was also involved in RW planning councils where she gained crucial leadership skills.

Focus on Supervision to Support the Retention of CHWs.

Over several years, the Multnomah County Health Department HIV Clinic integrated CHWs into its medical home model—these CHWs were called patient navigators. After the first year of working with the navigators, additional adaptations to the model needed to be made. The initial plan for supervision of the navigators was very traditional, designed for staff who worked onsite, with predetermined times to meet with supervisors. Once the navigators started working in the field, supervisors got together with the navigators to hear what they thought would be

most helpful. As a result of CHW input, supervision ratcheted up. For field safety, the navigators carried a charged work cell phone. Whenever they left the clinic to meet a client in the field, a “status update” email was sent to all staff (including supervisors). A protocol was established for checking in after a field visit. In addition to the formally assigned supervisor, navigators were given access to all supervisors at the HIV clinic so that in an emergency, navigators could get real-time support even if the assigned supervisor was unavailable. Clinic staff also worked together to develop and implement a formal situation debrief process that supported navigators and other clinic staff following disturbing, difficult events, like witnessing interpersonal violence. (See the [Appendix L](#).)

Several guiding principles evolved for supervisors to address staff stress related to field-based work. First, whenever a client's behavior or a situation was out-of-control, navigators were instructed take a step back and consult with a supervisor or co-worker—they were not expected to handle the situation alone. Second, supervisors created space for navigators to be creative in problem solving with clients—even in dicey situations. Third, navigators debriefed difficult situations in a way that best suited the navigator—the options varied from informal discussions to the formal debrief protocol.

Recruit CHW Candidates from Formal and Informal Channels

CHW recruitment is most successful when it is pursued through multiple pathways simultaneously in the community, using strategies from formal advertising or postings to informal word-of-mouth. Key factors to think about include the characteristics of the community and population you are trying to engage in HIV care and treatment, and how you will reach out to organizations to recruit individuals from that community. For example, if you want to use CHWs to engage young women, share job descriptions with youth associations or women's health clinics, or even beauty salons. In other words, think of places where young women would congregate, spend their time and are easily reached. Franklin Primary Health Center, a federally qualified health center in Alabama, circulated a listing for a CHW externally and to community partners to find people with experience working not only with HIV, but other human services fields such as substance use and mental health, conditions commonly experienced by their patients.

Establish a Hiring Team and Develop Interview Questions










Interviews for CHW positions can be conducted one-on-one or in groups (recommended) consisting of more than one member of the care team and the CHW. This facilitates effective integration of the CHW into the care team. In addition, partners who will be working with the CHW may be included.

Here are examples of individuals to invite to the interview process:

- Health care provider (e.g., nurse practitioner, physician assistant, physician)
- Behavioral health staff
- Other support services staff (e.g., benefits counselor, outreach workers, etc.)
- Other CHWs
- Case managers
- Program supervisors
- Administrative directors
- Community partners
- Representatives from Consumer Advisory Board.

Recruiting CHWs

Some suggested channels to recruit CHWs include the following:

-  Advertising and postings on the internet (e.g., organization's website, job websites), in newspapers, and at public employment office¹⁷
-  Community partners such as churches, clinics, local businesses, and human services
-  Social media
-  CHW associations
-  Consumer advisory boards
-  Asking health care providers about candidates from their patient population or existing staff
-  Networking with community colleges, substance use treatment programs, and organizations who work with individuals with histories of substance use, homelessness, mental health, or incarceration
-  Local and state public health departments or state departments of labor
-  Public health associations/institutions

During an interview, the candidate should be provided with clear expectations for the job, including typical CHW roles and tasks. Have a ready list of questions for the candidate to address. The candidate could be asked about his or her relationship with and knowledge of the community, motivation for the job, comfort with the job requirements, and overall work experience.

Some sample interview questions can be found in [Appendix D](#) and include:

- Provide a scenario and ask how the candidate would address a specific need with a client or work with a team member to address a need.
- Ask about a candidate's readiness to talk about HIV. For peer CHWs, part of the role could be a mentor and sharing experience about living with HIV. Ask how they might respond to someone who expresses fear of disclosing his or her status or not taking prescribed HIV medication. This can give an indication of one's ability to respond to people with HIV who may be struggling with acceptance of HIV or engaging in care. Additional sample questions can be found in the [Building Blocks to Peer Success toolkit](#).

¹⁷ Gutierrez Kapheim M and Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute, January 2014.

Select a CHW

Selection criteria for hiring a CHW should be specific to the needs of the program. As suggested earlier in this section, an employer should consider how the organization plans to utilize a CHW, and focus on finding a candidate who meets those needs. Creating a panel of advisors for the selection process can ensure the appropriate person is selected. The panel may include: health care providers, medical case managers, and consumer advisory members, in addition to the potential supervisor and HR team.

Factors that should be considered in hiring a CHW include the individual's connection to the community, background, personality, education, and skills. An important recommendation in hiring is that CHWs are hired primarily for their understanding of the populations and communities they serve and the skills they bring to your organization.¹⁸

Considerations for Hiring Peer CHWs who are Clients

As mentioned earlier, CHWs may be recruited from your organization's client population and this can be an effective recruitment strategy. Check your organization's policy about hiring a current client as a CHW. When selecting a candidate who is a client, here are some points to resolve prior to completing the hiring process:

- **Be clear.** Clearly discuss the effect of salary and compensation on the CHWs benefits or entitlements. This will avoid unnecessary stresses for the CHWs or managers.
- **Consider different levels of employment.** One agency has 3 levels of employment: full-time, part-time, and per diem. The part-time and per diem positions allow people with disabilities to apply for the CHW position. This will help the peer CHW to work designated hours without worrying about losing disability benefits, or if the CHW's health prevents him or her from working full-time. Benefits would be based on the part-time or per diem status of the agency. It is important that the full-time vs part-time decision be based on program needs. Given the nature of CHW work, it may be



Who Should be Involved in the Selection Process?

A broad group of HIV care team members (e.g., health care providers, medical case managers, and program supervisors, consumer advisory members at a minimum)



Qualities of a Successful CHW

1. Case management experience
2. Adaptability
3. Cultural competence
4. Substance use background
5. Language capacity
6. Personal readiness (peer)
7. Communication skills
8. Able to participate in a team
9. Able to work independently

¹⁸ Gutierrez Kapheim M and Campbell J. Best practice guidelines for implementing and evaluating community health worker programs in health care settings. Chicago, IL: Sinai Urban Health Institute, January 2014; Hirsch G. Building a sustainable community health worker workforce in Massachusetts. ASTHO-Supported Primary Care and Public Health Collaborative Workforce Committee. December 11, 2013. www.astho.org/Workforce-Committee-CHW-Presentation-12-11-13/

challenging to provide adequate coverage and continuity of service with part-time staff.

- **Share the privacy/confidentiality procedures of the clinic.** If you hire a person who receives care at the clinic, be sure to explain clearly the policy about access to medical records and establish a policy about boundaries between resolving needs as a client and the professional role with other care team members. Assure that the CHW is trained on confidentiality, Release of Information (ROI) forms and requirements. Provide samples of common types of ROIs especially those involving partnering agencies. Determine if the CHW has any conflict of interest with other patients; if so, determine how this will be handled. It is essential that a CHW who is also a patient understand how to report any conflicts of interest—especially if the CHW wants to establish a trusting relationship with a client.

“Choose CHWs who are: flexible, open-minded/not afraid, knowledgeable, resourceful, dedicated, passionate.”



SECTION 3

Orientation and Training CHWs, Supervisors, and Staff

- Preparing CHWs
- Establishing Connections
- Training for Certification
- Staff Training
- Ongoing Education and Technical Assistance

Section 3

Orientation and Training CHWs, Supervisors, and Staff

(See also CHW Training Curriculum)

As a full member of the team, CHWs are subject to the same policies and procedures as all of the organization's employees and, as such, should complete all required job and agency-specific orientations.

Space is a critical issue to resolve prior to bringing a CHW on board so the CHW can fulfill his or her roles and responsibilities. Finding appropriate space prior to the CHW's employment start date is essential. The CHW will need a private confidential space similar to health care providers and case managers. If your organization's space is limited, then work out a plan to share space with other care team members or find a space that can be reserved for CHWs to work with clients even during busy clinic days. Allow for flexible work schedules from home or in the field with regular communication with supervisors.





Required Resources for CHWs PRIOR to Onboarding


- Cellphone
- Computer/laptop
- Business cards
- Log-ins for electronic health records and other data
- A private office or access to a private space daily to meet with clients.


Setting CHWs up for Success


To help CHWs get started, the following activities should take place:


- 


Provide Contact Lists. Provide contact lists at partner agencies for assisting clients with identifying and accessing resources in the community.
- 


Set-up Care Team Meetings. Set-up meetings with the care team who will be interacting with the CHWs on a daily basis.
- 


Provide Systems Access and Resources. Schedule time with IT and Human Resources to get passwords and orientation to data systems, benefits information, building access, an ID badge, and resources.
- 


Complete Paperwork. Complete all necessary paperwork to access the building and organizational resources.
- 

Orient CHWs. Schedule specific orientation, such as new employee orientation, Health Insurance Portability and Accountability Act (HIPAA) training, human subjects research training, cultural competency training, and other basic content necessary for the job. Remember to call out confidentiality and documentation expectations related to Substance Abuse and Mental Health.
- 

Identify Documentation Requirements. Provide detailed training on documentation expectations, requirements, and processes.
- 

Share Organizational Policies. Provide copies of agency and department policies, such as home visiting policies, use of cars, transporting clients, privacy and confidentiality, use of cellphone, and safety protocols. Include examples of client and staff interactions that need the immediate attention of the supervisor.
- 

Keep CHWs Informed. Provide information about specific organization days, such as retreats, all-day staff meetings, and special events that the CHW is expected or invited to attend.
- 

Offer Trainings, Including Foundational Knowledge about HIV and CHW Core Competencies. Offer or connect a CHW with an initial 40-hour training course. If your state offers CHW certification, consider sending the CHW to complete this certification. If your state does not have a training program, evidence suggests best results by utilizing a training that incorporates adult learning principles and a population education approach. Suggested resources include: DEII Training, MP Salud, ORCHWA TX, DISH project, and state and local CHW associations.
- 

Update and Distribute Revised Workflows. The integration of CHWs into the care team will result in changes to some workflows. Revise workflows to include the CHW roles and responsibilities. Distribute updated workflows to all staff and review in staff meetings. How the agency handles internal and external referrals to CHWs needs to be clearly articulated, as does the process for client referrals to outside agencies/resources.

Additional CHW Training for Certification

Additional training is required for CHW certification. Intensive training should be provided to CHWs and program staff prior to and ongoing during service provision. While there are no national standards, the number of required training hours for CHWs to be certified in most states average 60–80 hours. (See [JSI Healthy Start EPIC Center](#) and our [sample training agenda](#).)

We recommend up to a 40-hour initial training.

Critical topics for the training include:

- Basic information about HIV
- Communication skills
- Role in the HIV care team—history of CHW in organization
- Motivational interviewing (MI)
- Trauma-informed care
- Documentation of work—how to document in field vs. in office
- Use of supervision
- Medical terminology, such as understanding the HIV viral lifecycle, medications, lab reports, as well as names of opportunistic infections.
- Cultural Competency/Humility
- Harm reduction
- Safety in the field
- Reporting and documenting critical incidents/sentinel events
- Maintaining professional boundaries
- Mandatory reporting—policies, procedures
- Working with challenging clients—when is enough, enough?
- Stigma and discrimination
- Resources for PrEP and other prevention resources
- Social Determinants of Health
- Common comorbidities (e.g. diabetes)

Provide Training for Organization Staff Members

Adding a new member to the HIV care team requires training existing staff about communication strategies, new referral processes, and documentation procedures. We recommend that organizations offer an initial training to all staff (including direct service, administrative, and security staff) about the value of the CHW, his or her role, responsibilities, and interaction with clients, including referrals, scheduling, and other relevant information. Provide detailed information about the CHW during organization-wide meetings, and via emails or newsletters.



Lessons from the Field

Legacy Community Health, developed a handout about the CHW staff member and their role. The McGregor Clinic created a palm card to be used with internal staff about CHW roles at the agency. (See [Appendix D.](#))

Establish Connections with Your Local AIDS Education Training Centers and Local CHW Associations

If your state has a local CHW association, make connections and provide contact information to CHWs and supervisors. (See [Appendix F.](#)) In addition to the training provided through the initiative, we encourage CHWs to sign up for mailing lists/email subscription lists to receive updates from their local AIDS Education and Training Centers. (See [Appendix G.](#)) These connections to both CHW and HIV associations can provide opportunities for professional growth and knowledge, and better advocacy for CHW positions. As mentioned earlier, CHWs are in a unique position as a member of the health care workforce to affect and promote health equity by elevating the voices of people who are often marginalized by the health care system.

Identify Certification Programs in Your Area and Offer Pathways for Certification

Encouraging CHW certification may help an organization with financing and sustaining the position as a member of the health care workforce. While not all states require certification to practice as a CHW, it can be a useful step for professional growth and development. Certification helps assure that CHWs share common knowledge and exposure to the same CHW principles and local resources. For resources about certification, contact your local Area Health Education Centers and/or community colleges, which may have programs in your area. (See [Appendix E](#) for a list of states with certification programs.)



SECTION 4

CHW Integration into the HIV Care Team: The Service Delivery Model

- CHW Outreach
- People with HIV Recruitment
- Referral Systems
- Explaining Multi-site Evaluation
- Post-Recruitment Tasks

Section 4

CHW Integration into the HIV Care Team: The Service Delivery Model

This section describes the major steps for effectively using CHWs as part of the care team. The program must be flexible and client-centered, working with clients to identify and achieve client-identified goals for treatment. The CHW program can use the CHW role, specific tasks, and activities to help the care team provide this approach. CHWs can be used in a range of program activities, from outreach and identification of clients who are in need of services, to providing support services in order to strengthen client retention in care and adherence to treatment. (See [Appendix A](#).)

Developing a Plan for CHW Outreach and Recruitment of People with HIV

Because they are familiar with the community and may share lived experiences with people with HIV, CHWs can play a crucial role in linking people and re-engaging them back into care. The CHW is the member of the team who, in working with the case manager, can help coordinate the needed services for a people with HIV, especially those with multiple or serious comorbidities. CHWs can help clients navigate the health care system by scheduling appointments; providing appointment reminders; accompanying them to appointments; and making referrals to housing, mental health care, or substance use treatment. CHWs can help complete paperwork and educate people with HIV about benefits, insurance, and the AIDS Drug Assistance Program (ADAP). CHWs can support treatment adherence in a number of ways. These include educating clients on HIV, understanding lab results, the viral life cycle, obtaining medications and discussing how to take medications as prescribed, medication adherence resulting in viral suppression, and developing adherence strategies.



Lessons from the Field

A CHW at the Southern Nevada Health District was a part of a women's group where she conducted outreach. The familiarity and trust their CHW established in that community helped individuals develop a relationship with the CHW, and as a result, the CHW was successful in re-engaging individuals in care.

CHWs at the 1917 Clinic at the University of Alabama, Birmingham participated in and led various community events where they were able to connect with individuals and re-engage them back into care.

Identify the specific priority populations to be served by CHWs. Typically, CHWs in Ryan White HIV/AIDS programs (RWHAP) serve:

- People who are not virally suppressed
- People who are newly diagnosed
- People who recently immigrated to the U.S. (in the past five years)
- People who have missed two or more appointments or have had only one medical appointment in the past six months (unless indicated by the health care provider)
- People experiencing homelessness/unstably housed situations
- People with substance use disorders
- People with mental health disorders
- People recently released from jail/prison
- Any combination of the above

Below are a few strategies to identify and recruit new clients from the community or recruit and re-engage existing clients who may have fallen out of care:

Look at Program Data. Look at your program's data to identify clients who have fallen out of care. In defining "out-of-care," prioritize clients who have not had a lab or medical visit at the clinic in at least six months or clients who are not virally suppressed. Set up a system to review and rerun this list on a regular basis. CrescentCare in New Orleans, LA, used an out of care list generated by their clinic to focus on contacting individuals who had fallen out of care as a starting point for their outreach efforts.

Leverage Surveillance Data. Connect with the public health surveillance office at your state health department to obtain lists of clients who have not had a viral load test in the past six months.

Review Testing Data. Review clinic testing data to identify eligible people who are newly diagnosed or who never linked to care. Review lists at weekly team meetings with health care providers and case managers, get updates from team members, and make a plan for which clients might benefit from working with a CHW.

Schedule Meetings with Team Members Such as the Case Manager. Have the CHW meet with case managers and health care providers to identify clients from their caseloads who also may benefit from CHW support. These could include clients struggling with medication adherence, who are not virally suppressed, or have multiple unmet needs. These could also be clients with mental health disorders, substance use, and/or unstable housing.

Leverage Case Managers. Have the case managers review their existing clients to assess their acuity, their barriers to care, and the need for CHW support. If a client might benefit from CHW support, the case manager can discuss this with the team. If the team (including the CHW) agrees that CHW support is needed, the case manager can initiate a referral to the CHW program. Depending on the program workflow, the CHW can work with the case manager, other team members, and the client to develop a plan of action.

Review Appointment Data. Review appointment data to identify clients who have missed two or more appointments and have not rescheduled. Appropriate staff, including the CHW, can reach out to these clients to check in as agency policy allows and try to re-engage the person into care.

Recruiting Clients and Seeking Referrals

Once you have reviewed your out-of-care lists and referrals from providers, then move to seeking referrals from other community partners. For example, with support from the Administrative Supervisor, the CHW can reach out to partner agencies, such as local or state health departments and their HIV/STI clinics, places that have PrEP (pre-exposure prophylaxis) programs, substance use treatment agencies, shelters, and other community-based agencies that provide services to people with HIV. Reach out to partner agencies that conduct HIV testing and introduce the CHW to make connections and referrals of potential individuals to the clinic. This could be done by the administrative supervisor, or by the CHW with support from the administrative supervisor. As mentioned in [Section 3](#), provide CHWs and other staff with written workflows and information about the various internal and external referral processes.

Once you have reviewed your out-of-care lists and referrals from providers, then move to seeking referrals from other community partners.



Lessons from the Field

Southwest Louisiana AIDS Council (SLAC) created a referral process for those newly diagnosed and coming back into care. After seeing a provider, clients are connected with a Linkage Care Coordinator who takes them through the referral process, first talking with support services (where clients meet a CHW). They then work with Medical Case Management (MCM), specialized services, and at the end sign off with a nurse. Although the Linkage Care Coordinator takes the client through the initial referral process, the CHW is able to work with clients at any point to help further with MCM or specialized services after the initial process is complete. (See [Appendix H](#).)

The CHW program at the Southern Nevada Health District received their referrals from the community. They created a process so that community referrals first go through the program manager and are then passed to the supervisor, who then assigned new clients to a CHW.

Set up an Internal and External Referral and Tracking Systems to Document the Identification and Recruitment Process (See [Appendix H](#))

If a person is referred to a CHW from the team, document this in the electronic health record. Create a system for health care providers or case managers to flag a client who may benefit from CHW support

(This could be via email alert or a flag in the EHR). Set a protocol for the timeframe for initial contact to be made after an individual is referred, such as “within 72 hours.” For internal referrals, a warm hand-off is ideal—that is, the referring staff member introduces the client and CHW in real time.



Lessons from the Field: CHWs and Health Care Providers using the EHR

If a person is referred to a CHW from the team, document this in the electronic health record. Create a system for health care providers or case managers to flag a client who may benefit from CHW support. (This could be via email alert or a flag in the EHR). At Legacy Community Health, the CHW receives referrals through the client’s electronic medical chart. Case managers, service linkage workers, and other CHWs may send flags, which include details or questions about the client that the CHW should address. The CHW will then log this referral into their own records.

The CHW at Legacy Community Health also used a flagging system in the EHR as a way to message the referring provider with an update about clients. The CHW also created a mechanism using Microsoft Excel to track information, such as the referral date, who made the referral, follow up, and outcome of CHW outreach efforts. Depending on the EHR system, this could also be done in the EHR system itself.



Suggested CHW Tasks and Activities

- Contact the client on a weekly basis to check in about progress of getting needs met, referrals and achieving the goal plan
- Conduct regular education sessions with clients
- Document daily activities on an encounter form and/or in the electronic health record. (See [Appendix J](#) for examples.)

To maintain communication with the care team, suggested items to document in the electronic health record include:

- Attempted contacts for follow-up appointments
- Referrals made and completed for other medical care or support services (such as mental health care, substance use treatment)
- Notes about client reported services or circumstances that could impact health care or taking medications (i.e., client reported losing their job and staying with parents, client reported mother passed away and missed medications, etc.)
- Notes related to medications-calling in at pharmacy or picking up medications



Huddle (v.) *To gather together*

Huddles (sometimes called “pre-clinic conferences”) are brief meetings among all members of the care team to discuss the day’s schedule. They typically occur before each half-day of appointments (in the morning and after lunch) and last about 15 minutes. Participants frequently include: primary care providers, nurses, medical assistants, behavioral health staff, medical case managers, CHWs, and any other team members involved in direct client care (e.g., panel managers, peer specialists, etc.). Huddles provide an opportunity to ensure that the team is on the same page about individual patient care plans and any acute issues to be addressed. The CHW will need orientation to their role in the huddle including what information they may be asked to contribute. It is also important for other members of the care team to see the value that CHWs bring to a huddle.

Post-Recruitment Tasks

Once clients are recruited into the CHW program, the following tasks are carried out by the CHW in accordance with his/her job responsibilities with monitoring and support from a supervisor:

- With information from the case manager, the CHW will meet with the client to develop a care plan ([Appendix I](#)) that consists of client-identified goals to achieve. The care plan should include regular meetings between the CHW and the client. (See [Appendix I](#).) Once completed, the care plan can be uploaded into the electronic health record so all team members can view it.
- The CHW attends team meetings where the HIV care team communicates in person, via telephone, or the electronic health record to discuss cases, identify new clients for follow up, and document progress of existing clients. This could be carried out in several ways:
 - » Daily clinic huddles where CHWs learn about the status of current clients and share information with the team about clients and their activities with them
 - » Weekly team meetings where cases are reviewed and overall clinic activities are discussed to ensure quality improvement
 - » Touching base with team members informally as needed
- CHW meets weekly with administrative supervisor, to debrief weekly activities and to discuss activities for the next week; this is a time to troubleshoot challenges related to clients or staff. (See [Section 5](#).)
- CHW participates in clinical supervision at least once per month.
- CHW establishes a transition or close-out plan for clients who are ready for less intensive services, who become inactive, or hard to reach after repeated attempts. It is critical that team members and clients are informed of any changes to CHW assignments. The decision needs to be documented in the medical record as well. When possible, clients should be involved in the decision to transition and be cognizant of the plan moving forward. Consider the following when developing a transition or close-out plan:

Timing. After 3-4 months or when the first care plan goals are achieved, the CHW will work with the client, case manager, and care team to determine if this person is ready for a transition from working intensively with a CHW to a medical case manager for more routine care.

- **Examples of Criteria for Transition Readiness.** Identify the criteria for transitioning or closing CHW cases. Criteria for client outcomes may include: attending medical appointments regularly; demonstrating medication adherence, including picking up prescriptions and managing side effects; engaging in substance abuse/mental health services; resolution of housing and legal issues; and/or viral suppression. Use of an acuity assessment and talking with team members to decide if a client is ready for transition is crucial.
- **How to Handle Returning Clients.** Have a plan to handle clients who have transitioned to routine care with a medical case manager and the rest of the care team, but later develop a need for additional CHW support.
- **Reassess Barriers to Care Needs.** Have a process to determine if the CHW should continue with the client. If the decision is made to continue with the client, then the CHW will complete a new client care plan and establish additional goals.

The CHW Supervisor–The CHW’s CHW

Leader	Advance team building; mastering politics of identity, power, and privilege; confronting historical discrimination
Director	Managing a mix of workers; using experience, skills, and knowledge appropriately
Educator/Teacher	Teaching skills to CHWs
Facilitator	Conflict prevention and resolution; problem solving
Mentor/Coach	Professional skills and leadership of CHWs
Evaluator	Performance assessment; giving feedback
Advocate	Advocate for the CHW; encourage the CHW to be an advocate
Collaborator	Foster relationship building and maintenance inter and intra-agency



Lessons from the Field

At Franklin Primary Health Center, a rural health clinic, keeping up with people with HIV who may live far away from the clinic is essential to ensure they get their medications and maintain viral suppression. The health center has a policy that all patients who miss an appointment receive a weekly home visit, and all new patients receive at least one.

It is recommended that an agency workflow be developed, reviewed, and shared with all health care team members. The workflow should reflect key steps of the CHW work. (See [Appendix H](#).)



CHW Home Visits

CHW's work with clients occurs both inside and outside the clinic walls. Part of the CHW role is to make home visits to clients as necessary and work in the community—meeting with partners to obtain services directly with their clients or on behalf of clients. The CHW needs guidance from supervisors about field safety.

“Don't be disappointed if you don't see immediate change after implementing your program. Change sometimes happens slowly, no matter how much love and attention you are putting in.”



SECTION 5

CHW Supervision

- Types of CHW Supervision
- Supervision Steps and Structure
- CHW Supervision Tips
- Supporting CHW Growth, Safety, and Autonomy

Section 5

CHW Supervision

(See also Supervisor Training Curriculum.)

Agencies should provide administrative and clinical supervision to CHWs on a consistent schedule. Supervision is critical for ensuring the integration of the CHW into the care team and CHW success.

Types of CHW Supervision

Administrative supervision focuses on two components:

1. **Accomplishing the goals of an organization**, including activities such as promoting effective communication between staff to encourage the efficient delivery and monitoring of the CHW roles, or discussion of the CHWs responsibilities and tasks within the policy and procedures set forth by the organization.
2. **Providing day-to day-support, or supportive supervision** in which the supervisor provides an opportunity for the CHW to discuss issues that emerge as a result of the CHW's work with clients and peers that may impact the CHW's life experience. Supervision meetings should support the CHW by providing time to discuss what is working well and how to address problems. Such support helps the CHW maintain boundaries which can help prevent burnout in the position. Administrative supervision should be provided by a non-clinical staff member on a weekly basis to help the CHW troubleshoot challenges with clients and staff, and find resources to help them carry out their daily tasks. Supervisors should also seek feedback from CHWs on how best to support them in their work. Supervisors should assist the CHW to develop a self-care plan; the supervisor should follow up with the CHW to assess self-care and burnout. (See the Supervisor Training Curriculum for training on Self-care.)

Clinical supervision provides the opportunity for CHWs to explore:

- How their work with clients can trigger certain reactions for either their clients or themselves
- Ways to maintain healthy relationships with clients and other staff members

Clinical supervision may also include how the CHW's work interfaces with clinical issues that the client may be experiencing. *Clinical supervision should be provided by a licensed clinician (social worker,*

counselor/therapist, behavioral health consultant, psychiatric nurse practitioner or psychiatrist) to provide the CHW with techniques for managing challenging client behaviors, addressing their own issues that could affect their work, and avoiding burnout. Both of these types of supervision are important for an organization to provide to CHWs for support and retention, and to ensure that CHWs are effective in their work. Many people in the CHW role may have experienced trauma or are suffering from stigma due to living with HIV or having shared life experience of other types (e.g., incarceration, substance use).

Supervision, especially clinical supervision, provides the structure and support for CHWs to maintain a healthy relationship with clients and grow as a person. Clinical supervision should occur at least monthly. Ideally, the CHW should also have access to drop-in clinical supervision to address unexpected issues that are urgent in nature. The administrative supervisor can assist with this process (See [Supervisor Training Curriculum](#).)

Administrative Supervision Steps and Structure

One individual should be responsible for providing administrative supervision to the CHW; that is, a CHW should not have multiple administrative supervisors. The administrative supervisor's primary responsibility is to work with the CHW to manage client caseloads and their day-to-day activities. This person's responsibilities include:

- Assisting in managing referrals to the CHW from care team members and other partner agencies
- Assisting in developing steps to make sure the CHW is integrated into the care team
- Assigning new clients and helping to identify inactive and active clients, as well as those who may need to be discharged from the program
- Helping the CHW manage their schedule and work to decide on activities such as home visits
- Conducting check-ins for safety
- Managing CHW-client boundaries with clients and any potential staff-client issues
- Helping the CHW learn how to talk to clients about their HIV status
- Ensuring the CHW has access to resources to document their work in a professional and timely manner in agency records
- Performing annual reviews, which ideally would include confidential feedback from health care providers, case managers, and partners who work with the CHW

The best approach to administrative supervision is a strengths-based approach. A strengths-based or asset-based perspective is one that is focused on individual, group, or community resources, abilities, and/or talents.

The best approach to administrative supervision is a strengths-based approach. A strengths-based or asset-based perspective is one that is focused on individual, group, or community resources, abilities, and/or talents.¹⁹ This approach is based in the assumption that the solutions to community “problems” lie within the community, and that individuals are experts in their own lived experience. As such, engaging them in decision-making will lead to solutions that are relevant, realistic, and sustainable. The administrative supervisor should also encourage the CHW to practice self-care.

During supervision, it can be important to assess maintenance of professional boundaries between the CHW and supervisory staff. The administrative supervisor is usually not a clinician (e.g., social worker, counselor/therapist, psychiatric nurse practitioner, or psychiatrist) but training in supportive supervision techniques is important for them.



Tips for Administrative Supervision

- Provide regular formal on-on-one administrative supervision at least once-per-week. Encourage self-reflection as a way to focus these meetings. Maintain an “open-door policy” so the CHW can feel comfortable bringing issues to you in between formal supervisory meetings.
- Administrative supervisors should establish a regular place and time for supervision to discuss work, cases, and review documentation. A checklist may be helpful to a supervisor to review topics and provide feedback to staff. [Appendix K](#) contains a sample checklist used for clinical supervision, but may also be useful to administrative supervisors for discussing topics to support CHW work. It is important that supervisory staff get support from their managers.

If your organization has more than one CHW you may want to consider offering group supervision to discuss cases and strategies and problem solve as group, in addition to individual supervision.

- If CHWs are people with HIV and also receive care at your agency, the administrative supervisor may need to specifically address balancing the CHW’s role as a member of the care team versus being a client. Talk with the CHW about how to discuss client cases with the care team, and



Lessons from the Field

At East Carolina University, administrative supervisors maintain an “open door policy” on top of regularly scheduled administrative supervisor check-ins. CHWs also receive regular monthly clinical supervision with behavioral health providers. In interviews with the CHWs, they described the importance of regular, structured supervision time on top of having informal access to administrative supervision.

¹⁹ Kim, JS. (2008). Strengths Perspective. *The Encyclopedia of Social Work*. Available at: <https://oxfordindex.oup.com/view/indexcard/10.1093/002f9780199975839.013.382>



Lessons from the Field: CrescentCare's Supervision Structure

At CrescentCare in New Orleans, LA, CHWs meet weekly for administrative supervision and monthly for clinical supervision. CHWs are viewed as a priority. Despite busy schedules, both CHWs and the supervisor find time to meet, because consistency is important to meet clients' needs, and to ensure that the CHWs receive necessary support. During supervision, case consultation is provided to address client needs. Strategies to strengthen relationships and support CHW integration into the care team, successes, and opportunities for improvement are also discussed.

CrescentCare also has consistent meetings for supervisors to discuss challenges and opportunities to improve the agency's supervision system for CHWs and other staff. This time also promotes self-care for supervisors.

expectations around confidentiality and privacy with respect to accessing medical records. Advocate for the CHW as a professional member of the team and guide the care team members on the CHW's role. The administrative supervisor's role is critical for establishing trust and strong working relationships between the CHWs and other care team members.

- Develop and maintain a process for formal and informal debriefing for difficult and traumatic situations with which CHWs and other staff may be involved, including the death of a client. Determine what the roles of both the administrative and clinical supervisors are in the process and what the contingency plan is if neither are available to address an urgent need.
- Help CHWs develop personalized self-care plans and provide administrative support for self-care.
- Identify opportunities for professional growth and development. The McGregor Clinic's CHW spends 50% of her time with the prevention team, so she is also trained in testing and counseling. Encourage CHWs to participate in state associations, advocacy groups, and to attend national conferences to develop skills.
- Create an equitable approach for expressing appreciation for the work your CHWs (and other staff) perform. Celebrate successes!



Tips for Ensuring CHW Safety

The development and implementation of a formal process to debrief situations that supports CHWs and other clinic staff following disturbing, difficult events will help to prevent burnout and identify potential safety issues. (See [Appendix L](#).)

Tips for ensuring the safety of CHWs include:

- Create protocols that support safety in the field.
- Establish protocols to support CHWs when they are working out of the clinic.

Examples include:

- » CHWs should always carry a charged cell phone.
- » Whenever CHWs leave the clinic to meet a client in the field, a “status update” email or text with a brief summary of where the CHW will be and when they expect to return is sent to key staff (including supervisors).
- » CHWs check in after a field visit is completed by sending a “status update” email or text stating field work is complete.
- » In addition to the formally assigned supervisor, CHWs should be given access to all supervisors at the RWHAP provider site so that in an emergency, CHWs can get real-time support.

Clinical Supervision Steps and Structure

Use a trauma-informed care approach. A trauma-informed care (TIC) approach recognizes that CHWs are working with clients who may have experienced life events with harmful effects that may have lasting impact on their emotional, spiritual, and physical well-being. It is essential to create an environment where staff and clients feel they are safe and can manage stress. Clinical supervision provides the CHWs with a safe, uninterrupted time to share experiences and gain a deeper understanding of reactions that are triggered in their work as CHWs. As CHWs work with people with HIV, they may hear about experiences of trauma or stigma from a client. These experiences can be transferred to the CHW which, in turn, may bring up their own trauma or reactions and make it hard to maintain a relationship with clients. Clinical supervision can help a CHW manage those reactions, maintain their relationship with clients and staff, and prevent burnout.



Tips from the Field

A supervision structure at an urban Midwest clinic comprises an administrative supervisor (B.A. degree) who meets individually with peers to review caseload size, frequency of client contact, completion of case notes in the EMR, documentation of case conferencing with the care team, follow-up on clients who are on the lost-to-care lists, any workplace concerns, and discussion of attendance or time-off requests. Group clinical supervision—facilitated by a Licensed Clinical Social Worker—occurs as part of the team’s monthly meetings where each peer shares a client case, the successes and challenges, and assessment for boundaries, transference, and countertransference.

Establish peer supports for CHWs via regular meetings with CHWs in other departments across your organization. If other departments (such as behavioral health, adult medicine, or pediatrics) employ CHWs, encourage CHWs across departments to meet regularly (monthly or bimonthly) to share and discuss strategies for working with their respective client populations. This can provide additional support for CHWs across the organization.

At most of the participating RWHAP clinics, clinical supervision was provided individually for at least one hour weekly for the first three months, and then subsequently for a minimum of one hour monthly. CHWs were also included in any group supervision with case managers, peer navigators, or other relevant staff.

Support CHW Professional Growth

Connect and encourage CHWs to be active members of local and state organizations for workforce development, HIV planning, and other advisory groups that can support their work and address the needs of clients.

As part of professional development, supervisors can play an active role in supporting CHWs to join local and state advocacy organizations, such as Ryan White Planning Councils, housing committees and coalitions, and other similar groups. Participation in these groups can help CHWs build their skills and knowledge about HIV and other social or medical conditions that may impact their work with clients. (See [Section 7](#).)

“ To CHWs: Get and stay connected to CHW networks and associations as a way to connect/recharge/learn/teach.”



Tips from the Field

- Supervisory and management staff need to be flexible and nimble enough to respond in real time to CHW issues. CHW work is rarely linear.
- CHWs who come to the job with more experience may be more resilient and need less support and supervision. Be prepared to provide more direct supervision and debriefing time to less experienced CHWs.
- CHWs and clients alike may learn best by doing. Support experiential learning.
- Start small. Implement a new CHW program with a small number of clients and grow the caseload slowly.
- Performance Assessment is a key element of supervision. The 1917 Clinic at the University of Alabama, Birmingham uses a staff assessment tool that includes a staff self-assessment. It can be a good experience for staff to participate in their performance assessment including setting goals for themselves. (See [Appendix K](#).)
- Establish clear expectations around client-CHW boundaries particularly around texting and phoning clients as well as after-hours work. Monitor what is going on and address problems in real time. (See [CHW Training Curriculum](#).)
- Collect and address feedback from your care team about the successes and shortcomings of the new CHW services. Everyone's input can help to strengthen the services and clinical outcomes of clients receiving them.
- Approach the work with a trauma-informed care lens. Decide what trauma-informed care means in the context of your organization and provide ALL staff with training. The Jacques Initiative in Baltimore uses a [Trauma Informed Care Supervision Guide](#) to support staff in their work with clients. (See [Appendix K](#).)
- There can be a feeling of "three-steps forward, one-step back" when working with people with HIV who have high unmet needs. Encourage CHWs and the entire care team to celebrate any success no matter how small.
- Remember to coach your CHWs on charting in the medical record. Review chart notes on a regular basis. In the beginning, the form and content of all chart notes should be reviewed with the CHW and feedback provided. Once the CHW has satisfactorily demonstrated proficiency in documentation, the frequency of chart audits can be scaled back. In addition to the quality of the written documentation, the supervisor needs to assure that chart notes are completed in a timely manner for all encounters.



SECTION 6

Quality Improvement (QI) and Evaluation of CHW Programs and Interventions

- General Quality Improvement and Evaluation Steps
- Sample Logic Model

Section 6

Quality Improvement (QI) and Evaluation of CHW Programs and Interventions

Ensuring quality of care and services requires ongoing assessment and evaluation of program goals and objectives. CHW programs should establish evaluation structures that address both 1) process indicators and 2) outcome indicators, including those that address how the program is being implemented and those that address the effectiveness of the program. All programs should also conduct regular ongoing quality improvement (QI) activities.

Establishing systems to document the activities of CHWs can help the care team identify the contributions of the CHWs in meeting client needs and achieving clinic goals. These systems can also help improve the quality of the care team's service delivery by identifying gaps in referral and communication systems, and call to the team's attention barriers that clients experience that limit access to care or adherence to treatment.

General Quality Improvement and Evaluation Steps

Below are some basic steps that can be taken to ensure ongoing quality and process improvement:

1. **Develop a logic model.** One of the first steps to help think about how to conduct quality improvement and internal evaluation activities is to create a logic model for the CHW program.

A logic model is a tool that describes the program's:

- Goals and objectives
- Inputs (e.g., staff, resources required for the program to achieve the goals and objectives)
- Outputs (e.g., measures to track the progress of CHW activities, number of referrals to mental health made by the CHW, number of group HIV education sessions, number of outreach events to recruit clients)
- Short-term outcomes (e.g., increased knowledge of HIV, increased rate of completion of client referrals)
- Medium-term outcomes (e.g., increased retention in care)
- Long-term outcomes (e.g., increased viral suppression)

A logic model can guide the program and provide data and information on its progress and success, as well as gaps that need to be addressed. [Figure 3](#) shows a sample logic model for a CHW program working to enhance linkage and retention in care for people with HIV who are newly diagnosed and out of care.

2. **Establish monitoring and evaluation systems** to document and track referrals and other CHW activities that feed into the overall clinic's quality management system. Assure CHW work is reflected in the quality improvement activities and management structure.
3. **Assign a team member, preferably the administrative supervisor, to oversee the documentation of the CHW work.** Review this documentation at least monthly (and more often in the earlier stages to address any challenges or irregularities) and report to the clinic/organization's quality management team.
4. **Identify process and quality targets and regularly measure progress against those targets.** Targets should be specific and measurable. One way to do this is to identify targets for the short, medium, and long-term outcomes that are included in the logic model. This will help determine how well the CHW program is meeting its goals. For example, you may want a target of at least 80% of clients being screened for STIs, or you may want to see a 25% increase in rates of viral suppression among enrolled clients. Targets should be meaningful, but also attainable. Be selective about the number of outcomes to measure; more is not always better. Review progress for each target regularly to identify progress, develop action plans for improvement, and modify targets as needed. (See [Appendix M](#).)
5. **Implement a "Plan, Do Study Act (PDSA)" cycle to try out new tasks for CHWs to help engage clients in care.** Plan Do Study Act is a quality improvement approach where staff come up with a new task to address an identified gap in services or challenge in the organization, collect information in a specified time frame to examine if the new task is working, and then examine the data to determine how the program or policy can be adapted.²⁰ Using the PDSA cycle work with CHWs and clients to come up with simple tasks or activities that could impact retention in care and viral suppression. Review this documentation at least monthly (and more often in the earlier stages to address any challenges or irregularities) and report to the clinic/organization's quality management team.

²⁰ Institute for Healthcare Improvement. Model for Improvement: Plan-Do-Study-Act (PDSA) Cycles. Accessed on April 21, 2019 at <http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>.



Lessons from the Field: Involving CHWs in Quality Teams through the PDSA Process at Multnomah County Health Department (MCHD)

CHWs were involved in all aspects of Quality Improvement (QI) at the MCHD HIV Clinic on an ongoing basis. CHWs were trained along with other staff on QI methods. CHWs designed and lead several innovative improvement projects. These projects addressed concerns raised by both coworkers and clients.

For example, one CHW helped to address the issue of HIV and methamphetamine (meth) use in the gay community after hearing from clients about their struggles with meth and sex. The CHW and clients came up with the idea of using a book group format to pull together a support group around meth use and healthy living with HIV. The Thriving Men Book Club was created and piloted.

With the help of clients and the clinic's Client Advisory Board (CAB) members, the CHW created a book list and polled clients to access level of interest, days and time and most convenient locations. The findings were presented to the clinic management team (CMT). The idea was well received by CMT with one caveat—that the CHW collaborate with licensed counseling staff to deal with difficult emotions that might surface during the group discussion. Clinic leadership was also helpful with providing space, copies of books and refreshments. The first book was *Men, Meth and Lust* by David Fawcett. The CHW used discussion guides and exercises from the author to help the group find meaning and applications of the book's principles. Attendance fluctuated over the eight-week pilot, but a core group quickly surfaced and there was a regular attendance of 8 to 10 clients each session. Clients developed new insights into meth as well as new ways to relate and connect with their peers. Each session, clients provided feedback for improving the book group. The CHW was responsible to make these improvements. The buy in and cooperation of clients, management and CAB made this QI project a great success. The group went on to read other self-help books.

Another example is the service called Here for You! The clinic's Community Advisory Board (CAB) had piloted a clinic orientation and information sharing service called Here for You! Volunteer CAB members would set up coffee, tea and snacks in a designated area in the waiting area. CAB members welcomed clients and answered common questions about the clinic and HIV resources in the community. Sometimes clients would reveal serious issues that needed a quick intervention by a staff member. The CHW team through trial and error, decided to coordinate their schedules so that at least one of them was in clinic during Here for You! to support the CAB volunteers. This partnership enriched the CAB's volunteer efforts and improved client's real-time access to CHWs. It also helped CHWs connect with homeless clients who tended to drop in for coffee and treats during Here for You!

Figure 3. Sample Logic Model

Inputs	Outputs	Short-term Outcomes	Medium-term Outcomes	Long-term Outcomes
<p>Staff</p> <ul style="list-style-type: none"> • CHWs • Supervisors • Other health workers <p>Organizational</p> <ul style="list-style-type: none"> • Strong strengths-based supervision structure • Team meetings <p>Community Resources</p> <ul style="list-style-type: none"> • Access to other community health organizations <p>Technology</p>	<p>Client Recruitment/Referral to CHW</p> <ul style="list-style-type: none"> • Outreach (leaving the clinic and finding new clients) • Referrals to CHWs by case managers or other clinic staff • Presentations by CHWs at other community organizations (to find new clients) • Finding clients who have fallen out of care <p>CHW Documentation</p> <ul style="list-style-type: none"> • Goal plan • Encounter form • Assessment form • Reassessment form <p>Care Team Meetings</p> <ul style="list-style-type: none"> • CHWs in attendance • Discussing clients utilizing CHW services <p>CHW Supervision</p> <ul style="list-style-type: none"> • Administrative • Supportive • Clinical 	<ul style="list-style-type: none"> • Increased referrals to community partner organizations • Increased vaccination rate • Increased STI screening rate • Increased PAP/anal screening rate • Increased colonoscopy screening rate • Increased mammogram rate • Increased bone density screening rate • Increased client self-efficacy • Increased client knowledge of HIV 	<ul style="list-style-type: none"> • Increased client health literacy • Decreased self-stigma • Decreased client unmet needs • Increased linkage to care • Increased retention in care • Increased medication adherence • Increased integration of CHW in care team • Improved perception of CHW as valued member of care team • Increase in client satisfaction 	<ul style="list-style-type: none"> • Increased viral suppression • Decreased emergency department visits • Decreased hospitalizations



SECTION 7

Professional Development: Certification and Financing

- Encourage CHW Professional Development
- Local, State, and Regional CHW Networks
- Core Competency Training
- Becoming CHW Certified
- Useful Resources

Section 7

Professional Development: Certification and Financing

Because CHWs are so effective at helping to manage chronic disease, improving access to health care and preventive services, and serving vulnerable populations with complex needs, the CHW workforce has become the subject of intense focus in research and health policy development. CHWs are recognized as primary care professionals under federal law, and there are over 40 local, state, and regional CHW networks and associations across the U.S.



Did You Know?

- A growing number of states have adopted or are considering formalized credentialing programs for CHWs.
- Multiple federal grant programs are demonstrating the effectiveness of CHW interventions.
- State health departments are promoting CHW workforce development and supporting CHW employment to address a range of public health issues.
- Health providers are employing CHWs in integrated care teams to address multiple diseases and conditions.

Because CHWs are so effective at helping to manage chronic disease, improving access to health care and preventive services, and serving vulnerable populations with complex needs, the CHW workforce has become the subject of intense focus in research and health policy development.

Encourage Participation in Local, State, or Regional CHW Networks

Appendix F lists states with active CHW organizations, which typically provide opportunities for training and professional networking, and which may be involved in supporting workforce development initiatives, such as state certification programs. A national professional organization, the National Association of Community Health Workers (NACHW) exists to support and strengthen the profession's capacity to promote healthy individuals and communities. We encourage organizations to support CHW membership in NACHW.

Support CHWs in Completing Core Competency Training

A number of states have or are developing standardized training to assure CHWs have sufficient mastery of the roles and skills defined by the CHW Core Competency (C3) Initiative²¹ or similar standards. These standardized CHW training programs may be offered by independent training organizations, community colleges, or other entities. They are increasingly becoming integrated into publicly sanctioned CHW credentialing programs. Information about core competency and specialized training for CHWs in your state should be available from your state health department.

Encourage CHWs to Become Certified

Voluntary certification of CHWs is growing as a result of advocacy and initiatives by national CHW leaders and other key stakeholders to promote increased recognition and support for the workforce and in response to providers and payers who desire standardized CHW scopes of practice and training. Refer to Appendix E to see the status of CHW certification in your state. For more information about certification and training, visit the Association of State and Territorial Health Officials.



Lessons from the Field: Training CHWs in Texas and Maryland

Legacy Community Health in Houston sent the Community Health Worker in their HIV Linkage Program to the State of Texas Promotor(a)–Community Health Worker training and certification program. The CHW participated in a 160-hour competency-based training program, gaining skills to work in the primary health care and community settings. (<https://www.dshs.texas.gov/mch/chw/chwdocs.aspx>)

CHWs at the Jacques Initiative in Baltimore, MD, are participating in continued training with the Baltimore Area Health Education Center (AHEC) in conjunction with the Maryland AHEC. The Maryland Workgroup recommends this training for Workforce Development, which is currently active in CHW certification in Maryland. More information can be found at:

<http://www.medschool.umaryland.edu/mahec/Community-Health-Worker-Training-Institute/>
<http://baltimoreahec.org/community-health-worker/>

Maryland State Certification:

<https://health.maryland.gov/mhhd/Pages/Community-Health-Worker.aspx>

²¹Rosenthal, 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



Useful Resources

Center for Advancing Health Policy and Practice. (2009). Building Blocks to Peer Program Success: A Toolkit for Developing HIV Peer Programs. Available at: <https://ciswh.org/resources/HIV-peer-training-toolkit>

Sarango, M. (2014). Peer Re-engagement Intervention Project: Enhanced Peer Intervention Manual. Available at: <http://cahpp.org/wp-content/uploads/2015/04/intervention-manual.pdf>

Massachusetts Department of Health. (2016). Strategic Peer Enhanced Retention in Care (SPECTRuM) Manual. Office of HIV/AIDS. Available at: www.mass.gov/service-details/the-strategic-peer-enhanced-care-and-treatment-retention-model-spectrum

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

Center for Community Health and Development at the University of Kansas. Community Tool Box. Available at: <https://ctb.ku.edu/en>

JSI Healthy Start EPIC Center healthy start CHW online training and supervisor guide <https://healthystartepic.org/training-and-events/healthy-start-community-health-worker-course/>

Edward M. Kennedy Community Health Center CHW Orientation <http://www.centerforhealthimpact.org/wp-content/uploads/2015/12/CHW-Orientation-Toolkit.pdf>

CHW National Education Collaborative Guide Book (See [Appendix F.](#))

CDC CHW Certification Study link <https://www.cdc.gov/dhdsp/pubs/toolkits/chw-ta-background.htm>

CHW Central <https://www.chwcentral.org/>

APPENDIX

A Guide to Implementing a Community Health Worker (CHW) Program in the Context of HIV Care

Improving HIV Outcomes through the
Integration of CHWs in Care Teams



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APPENDIX A

C3 Roles and Skills¹

	Role	Sub-Roles
1	Cultural Mediation among Individuals, Communities, and Health and Social Service Systems	<ul style="list-style-type: none"> a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Education systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication
2	Providing Culturally Appropriate Health Education and Information	<ul style="list-style-type: none"> a. Conducting health promotion and disease prevention education in a manner that matched linguistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)
3	Care Coordination, Case Management, and System Navigation	<ul style="list-style-type: none"> a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping to address other barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges
4	Providing Coaching and Social Support	<ul style="list-style-type: none"> a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups
5	Advocating for Individuals and Communities	<ul style="list-style-type: none"> a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy
6	Building Individual and Community Capacity	<ul style="list-style-type: none"> a. Building individual capacity b. Building community capacity c. Training and building individual capacity with CHW peers and among groups of CHWs
7	Providing Direct Service	<ul style="list-style-type: none"> a. Providing basic screening tests (e.g. heights & weights, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g. direct provision of food and other resources)
8	Implementing Individual and Community Assessments	<ul style="list-style-type: none"> a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environment assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)

¹Rosenthal, E.L., Rush, C.H., and Allen C.G. Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field. Progress Report of the Community Health Worker (CHW) Core Consensus (C3) Project: Building National Consensus on CHW Core Roles, Skills, and Qualities. 2016; <http://www.chwcentral.org/understanding-scope-and-competencies-contemporary-look-united-states-community-health-worker-field>.

Role	Sub-Roles
9	Conducting Outreach <ul style="list-style-type: none"> a. Case-finding/recruitment of individuals, families and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events
10	Participating in Evaluation and Research <ul style="list-style-type: none"> a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: <ul style="list-style-type: none"> a. Identification of priority issues and evaluation/research questions b. Development of evaluation/research design and methods c. Data collection and interpretation d. Sharing results and findings e. Engaging stakeholders to take action on findings
Skill	Sub-Skill
1	Communication Skills <ul style="list-style-type: none"> a. Ability to use language confidently b. Ability to use language in ways that engage and motivate c. Ability to communicate using plain and clear language d. Ability to communicate with empathy e. Ability to listen actively f. Ability to prepare written communication including electronic communication (e.g. email, telecommunication device for the deaf) g. Ability to document work h. Ability to communicate with the community served (may not be fluent in language of all communities served)
2	Interpersonal and Relationship-Building Skills <ul style="list-style-type: none"> a. Ability to providing coaching and social support b. Ability to conduct self-management coaching c. Ability to use interviewing techniques (e.g. motivational interviewing) d. Ability to work as a team member e. Ability to manage conflict f. Ability to practice cultural humility
3	Service Coordination and Navigation Skills <ul style="list-style-type: none"> a. Ability to coordinate care (including identifying and accessing resources and overcoming barriers) b. Ability to make appropriate referrals c. Ability to facilitate development of an individual and/or group action plan and goal attainment d. Ability to coordinate CHW activities with clinical and other community services e. Ability to follow-up and track care of referral outcomes
4	Capacity Building Skills <ul style="list-style-type: none"> a. Ability to help others identify goals and develop to their fullest potential b. Ability to work in ways that increase individual and community empowerment c. Ability to network, build community connections, and build coalitions d. Ability to teach self-advocacy skills e. Ability to conduct community organizing
5	Advocacy Skills <ul style="list-style-type: none"> a. Ability to contribute to policy development b. Ability to advocate for policy change c. Ability to speak up for individuals and communities

	Skill	Sub-Skill
6	Education and Facilitation Skills	<ul style="list-style-type: none"> a. Ability to use empowering and learner-centered teaching strategies b. Ability to use a range of appropriate and effective educational techniques c. Ability to facilitate group discussions and decision-making d. Ability to plan and conduct classes and presentations for a variety of groups e. Ability to seek out appropriate information and respond to questions about pertinent topics f. Ability to find and share requested information g. Ability to collaborate with other educators h. Ability to collect and use information from and with community members
7	Individual and Community Assessment Skills	<ul style="list-style-type: none"> a. Ability to participate in individual assessment through observation and active inquiry b. Ability to participate in community assessment through observation and active inquiry
8	Outreach Skills	<ul style="list-style-type: none"> a. Ability to conduct case-finding, recruitment and follow-up b. Ability to prepare and disseminate materials c. Ability to build and maintain a current resources inventory
9	Professional Skills and Conduct	<ul style="list-style-type: none"> a. Ability to set goals and to develop and follow a work plan b. Ability to balance priorities and to manage time c. Ability to apply critical thinking techniques and problem solving d. Ability to use pertinent technology e. Ability to pursue continuing education and life-long learning opportunities f. Ability to maximize personal safety while working in community and/or clinical settings g. 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]) h. Ability to identify situations calling for mandatory reporting and carry out mandatory reporting requirements i. Ability to participate in professional development of peer CHWs and in networking among CHW groups j. Ability to set boundaries and practice self-care
10	Evaluation and Research Skills	<ul style="list-style-type: none"> a. Ability to identify important concerns and conduct evaluation and research to better understand root causes b. Ability to apply the evidence-based practices of Community Based Participatory Research (CBPR) and Participatory Action Research (PAR) c. Ability to participate in evaluation and research processes, including: <ul style="list-style-type: none"> a. Identifying priority issues and evaluation/research questions b. Developing evaluation/research design and methods c. Data collection and interpretation d. Sharing results and findings e. Engaging stakeholders to take action on findings
11	Knowledge Base	<ul style="list-style-type: none"> a. Knowledge about social determinants of health and related disparities b. Knowledge about pertinent health issues c. Knowledge about healthy lifestyles and self-care d. Knowledge about mental/behavioral health issues and their connection to physical health e. Knowledge about health behavior theories f. Knowledge about public health principles g. Knowledge about the community served h. Knowledge about United State health and social service systems

APPENDIX B

C3 Roles and the HIV Care Continuum²

Role	Sub-Roles	Example Links to HIV Continuum of Care
1 Cultural Mediation among Individuals, Communities, and Health and Social Service Systems	<ul style="list-style-type: none"> a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Education systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication 	Support and increase linkage, retention in care and adherence to treatment by: <ul style="list-style-type: none"> • Linking newly diagnosed in community to HIV care • Educating people with HIV about treatment and appropriate use of services
2 Providing Culturally Appropriate Health Education and Information	<ul style="list-style-type: none"> a. Conducting health promotion and disease prevention education in a manner that matched linguistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease) 	Improve adherence to treatment by: <ul style="list-style-type: none"> • Provide structures educations sessions about HIV, viral life cycle, treatment, side effects and support for treatment adherence • Understanding ADAP
3 Care Coordination, Case Management, and System Navigation	<ul style="list-style-type: none"> a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping to address other barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges 	Support retention in care by: <ul style="list-style-type: none"> • Assist with referrals for transportation, housing, substance use treatment, mental health treatment, food, and other basic needs • Education about the HIV service system
4 Providing Coaching and Social Support	<ul style="list-style-type: none"> a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups 	Support retention in care and adherence to treatment by: <ul style="list-style-type: none"> • Mentoring and coaching on how to talk with providers about HIV medications • Emotional support for people with HIV • Support with stigma and disclosure • Addressing resistance to treatment • Share life experiences and managing life with HIV (peer CHW)

²Amended from Rosenthal, E.L., Rush, C.H., and Allen C.G. Understanding Scope and Competencies: A Contemporary Look at the United States Community Health Worker Field. Progress Report of the Community Health Worker (CHW) Core Consensus (C3) Project: Building National Consensus on CHW Core Roles, Skills, and Qualities. 2016; <http://www.chwcentral.org/understanding-scope-and-competencies-contemporary-look-united-states-community-health-worker-field>.

Role	Sub-Roles	Example Links to HIV Continuum of Care
5 Advocating for Individuals and Communities	a. Advocating for the needs and perspectives of communities b. Connecting to resources for basic needs (e.g. food and housing) c. Conducting policy advocacy	Support individual capacity by (see 1-4) <ul style="list-style-type: none"> • Serve on planning councils and consumer advisory boards
6 Building Individual and Community Capacity	a. Building individual capacity b. Building community capacity c. Training and building individual capacity with CHW peers and among groups of CHWs	See role 5
7 Providing Direct Service	a. Providing basic screening tests (e.g. heights & weights, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g. direct provision of food and other resources)	Support treatment adherence by: <ul style="list-style-type: none"> • Prescription pick up and education on medication and side effects
8 Implementing Individual and Community Assessments	a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environment assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)	<ul style="list-style-type: none"> • Working with case manager on assessing needs of people with HIV and developing care plans
9 Conducting Outreach	a. Case-finding/recruitment of individuals, families and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events	Support linkage and retention: <ul style="list-style-type: none"> • Re-engage to the lost to follow up • Appointment reminders and accompaniment • Home visits for check-ins • Recruitment in community and attendance of events to reach newly diagnosed, hard to reach populations
10 Participating in Evaluation and Research	a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: d. Identification of priority issues and evaluation/research questions e. Development of evaluation/research design and methods f. Data collection and interpretation g. Sharing results and findings h. Engaging stakeholders to take action on findings	<ul style="list-style-type: none"> • Documentation of activities as part of the care team in the electronic health records

APPENDIX C

Quick Start Handout

Please answer the following questions to assess your organization's initial capability to implementing a CHW program:

- How will CHWs complement the roles and responsibilities of other team members such as case managers?
- What is the current caseload for case managers and the health care providers?
- What tasks can CHWs do to support the work of case managers in addressing client needs?
- How many CHWs can be hired to work with the team? Who will supervise the CHWs?
- Where will the CHW be housed: in a medical department or a CHW department?
- As a Ryan White Program, how will the CHW interact and support Case manager(s)?
- How will the CHW be integrated as a member of the care team?
- How can the CHW best be used to engage hard to reach populations?
- Are there specific populations that your organization wants the CHW to focus on for outreach?

APPENDIX D

Sample Job Descriptions

Job Description: Care Navigation Team Peer Advocate³

Position Summary: The Peer Advocates (PAs) will be members of the HIV/AIDS community (PLWHA) who will provide intensive home and community-based intervention services to support linkage and retention of clients (PLWHA) in healthcare. The Peer Advocate may accompany or meet individuals enrolled in care through the Hope Center to the services (as needed) to help to successfully navigate these systems and address barriers to successful retention in care. CNT Peer Advocates will assist in outreaching to clients newly diagnosed and lost to care and support engagement, support clients in achieving optimum health outcomes through the identification and removal of barriers, conduct orientation to medical services, accompany to appointments (as needed), provide education, offer emotional support and linkage to support services and system, address language and cultural barriers and assist the team with screening for co-morbidities which can impact access and retention in care.

Supervision: Behavioral Health Counselor Supervisor.

Activities:

- a. Act as a member of the multidisciplinary Care Navigation Team to address the needs of clients.
- b. Provide support to referred clients by assisting with navigation of medical appointments, orientation to care system/services, peer support and collaborating on addressing the needs identified in the joint service care plan.
- c. Offer emotional (peer-to-peer) support and assist with linkage needed to mental health services.
- d. Complete initial client intake (completing goal planning) and maintain enrollment of 20-25 clients per year.
- e. Participate as a member of the multidisciplinary team weekly staffing.
- f. Work with the Community Nurse to monitor kept medical appointments & CD4 counts quarterly to review each client's adherence.

³ Georgia Department of Public Health, North Central Health District, The Hope Center, Macon, GA.

- g. Help remove barriers to attending medical appointments by referring to appropriate professionals as needed such as mental health services, case management, substance abuse treatment, coordination of transportation, & delivery of on-site child care.
- h. Conduct home visits as appropriate to execute plan of care for clients.
- i. Maintain and complete required documentation for the client record for each care plan & intervention completed.
- j. Complete trainings in the delivery of strength-based care and complete required orientation.
- k. Attend CNT and medical provider staffing's.
- l. Participate in the Ryan White Care Consortium Meeting.

Minimum Qualifications:

- 1. 21 years of age or older
- 2. High School diploma or GED
- 3. Basic computer skills (familiarity with Microsoft Word and Excel, preferable)
- 4. Access to reliable transportation.
- 5. Have appropriate skills, relevant experience, cultural and linguistic competency, knowledge about HIV/AIDS & client confidentiality and knowledge of available health and social services related resources.

Preferred Qualifications:

- 1. Persons of color living with HIV.
- 2. Prior participation in consumer leadership training.

My signature indicates I have read and understand the above job description.

_____	_____
Employee	Date
_____	_____
Supervisor	Date

Job Description: Community Nurse Case Manager⁴

Position Summary: The Community Nurse Case Manager serves as a medical case manager for those newly diagnosed and/or those never in care or lost to care (lost-to-care are individuals who have no evidence of medical care for 12 months or more). This position is focused on improving the engagement and retention of people living with HIV/AIDS (PLWHA) in primary medical care that is consistent with HIV/AIDS clinical guidelines. The position functions as an integral part of the Hope Center's Care Navigation Team, consisting of a medical provider/nurse, case manager and Peer Advocates, charged with utilizing and evaluating innovative strategies to ensure newly diagnosed, never-in-care and lost-to-care PLWHA are engaged, re-engaged and retained in HIV care. Operating within the Hope Center and within the North Central Health District, this position coordinates closely with the clinical team of each enrolled client to ensure effective medical coordination; provides medical services to enrolled clients in nontraditional settings including visits in the home; and participates in clinical quality management and evaluation efforts both within the client's chosen HIV primary care provider site and the Care Navigation Teams.

Supervision: Behavioral Health

Activities:

1. Coordinate closely with chosen HIV medical provider of each enrolled client to:
 - a. Develop individualized treatment plan, assist with examination and treatment
 - b. Schedule ancillary medical care visits, provide follow-up to ensure appointments are kept
 - c. Work with pharmacies to ensure prescribed medications are received
 - d. Track health outcomes, laboratory results and procedures
 - e. Provide treatment adherence education
 - f. Perform other activities for effective medical management of patient needs
2. Participate fully with Care Navigation Teams to:
 - g. Complete Bio-psychosocial Acuity and other assessments
 - h. Develop care engagement plans, monitor and update plan goals
 - i. Assist with project evaluation efforts
 - j. Provide on-call clinical consultation to team members, including Disease Intervention Specialists performing outreach
3. Perform medical services via home visits to:
 - k. Assess the impact of the home environment on the health of enrollees
 - l. Provide health education and referrals tailored to household needs
4. Assist in clinical quality management efforts at HIV medical provider sites, to include:
 - m. Participating in quality improvement activities according to the site's quality management plan and designated performance indicators

⁴Georgia Department of Public Health. North Central Health District, The Hope Center, Macon, GA.

- n. Review medical records of enrolled clients to ensure care received is consistent with established HIV/AIDS clinical guidelines. These activities may be coordinated with existing Ryan White Part A or Part C clinical chart reviews.

Minimum Qualifications:

- 1. Graduate of an accredited school of nursing with current RN licensure in the state of Georgia, with 3-5 years of clinical experience, preferably in home-based or community-based nursing care.
- 2. Computer skills.
- 3. Access to reliable transportation.

My signature indicates I have read and understand the above job description.

_____	_____
Employee	Date
_____	_____
Supervisor	Date

Job Description: Linkage to Care Case Manager⁵

Position Summary: The Linkage to Care case manager is responsible for coordinating services for Ryan White eligible clients and patients of the HOPE Center. This position assigned to the HOPE Center will be focused on providing medical case management to those newly diagnosed or new to care, who are living with HIV/AIDS. The position works closely with a Care Navigation team that includes medical providers and peer advocates. The Linkage to Care case manager works intensively with clients for a minimum of 90 days coordinating care services that engage and retain clients in their care and treatment.

Supervision: Behavioral Health Counselor Supervisor.

Activities:

1. Intake
 - a. Verification of HIV status
 - b. Consent to participate
 - c. Verification of financial eligibility
 - d. Contact information, demographic information
2. Assessment
 - a. Assessing the client's status according to the following areas:
 - i. Financial and Resource Evaluation
 - i. Substance Use and Mental Health Screening
 - ii. Stability of Housing Screening
 - iii. Domestic Violence Screening
 - iv. Transportation to Medical Appointments
 - v. Immunizations, Nutritional and other Basic Needs
 - vi. Clients' readiness to take meds or adherence
3. Wellness Plan (client involvement)
 - a. Development of Wellness Plan
 - b. Implementation of Wellness Plan
4. Monitoring, Follow-up, Reassessment
 - a. Track adherence, labs, progress of care
 - b. Follow-up on referrals
 - c. Update Wellness Plan as needed
 - d. Follow-up with client on progress towards identified goals
5. Service Coordination and Resource Identification
 - a. Complete Housing Information and Referral Center (HIRC) to ensure identified resources are entered into HIRC database

⁵ Georgia Department of Public Health. North Central Health District, The Hope Center, Macon, GA.

- 6. Administration and Reporting
 - a. Completion of client eligibility screening
 - b. Complete and submit required forms appropriate contacts
 - c. Complete assessments as required by RWPB Policy and Procedure Manual
 - d. Monthly/Quarterly grantee reporting requirements
 - e. Financial record keeping and reporting
- 7. Other duties and responsibilities
 - a. Attendance at required trainings
 - i. Case manager meetings/teleconferences

My signature indicates I have read and understand the above job description.

_____	_____
Employee	Date
_____	_____
Supervisor	Date

CHW Program Internal Handout–Legacy Community Health

Do you have a patient with HIV that is struggling to stay in care?

A CHW can help! They can:

- ✓ Meet with newly diagnosed or out of care patients with HIV, regardless of Ryan White or insurance status
- ✓ Conduct one-on-one education sessions with patients regarding HIV, medication adherence, and lab results
 - No time limit to patient meetings
- ✓ Act as a liaison between patient and providers/case managers, as well as pharmacy, eligibility, and financial services
- ✓ Empower clients to become advocates for their care



Contact for questions or referrals:
Savanna (Savi) Bailey x6530
Community Health Worker
Based out of LMM and LMC



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Sample Interview Questions—Legacy Community Health

Example Interview Questions

- Give me an example of a time that you felt you went above and beyond the call of duty at work.
- Can you describe a time when your work was criticized?
- Have you ever been on a team where someone was not pulling their own weight? How did you handle it?
- Tell me about a time when you had to give someone difficult feedback. How did you handle it?
- What is your greatest failure, and what did you learn from it?
- What irritates you about other people, and how do you deal with it?
- If I were your supervisor and asked you to do something that you disagreed with, what would you do?
- What was the most difficult period in your life, and how did you deal with it?
- Give me an example of a time you did something wrong. How did you handle it?
- Describe how you would handle a situation if you were required to finish multiple tasks by the end of the day, and there was no conceivable way that you could finish them.
- What do you look for in terms of culture—structured or entrepreneurial?
- What is your personal mission statement?
- What are three positive things your last boss would say about you?
- What negative thing would your last boss say about you?
- What three character traits would your friends use to describe you?
- What are three positive character traits you don't have?
- If you were interviewing someone for this position, what traits would you look for?
- List five words that describe your character.
- Tell me about yourself.
- What are your strengths?
- What are your weaknesses?
- Why do you want this job?
- Where would you like to be in your career five years from now?
- What's your ideal company?
- What attracted you to this company?
- Why should we hire you?
- What did you like least about your last job?
- When were you most satisfied in your job?
- What can you do for us that other candidates can't?

- What were the responsibilities of your last position?
- Why are you leaving your present job?
- What do you know about this industry?
- What do you know about our company?
- Do you have any questions for me?
- How would you describe your work style?
- What would be your ideal working environment?
- Give examples of ideas you've had or implemented.
- What techniques and tools do you use to keep yourself organized?
- If you had to choose one, would you consider yourself a big-picture person or a detail-oriented person?
- Tell me about your proudest achievement.
- Who was your favorite manager and why?
- What do you think of your previous boss?
- What kind of personality do you work best with and why?
- What are you most proud of?
- What are three positive character traits you don't have?
- If you were interviewing someone for this position, what traits would you look for?
- What is your greatest fear?
- What will you miss about your present/last job?
- What is your greatest achievement outside of work?
- What do you do as down time for self-care?
- How do you balance who you are verses what you do?
- How would you feel about working for someone who knows less than you?
- Tell me one thing about yourself you wouldn't want me to know.
- Tell me the difference between good and exceptional.
- What do you like to do for fun?
- What do you do in your spare time?

Source: Legacy Community Health

Community Health Worker Program Rack Card–The McGregor Clinic

The Role of Community Health Workers (CHWs) in HIV Care, Treatment and Support

What a Community Health Worker Does

As members of the health care team, CHWs promote treatment adherence and foster trust in the health care system. They help clients navigate the, sometimes, intimidating world of HIV treatment and service by providing a range of support activities that include:

- Explaining the basics of HIV/AIDS and self-care to the newly diagnosed and recently re-engaged
- Connecting people with needed services
- Facilitating positive behavior change using culturally appropriate coaching techniques
- Empowering clients to become self-advocates along their treatment journey
- Acting as liaison between clients, case managers and medical providers

For people living with HIV/AIDS, the realities of treatment and self-care can be overwhelming. Through shared experiences and knowledge of the community, CHWs can relate to clients in a way that health care medical staff often cannot. Community Health Workers offer encouragement and emotional support by:

- Offering a safe space for clients to express perceived barriers to treatment while offering strategies for success
- Serving as a “voice of experience” by proactively addressing and discussing shared cultural issues
- Inspiring healthy self-management behaviors

CHWs are an empathetic and understanding shoulder to lean on reminding clients that they are not alone.

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Community Health Worker Job Description–Southern Nevada Health District



Community Health Worker Job Description

Background: The Southern Nevada Health District (SNHD or the District) Community Health Workers (CHW) fall under the Disease Data Collection Specialist (DDCS) classification. The District's HIV Care Services programs work under the overarching theories of self-efficacy and harm reduction and utilize strengths-based and client-centered principles to ensure that decisions are inclusive of and guided by patient preferences. The District's HIV Care Services team include CHW's, clinic providers, medical assistants, clinic nurses, nurse case managers, social worker/linkage coordinator, eligibility workers, and a medical case manager. Interdepartmental collaboration with the Office of Epidemiology and Disease Surveillance allows for coordination of services to quickly engage newly diagnosed or re-engage out-of-care clients in medical care.

Job Summary: CHW's are integral members of the District's HIV Care Services team. They collaborate with the interdisciplinary team as well as community partners to develop and implement strategies to improve care and health outcomes for people living with HIV (PLWH). CHW's will use their unique positions as trained community members to provide trust-based information, education, and peer support; help clients cope with and overcome fear; walk clients through the complex healthcare system; help bridge gaps that may exist between clients and healthcare service providers; and help clients strategize and develop practical life skills for self-management in the context of a complicated life.

Primary Responsibilities:

- Identify individuals newly diagnosed with HIV and not sufficiently engaged in HIV medical care by utilizing incoming referrals, clinic information on missed appointments, and outreach to various community organizations and venues;
- Work to build trust and confidence of clients;
- Provide accurate information to clients about living with HIV including benefits and challenges of HIV care and treatment and available services;
- Provide information on prevention of further transmission;
- Provide one-on-one assistance to engage or re-engage clients in medical care;
- Recognize that even small steps count: provide positive affirmations to help clients develop self-efficacy and confidence about their participation in HIV treatment and self-management;
- Work effectively with interdisciplinary team to identify service gaps such as transportation, housing, and mental health and substance use disorders;
- Attend and participate in team, morning, and community partner meetings regularly
- Refer clients to available services within the District and in the community;
- Accompany clients to appointments at the request of clinic or client;
- Apply appropriate role definition and skilled boundaries;
- Promote the CHW program in consultation with program supervisor;
- Complete all research related assessments and documentation in a timely manner, if work is part of a research study
- Maintain confidential and accurate files;
- Comply with agency policies and procedures, including but not limited to maintaining confidentiality of clients and business operations in accordance with SNHD policies;
- Other duties as assigned.



COMMUNITY HEALTH WORKER I/II

Class Code:
2971

Bargaining Unit: Eligible

SOUTHERN NEVADA HEALTH DISTRICT
Established Date: Oct 25, 2018
Revision Date: Oct 29, 2018

SALARY RANGE

\$18.11 - \$25.32 Hourly

\$1,449.02 - \$2,025.60 Biweekly

\$37,674.58 - \$52,665.72 Annually

DEFINITION:

To provide services that increase health knowledge, self-sufficiency and support self-management of diseases and health conditions to assigned clients/families through a range of activities such as outreach, health education, connecting individuals with resources, informal counseling, social/peer support and advocacy.

To support providers, health educators and case management teams through an integrated approach to care management and community outreach.

A year of community outreach experience is necessary if advancement is to be considered. Advancement to a CHW II position is not automatic and is based on position availability, funding, minimum requirements met, and interview outcomes.

EXAMPLES OF ESSENTIAL RESPONSIBILITIES AND DUTIES:

EXAMPLES OF ESSENTIAL RESPONSIBILITIES AND DUTIES – This class specification lists the major duties and requirements of the job and is not all-inclusive. Incumbent(s) may be expected to perform job-related duties other than those contained in this document and may be required to have specific job-related knowledge and skills

- Responsible for establishing trusting relationships with community members, clients and their families from diverse populations while providing general support and encouragement.
- Conducts interviews and communicates effectively with clients using basic motivational interviewing and goal setting via phone calls, home visits and visits to other settings where clients can be found.
- Demonstrate sensitivity and understanding of diverse socioeconomic, cultural, ethnic and health issues.
- With case manager/provider/health educator oversight, provides services such as case management, care coordination and system navigation of medical care and/or community resources through informal counseling/education, social/peer support, and the tracking of client progress/well-being.
- Responsible for client interactions and education involving health issues such as HIV/AIDS, substance abuse, chronic disease, behavioral health, child-rearing,

4/9/2019

Southern Nevada Health District - Class Specification Bulletin

parenting or other health concerns.

- Conducts health promotion and prevention education that is sensitive to the cultural and linguistic needs of participants and/or community.
- Prepares and maintains appropriate paper work and records. Complete documentation and data entry needed for medical records and grant funding.
- Acts as client and community advocate; advises clients on available and appropriate medical and social services; advocates for the needs and perspectives of the communities.
- May provide program outreach such as home visiting activities, participate in individual and community assessments, community outreach and health screening events, distribution of flyers and brochures, and deliver presentation at local agencies and community events.

QUALIFICATIONS:

QUALIFICATIONS

Knowledge of:

- Principles and procedures of medical record keeping/documentation correct business English, including spelling, grammar and punctuation.
- Pertinent Federal, State and local laws, codes, and regulations applicable to the program assigned.
- Community resources appropriate to the health/social needs of clients and their families.
- Current information pertaining to the symptoms, control, treatment, and effects of chronic disease and/or conditions (HIV/AIDS, substance abuse, mental illness, etc.) on clients and their families applicable to the assigned program.
- Collaborative case planning with the care team.
- Computer applications related to the assigned position such as Microsoft Word/Outlook and an Electronic Health Record.

Ability to:

- Utilize the most appropriate community resources to provide effective client services.
- Work with diverse populations in a health or human services program.
- Prepare clear and concise reports, correspondence and other written materials.
- Operate a computer and software applicable to the position.
- Use initiative and independent judgment within established procedural guidelines; organize own work, set priorities and meet critical deadlines.
- Establish and maintain effective working relationships.
- Communicate well orally, in writing and over the telephone. with a variety of individuals from diverse backgrounds.

TRAINING AND EXPERIENCE GUIDELINES

COMMUNITY HEALTH WORKER I

Training

- Equivalent to graduation from high school

Experience

- Preferred: minimum of one year of experience in non-profit/community advocacy work or completion of Community Health Worker training
- Prior experience in medical record keeping desirable.

COMMUNITY HEALTH WORKER II

4/9/2019

Southern Nevada Health District - Class Specification Bulletin

A complete understanding of the surveillance systems is necessary if advancement is to be considered. Advancement to a Community Health Worker II position is not automatic and is based on position availability; funding, minimum requirements met, and interview outcomes.

Training

- Equivalent to graduation from high school

Experience

- Minimum of one year of experience in community out-reach work
- Completion of Community Health Worker Certificate Program
- Prior experience in medical record keeping desirable.

License/Certification

- Possession of or ability to obtain and maintain a valid Nevada Driver's License as a condition of employment.

SUPERVISION RECEIVED AND EXERCISED:

Supervision provided by the Supervisor responsible for the program

SPECIAL NOTES AND REQUIREMENTS:

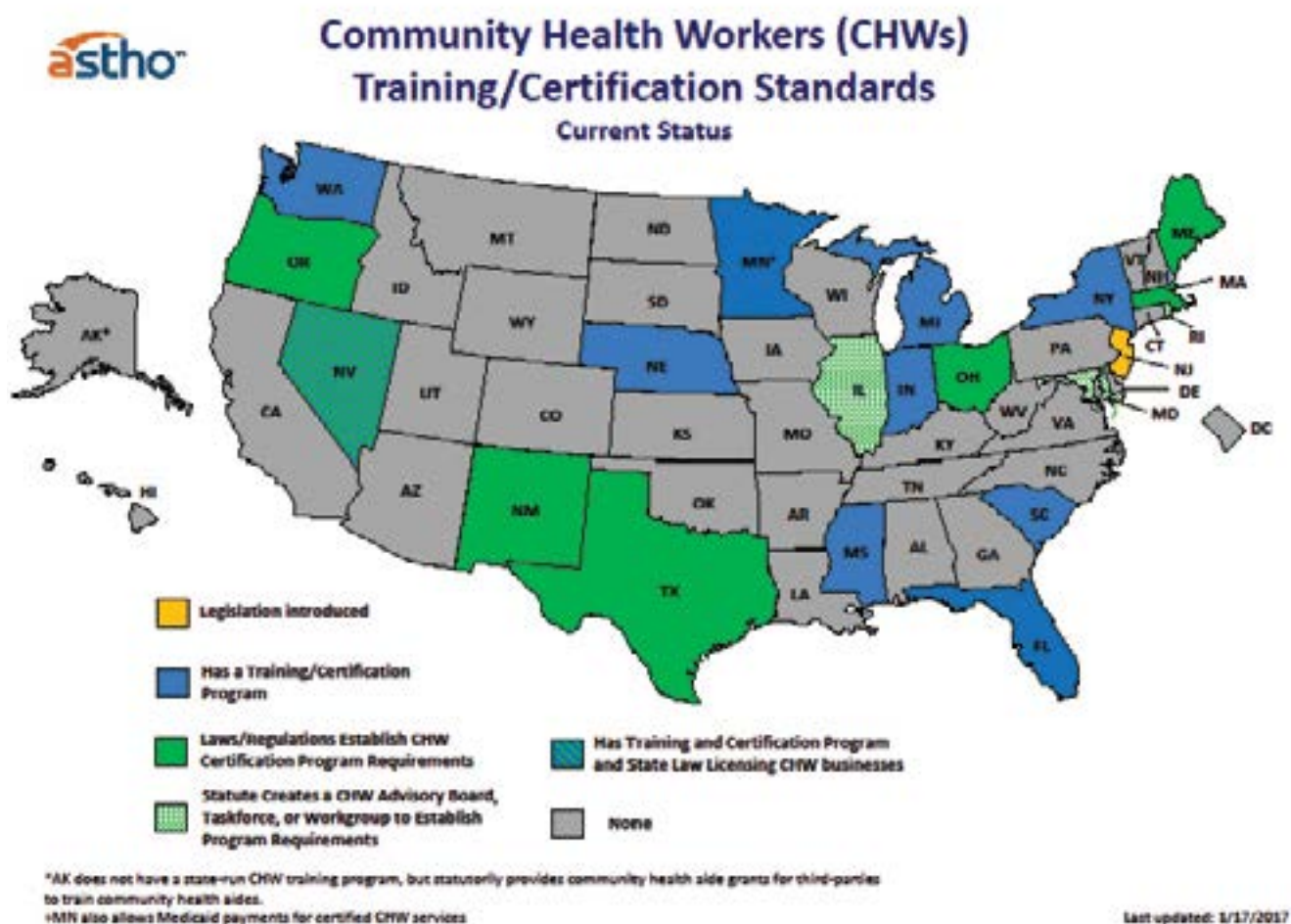
- May be required to be bilingual in Spanish/English
- May be required to visit individual client residences
- May work with individuals having infectious or communicable disease
- May work with small amounts of cash
- May be required to travel to different locations using own personal vehicle
- Work hours may occasionally include weekends and evenings

CONDITIONS:

All required licenses must be maintained in an active status without suspension or revocation throughout employment. Any employee may be required to stay at or return to work during public health incidents and/or emergencies to perform duties specific to this classification or to perform other duties as requested in an assigned response position. This may require working a non-traditional work schedule or working outside normal assigned duties during the incident and/or emergency.

APPENDIX E

List of States with CHW Certification and Training Programs⁶



For full document LINK: <http://www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards-Map/>

⁶ ASTHO. CHWs Certification Standards Map and Chart. Accessed at <http://www.astho.org/Public-Policy/Public-Health-Law/Scope-of-Practice/CHW-Certification-Standards-Map/>. 2017.

APPENDIX F

List of State CHW Associations

State	CHW Association?	Name of State Association	Website URL	Training Resources	HIV Resources	Other Useful Links
Alabama	no			N/A	N/A	
Alaska	yes	Alaska Community Health Aide Program	http://www.akchap.org/html/home-page.html	Yes	No	
Arizona	yes	Arizona Community Health Worker Association	http://www.azchow.org/	No	no	
Arkansas	yes	Arkansas Community Health Worker Association	http://www.archwa.org/	Yes	Chronic illness	
California	yes	California Association of Community Health Workers	http://www.cachw.org/	http://www.cachw.org/curriculum/	No	
Colorado	yes	Colorado Community Health Worker Collaborative	https://sites.google.com/site/copnchwcollaborative/home	N/A	N/A	
Connecticut	In progress			N/A	N/A	
Delaware	no			N/A	N/A	
Florida	Yes	Florida Community Health Worker Coalition	http://floridachw.org/	No	No	
Georgia	no			N/A	N/A	
Hawaii	no			N/A	no	
Idaho	yes	Idaho Community Health Worker Advisory Group	http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.aspx	not for public viewing	Not for public viewing	

State	CHW Association?	Name of State Association	Website URL	Training Resources	HIV Resources	Other Useful Links
Illinois	Not a specific association yet			http://www.sinai.org/content/suhi-projectcommunity-health-worker-programs-chicago%E2%80%99s-health-care-institutions-research-and	http://www.sinai.org/content/suhi-project-suhis-hivstd-related-evaluations	
Indiana	yes	Indiana Community Health Workers Association	http://www.inchwa.org/	http://www.in.gov/isdh/24942.htm	No	
Iowa	no			N/A	N/A	
Kansas	no			N/A	N/A	
Kentucky	yes	Kentucky Association of Community Health Workers	http://kyachw.org/	Not for public viewing	Not for public viewing	
Louisiana	yes	Louisiana Community Health Outreach Network	http://lachon.strikingly.com/	Not for public viewing	Not for public viewing	
Maine	yes	Community Health Worker Initiative of Maine	http://www.mechw.org/who.html	www.mechw.org/docs/resources/other/ME%20CHW%20Inventory-FINAL.docx	No	
Maryland	no, but in the works		http://www.institutephi.org/our-work-in-action/community-health-worker-initiatives/	http://esahec.org/services/community-health-worker-training/	N/A	
Massachusetts	yes	Massachusetts Association of Community Health Workers	http://www.machw.org/	http://www.machw.org/index.php?option=com_content&view=article&id=32&Itemid=146	no	
Michigan	yes	Michigan Community Health Worker Alliance	http://www.michwa.org/	http://www.michwa.org/chw-training/#MiCHWA_CHW_Curriculum	No	http://www.michwa.org/chwimpact/

State	CHW Association?	Name of State Association	Website URL	Training Resources	HIV Resources	Other Useful Links
Minnesota	yes	Minnesota Community Health Worker Alliance	http://mnchwalliance.org/	http://mnchwalliance.org/wp-content/uploads/2012/12/Minnesota-CHW-Curriculum-Outline-Updated-Feb-2015.pdf	No	http://mnchwalliance.org/explore-the-field/evidence-2/
Mississippi	no			N/A	N/A	
Missouri	no			N/A	N/A	http://clphs.health.mo.gov/lphs/pdf/sbar20141218chwsbarlpha.pdf
Montana	no, but developing			N/A	N/A	http://healthinfo.montana.edu/ahec-program-office/index.html
Nebraska	yes	Nebraska Community Health Worker Association	http://publichealthne.org/phan-sections/community-health-worker-section/	https://docs.google.com/viewer?url=http://publichealthne.org/wp-content/uploads/2015/04/CHWPolyPaper3-30-15editsPat.pdf&hl=en_US	No	
Nevada	yes	Community Health Workers of Nevada	http://chwnv.org/	http://chwnv.org/workforce-development/training-education/	No	http://chwnv.org/resources-materials/publications-about-chws/
New Hampshire	yes		http://www.snhahcec.org/Community-Health-Workers.cfm	Not for public viewing	Not for public viewing	
New Jersey	not yet			N/A	N/A	http://partnershipmch.org/programs/community-health-worker/
New Mexico	yes	New Mexico Community Health Worker Association	http://www.nmchwa.org/	https://nmhealth.org/about/phd/hsb/ochw/	no	
New York	yes	CHW Network of New York City	http://www.chwnetwork.org/	http://www.chwnetwork.org/Default.aspx?ssid=80&NavPTypeld=1297	https://www.health.ny.gov/diseases/aids/providers/training/nonclinical.htm	http://nyshealthfoundation.org/uploads/resources/new-york-community-health-worker-initiative-september-2010.pdf

State	CHW Association?	Name of State Association	Website URL	Training Resources	HIV Resources	Other Useful Links
North Carolina	no, but developing			N/A	N/A	http://www.ncmedicaljournal.com/content/77/2/129.full
North Dakota	no			N/A	N/A	
Ohio	yes	Ohio Community Health Worker Association	https://medicine.wright.edu/pediatrics/center-for-healthy-communities/ohio-community-health-workers-association	https://medicine.wright.edu/pediatrics/center-for-healthy-communities/community-health-worker-curriculum	No	
Oklahoma	no			N/A	N/A	
Oregon	yes	Oregon Community Health Worker Association	http://www.orchwa.org/	http://www.orchwa.org/resources/chw-programs-in-oregon/	http://www.cascadeaids.org/	http://www.orchwa.org/resources/newsletters/reports-publications/
Pennsylvania	yes	Penn Center for Community Health Workers	http://chw.upenn.edu/	http://chw.upenn.edu/impact	No	https://clinicaltrials.gov/ct2/show/NCT01900470?term=kangovi&rank=1
Rhode Island	yes		http://www.health.ri.gov/communities/about/workers/	http://chwassociationri.wixsite.com/chwari/certification	No	
South Carolina	yes			N/A	N/A	http://www.scphca.org/programs-services/community-development.aspx
South Dakota	no			N/A	N/A	http://sdworkforce.com/community-health-workers/
Tennessee	no, but developing			N/A	N/A	https://www.cdc.gov/dhdsp/programs/spha/docs/1305_ta_guide_chws.pdf
Texas	yes	Community Health Worker Texas	http://www.chwtexas.org/	https://www.dshs.texas.gov/mch/chw/Community-Health-Workers-Training-Information/	N/A	http://www.chwtexas.org/index.php?option=com_content&view=category&layout=blog&id=46&Itemid=71
Utah	yes	The Association for Utah Community Health	http://www.auch.org/programs/community-health-worker	Not for public viewing	Not for public viewing	

State	CHW Association?	Name of State Association	Website URL	Training Resources	HIV Resources	Other Useful Links
Vermont	no, but developing			N/A	N/A	http://campaignforaction.org/new-partnership-vna-community-health-workers/
Virginia	no, but developing			N/A	N/A	https://www.svhec.org/chw-va-healthcare-policy-development
Washington	no, but developing			http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/CommunityHealthWorkerTrainingSystem	No	http://www.hca.wa.gov/assets/program/chw_taskforce_report.pdf
West Virginia	no, but developing			N/A	N/A	https://www.svhec.org/chw-va-healthcare-policy-development
Wisconsin	yes	Wisconsin Community Health Worker Alliance	http://milahec.org/wichwa/	N/A	N/A	https://www.wpha.org/news/444981/WPHA-Community-Health-Worker-Section---Introductions-and-Plans.htm
Wyoming	no			N/A	N/A	

CHW National Education Collaborative Guide Book



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Graciela Camarena (Texas)
Durrell Fox (Massachusetts)
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Florida: Darlene Shearer - University of South Florida's Lawton and Rhea Chiles Center (Tampa)
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Oregon: Noelle Wiggins - Multnomah County Health Department's Community Capacitation Center (Portland)
Texas: Leticia Flores - El Paso Community College (El Paso)

Adapter Institutions

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Connecticut/New Jersey: Housatonic Community College, and Essex County College Camden AHEC
Florida: St. Petersburg College, Hillsborough Community College, and Central Florida Community College
Hawaii: Maui Community College and Kapi'olani Community College
Minnesota/Indiana: Minneapolis Community Technical College, South Central Technical College at Mankato, Ridgewater College, and Ivy Tech State College
Oregon: Portland State University
Texas: El Centro College and South Texas Community College

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To order a copy of the Project's DVD - "**Reflections on the CHW-NEC: Lessons Learned**"
go to the website: www.chw-nec.org



Jacob Sutton, videographer for the CHW-NEC Project.

Design and layout by Nancy E. Collyer, Senior Program Coordinator, The University of Arizona AHEC Program



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KEY CONSIDERATIONS FOR OPENING DOORS:

Developing Community Health Worker Education Programs

Developed by

The University of Arizona

Arizona Area Health Education Centers Program

Community Health Worker National Education Collaborative

1834 E. Mabel Street/P.O. Box 210425

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September 2008

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PREFACE

Acknowledgements

The Community Health Worker National Education Collaborative (CHW-NEC) first and foremost acknowledges community health workers (CHWs) for their ongoing efforts to improve the health of communities and improve access to quality and culturally competent health care services. CHWs all across the U.S. seek to build their capacity, leadership, recognition, and validation of competence through their participation in quality training programs. Colleges have emerged only relatively recently (since the 1990s) to develop and deliver educational programs and services for CHWs who are now recognized members of the community health care team in the U.S. We acknowledge and congratulate the colleges and the leadership and invaluable engagement of active and seasoned CHWs, themselves, for creating a new platform for education—providing a new door of entry to higher education and opportunity for both college credit and non-credit bearing educational services.

From 2004-2008, many supportive individuals in public health, community health workers of all types serving in broadly diverse settings, universities, colleges, many community health and human service agencies, employers, and many local, state, and federal government entities have contributed their time and insight for the CHW-NEC to achieve a “national community of practice.” The overall purpose of the CHW-NEC initiative was to identify and promote curricula and educational programs that best represent the most promising practices for uniquely non-traditional CHW student success in the U.S.

The authors wish to acknowledge community health workers for their ongoing efforts to best serve their communities, reduce health disparities, and promote equity in access to health care. To all the contributors and collaborative partners, we, indeed, say thank you. Additionally, we especially want to thank the leadership of the CHW-NEC Project Advisory Council Co-Chairs; these are seasoned CHWs, Yvonne Lacey of Berkeley, California and Durrell Fox of Boston, Massachusetts, who are recognized widely as national leaders in the CHW workforce movement. The CHW-NEC national advisory

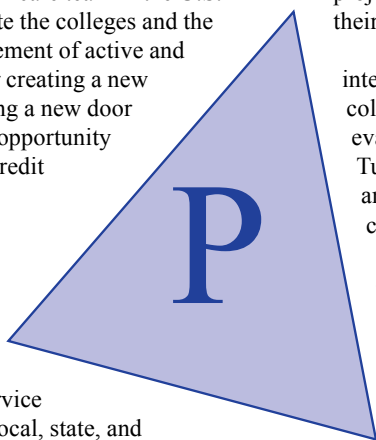
council was invaluable in guiding and informing the project to express the “key considerations” for achieving a national consensus on “promising practices” in the development and delivery of competency-based education for CHWs.

Additionally, we thank several individuals for their ongoing contributions as CHW-NEC project staff during the life of this project including most notably, Nancy Collyer of The University of Arizona Area Health Education Centers (AHEC) Program. In addition to this project, Nancy has worked actively to support the growth and development of the CHW field for many years. Also at The University of Arizona AHEC Program, we thank Jude Yandow, Kathy Trana, Linda Zimmerman, Rick Hodge, and project student aides, Sarah Deurloo and Richardo Silva, for their unique assistance and enthusiasm for this initiative.

At The University of Texas at El Paso, a community health intern, Eliza Lerma, assisted with some early investigation of college-responsive curricula. We also thank our external evaluator, Linda Scheu, of The Pima Prevention Partnership in Tucson for her contributions to the refinement of project goals and objectives and the evaluation processes she used for the careful documentation of outcomes and lessons learned.

Finally, we would like to acknowledge the valuable contributions and encouragement of our funders from the U.S. Department of Education’s Fund for the Improvement of Postsecondary Education (FIPSE), including project officers Karen Levitan, Lavonna Grow and Don Fischer.

Footnote: The CHW-NEC project was funded by the U.S. Department of Education’s Fund for the Improvement of Postsecondary Education. FIPSE funds initiatives which have a broad national application and replication or adaptation potential. They fund projects that address pressing or emerging postsecondary educational issues for the advancement of instruction and curriculum reform.



PREFACE

Letter from the Project Co-Directors

Beginning in the 1990s, the CHW field saw a trend in community health worker education shifting from a long-time tradition of employer coordinated on-the-job training to colleges playing an active role as partners in CHW education and workforce capacity building. This trend had its early roots in a San Francisco State University and City College of San Francisco project (1995) supported by the U.S. Department of Education's Fund for the Improvement of Postsecondary Education (FIPSE). This project resulted in the development of a "credit-bearing" CHW educational program known today as "Community Health Works" (Love, 2004). Building upon this model and other emerging college responsive programs, "Project Jump Start" at the University of Arizona also received funding from FIPSE in 1998. The focus of this postsecondary initiative was to create a credit-bearing approach for meeting the needs of CHWs through four Arizona community colleges (Proulx, 2000) predominately serving rural, socioeconomically disadvantaged, and special population (Native American tribal and Mexican Border area) neighborhoods.

Since these early college programs, many college-supported educational programs have been developed. Annually, for many years at the American Public Health Association (APHA) conferences, representatives of colleges and related CHW training organizations convened in a network to share approaches to CHW college-supported education. Through that networking, plans began to develop for a way to guide and coordinate growing college interests in CHW education. This networking led to the development, planning, and implementation of the "Community Health Worker National Education Collaborative."

The CHW-NEC formally began in the fall of 2004 when a FIPSE grant was awarded to the University of Arizona Area Health Education Centers Program. All of the participating postsecondary educational institutions in the project were at differing stages in their development of curricular offerings, and all were willing partners ready to work in a "*national community of practice initiative*" to explore the best approaches for college-supported CHW-responsive education. The FIPSE-funded CHW-NEC effort has gone a long way toward building trust and respect for a national learning community dedicated to defining and refining promising practices in CHW education.

This guidebook is now offered to the wider community of potential collaborators in CHW health and education communities in the hope that we can translate lessons learned during the project into "CHW-driven" educational programming. Reflected in this guidebook, CHWs, health care and human services allies, and representatives of some 22 college-based educational institutions have reviewed the most promising administrative and academic practices and have prioritized these into a set of "Key Considerations."

As one begins exploring the resources of this guidebook, the project also wishes to recognize the important CHW capacity-building work of those who were not in a college setting. The lessons learned in those non-collegiate settings have also contributed to this guidebook. To that end, as we close out the formal years of the FIPSE-funded CHW-NEC initiative, we have deliberately linked the nationally active CHW-NEC website and all its resources with the APHA CHW Special Primary Interest Group's (SPIG) new Committee on Education and *Capacitacion* and more recently with the American Association of Community Health Workers (AACHW). These organizations are postured to support continuing national coordination and active dialogue relating to CHW education. One can learn more about this on-going work by contacting the APHA CHW SPIG and the AACHW.

Community Health Workers of all titles and types (Outreach Workers, *Promotores*, Native Community Health Representatives (CHRs) and those recognized by many more titles) are now finding a new entry-point in postsecondary education, wherein the validation of the core competencies for this workforce and wherein curriculum "standards and credentialing" are now high on the national health and human services agenda. As the CHW field is becoming more "institutionalized" in the U.S., training, which had been largely outreach grant-project-driven and provided on-the-job, has become more heavily scrutinized. "College-supported and core competency-based education" has been growing in response to these trends in the CHW field. The Community Health Worker National Education Collaborative (CHW-NEC) personifies how postsecondary engagement with a breadth of contributions from the CHW workforce can reach a national consensus for the entry-level preparation of CHWs. There is now a broadly accepted "core-competency" definition for this workforce.

We hope you find that this guidebook and the project website www.chw-nec.org serve your interests well in the continuing development and delivery of quality curricula and instruction for U.S. community health workers everywhere.

Don Proulx and E. Lee Rosenthal
Project Co-Directors

PREFACE

Letter from the National Advisory Council Co-Chairs

On behalf of the Community Health Worker National Education Collaborative (CHW-NEC) National Advisory Council, we would like to present to you this CHW-NEC Guidebook, which chronicles the work and findings of a National Community of Practice project.

The CHW-NEC was funded in October 2004 through the U.S. Department of Education Fund for the Improvement of Postsecondary Education (FIPSE) and the project's national advisory council was called into action to guide and advise the initiative from the start. The origins of the program began with discussions on recommendations and lessons learned from the 1994-1998 *National Community Health Advisor Study* which sought input from many CHWs and employers of CHWs all over the country. Through site visits and interviews during the *Study*, we learned that CHWs were concerned about training, longevity of employment, salaries, and they also needed some understanding and common definition for a CHW. In the beginning (the early 60's and 70's), there was no clear information regarding what and who a CHW was - because each program defined the CHW role according to their specific programs, considering their regions, county, and city or town.

The fact that a first order of business for the CHW-NEC was to activate and support a CHW-led, majority CHW advisory council sent a message to the many CHW leaders that there was a new national project examining CHW training and college-responsive education that truly prioritized and valued the voice of CHWs, themselves.

The CHW-NEC journey from conceptual framework to a project in action was one filled with many challenges and successes each step of the way. One challenge that the project was successful in addressing was bringing together and supporting the CHW-NEC National Advisory Council, which was made up of members who were diverse in many ways including age, experience in the CHW profession, and states/regions in which they lived; cultures and communities they represented; all coming to the table with varying levels of expertise. This diverse group created an electric and exciting atmosphere at meetings and during monthly conference calls. One reason that the CHW-NEC has been a success is because the national advisory council and project staff were able to collaborate with and provide technical assistance for the core technical assistance partners and adapter institutions from across the country.

This diverse group of 10 active, experienced CHWs and five (5) CHW allies/partners all had a vision of working together to design a framework and to make recommendations for model CHW training and college-responsive education programs. Advisory council members came together from all regions of the country to guide, advise, and support the CHW-NEC project and its staff. We worked with staff to review programs and curricula for CHW training programs based at 22 colleges and universities, as well as some programs that were hosted by community-based organizations, like Area Health Education Centers (AHECs). We assisted in identifying promising practices influenced by lessons learned and recommendations from the project partners; a natural progression from the *National Community Health Advisor Study*. In addition, the Advisory Council developed a list of Key Considerations as a guideline which we felt would benefit CHWs individually, as well as various CHW training programs. These Key Considerations were developed as a blueprint for both existing programs and for newly emerging CHW college-responsive training programs and related educational initiatives.

We all agreed that it is important to continue to recognize the work of CHWs, especially at this time of declining quality health care services and related resources. We support standardizing CHW core roles and competencies and CHW leadership development. The Advisory Council held high hopes at looking back to see we were part of creating a formula that helped develop, maintain, and sustain successful CHW training programs nationally. We wanted to hear about programs that integrate CHW leadership in all levels of planning, implementation, evaluation, and sustainability. We already were having an impact due to the fact that we were able to bring together a national group of CHW leaders and top allies/partners to focus on CHW training and education for four years. This national focus has already had a positive impact on the many colleges, universities, and community-based organizations that participated in the CHW-NEC, and we hope to have an ongoing impact on CHW training, education, and capacity building nationally for many years to come.

The work of the CHW-NEC and the National Advisory Council has, indeed, continued well beyond the first three funded years. During the funded project years, the CHW-NEC co-sponsored a CHW training and education networking meeting each year at a session of the CHW Special Primary Interest Group (SPIG) during the annual meeting of the American Public Health Association (APHA). That collaboration helped to create a new CHW SPIG subcommittee, the

(Continued on next page)

PREFACE

Education and *Capacitación* Committee in which many CHW-NEC expert consultants and advisory council members are involved. The CHW-NEC National Advisory Council also shares some of its CHW leaders with the newly formed American Association of Community Health Workers (AACHW), so we plan to carry the Key Considerations and CHW-NEC torch with us as we further develop the AACHW.

We continue to link the CHW-NEC to the approximately 16 identified CHW-led networks and associations across the country (2008). We also look to continue to form alliances and provide technical assistance for community-based organizations, colleges and universities that wish to incorporate the “Key Considerations” outlined by the CHW-NEC into their CHW training and educational programs.

We urge you to make good use of this Guidebook and the Key Considerations, therein, as important tools for CHW workforce development, training, education, and ultimately for sustainability of CHWs and the CHW profession.

Thank you for your continued interest in the ever-changing and ongoing growth of the Community Health Worker profession.

Sincerely,



Durrell Fox

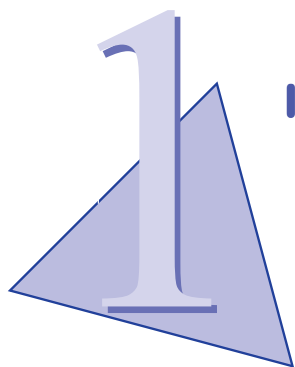
Co-Chair, CHW-NEC National Advisory Council
Boston, Massachusetts



Yvonne Lacey

Co-Chair, CHW-NEC National Advisory Council
Berkeley, California

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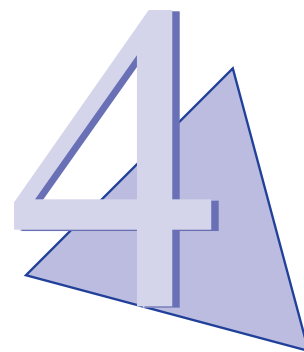
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1. INTRODUCTION

A. CHW-NEC Background

As the community health worker field has become more fully integrated in the U.S. health care and human services systems, training, which has traditionally and primarily been provided on-the-job and driven by episodic grant-funded “community outreach” initiatives, has received growing national interest in streamlining and “standardizing” educational efforts to guarantee “standards of competence.” In recent years, since about 1995*, college-supported education began to respond to basic and entry-level core competency-based training for the community health worker field. Now there is a burgeoning interest in recognizing and compensating the services of CHWs by Medicaid and Medicare reimbursements within federally recognized health care service organizations. Competency-validated education is a growing response nationally to these trends. For this to happen, however, a “national community of promising and broadly endorsed practice” is needed that prepares CHWs of all types and in all practice settings to validate core CHW competencies within the existing workforce and for the competency defined preparation of CHWs just entering the workforce.

In the CHW-NEC project, fifteen (15) adapting colleges were initially identified and supported by a partnership of six (6) collaborating technical assistance universities, colleges, and higher education-related entities, each of which had some direct experience in college-responsive educational programs and services for CHWs and their employers.

Bringing higher education institutions and CHW program individuals together, who could contribute unique direct experiences (“the good, the bad, and the ugly of it”) and lessons learned, with active seasoned CHWs, who could well inform “responsive” competency-defined curricula and instructional developments, was the primary design/ methodology of this “National Community of Practice” initiative—now widely known as the “Community Health Worker National Education Collaborative (CHW-NEC).” This FIPSE-funded project used a “logic model” as the initial framework for identifying and inviting collaborators who could bring direct experience and expertise to the project to target a set of “root causes or antecedent conditions” affecting the logical development of a national community of practice.**

This logic model and the antecedent conditions identified by the project are illustrated on the project website. The kick start to this national collaborative was a National Community of Practice Invitational Workshop hosted by The University of Arizona in Tucson in June 2005. This venue brought together a

nationally identified and committed collaboration team to develop a technical assistance approach and collaborative work plan for engaging the initial 15 adapter institutions, which expressed interest and institutional support for their participation in the project. These “adapters” were at varying places in their development of curricula, educational design/ methodologies, and delivery of instruction tailored to the expressed needs of their service regions across the U.S.

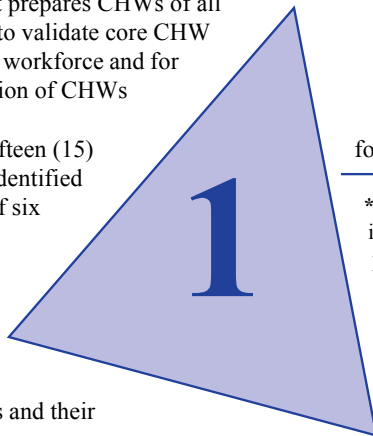
The project engaged an outside evaluator to develop an evaluation plan designed with four clear goals in mind:

1. The provision of available promising practice materials;
2. The testing and utilization of these materials to develop curricular plans and instructional delivery strategies which are most compatible with and responsive to the unique character and needs of the CHW workforce;
3. The implementation and evaluation of these curricular and instructional plans for student success and to meet employment competency demands; and
4. The dissemination of the lessons learned from engaging in this national initiative.

The evaluation plan was strategized to measure both the formative and summative objectives of the project.

*FIPSE funded the earliest college-responsive demonstration initiative in California. Known as “Community Health Works,” a performance-based curriculum and a CHW career ladder educational track was established in collaboration with CHW employers and through a partnership between San Francisco State University and the City College of San Francisco (1995-1998).

** As elucidated by Renger and Titcomb in “A Three Step Approach to Teaching Logic Models,” American Journal of Evaluation, Vol. 224, 2002.



1. INTRODUCTION

B. Collaborative Partnership Overview

This CHW-NEC project had a kick start because of several years working with the American Public Health Association (APHA) CHW Special Primary Interest Group (SPIG), wherein leaders nationally came together annually to review and recommend key considerations for effective educational programming for CHWs.

Arizona was particularly well suited to carry out a FIPSE-supported “Nationwide Community of Practice” initiative from 2004-2008, because of the groundwork and experience (lessons learned) in an Arizona FIPSE-supported initiative from 1998-2002 known as “Project Jump-Start.” This project worked with several community colleges, Arizona Area Health Education Centers (AHECs), CHWs themselves, and CHW employers to develop and deliver community college responsive education which was well informed by Arizona CHWs actively serving in disadvantaged and largely rural neighborhoods; these CHWs included Mexican border community Promotores and tribal nation Community Health Representatives (CHRs). The seasoned CHWs in this Arizona project essentially helped to teach the college faculty “what to teach and how to deliver it effectively” to serve non-traditional adult learners, many of whom were not high school or GED completers and who were largely representative of the same socioeconomically disadvantaged neighborhoods and cultures where they served. The project published a “Core Curriculum Guidebook for A Community Health Worker Basic Certificate Program” (January 2002, University of Arizona).

Another important set of lessons came from the experiences of an earlier FIPSE-supported “Community Health Works” collaborative project (1995-98) with San Francisco State University and the City College of San Francisco; this was largely urban-based in contrast to Arizona’s Project Jump-Start initiative. The California project approached college curriculum development and instructional delivery from a performance-based perspective. The Community Health Works project staff and some of the actively working CHWs from California also participated in an Annie E. Casey Foundation-supported National Community Health Advisor Study, carried out by the University of Arizona Rural Health Office (1994-1998). This study identified the knowledge, attitudes, and skills, which appeared to be common among community health worker programs across the country. Employers were particularly engaged by the San Francisco project to help inform and develop a CHW workforce career ladder which could be defined and differentiated into three levels of competence and job-level responsibility for CHW I, II, and III.

Regardless of rural, urban, or special population-based work, the issues of prominence in the CHW field have grown and changed in the decade since 1998 from the early exploration of the field’s status at the state and national level to the overall recognition and growth of the field in 2008. Among those changes and developments are:

1. The formation of CHW networks and associations across the states, regionally, and by ethnocentricity in many special population settings, including “Promotores” serving Hispanic cultures and Native American Community Health Representatives (CHRs) serving the tribal communities among many Indian Nations within the U.S.;
2. Considerations for the efficacy of higher education (college-level programming) responsiveness to serve CHWs as a growing national workforce;
3. Concern for who is informing the training “standards” and “CHW-character appropriate” educational practices nationally;
4. Questions relating to what are the nationally accepted CHW “core competencies” and concern for best practice validation of those competencies, whether through college or community-based credit-bearing training or non-credit and direct experience preparation; and
5. The desire for a “core-competency defined CHW workforce” that can be recognized for Medicare/Medicaid reimbursements to employers who hire CHWs. This workforce has largely been deployed to provide community health outreach, including neighborhood and family education, to reduce health disparities in socioeconomically disadvantaged neighborhoods and to connect people with the healthcare and human services they need.

The CHW-NEC project was designed to engage broad national partnerships in a process of national networking with the APHA CHW SPIG, with nationally recognized CHW service programs, through contacts with the CDC, with the Health Resources and Services Administration of the U.S. Department of Health and Human Services, and with other federal and state agencies. These partnerships all expressed a high level of interest in a national agenda that needed to document U.S. experience with the funding and deployment of outreach initiatives for primary care programs all across the country...programs which have trained and integrated community health workers to reach the most vulnerable populations in the nation over the past several years.

1. INTRODUCTION

This resulted in the identification of **CHW program experts** and **active/seasoned CHW leaders** nationally. These partners were invited and engaged in the project to help identify which educational institutions, which active/seasoned CHWs, and what national expert advisors might be interested in helping to inform a “national community of practice.” The project sought partners who would not just be interested in participating passively in the project’s work nationally. The project looked for potentially important **core technical assistance institutions** (primarily colleges) who were interested in participating in a collaborative and who were already engaged and ready to share lessons learned, including barriers experienced, in the development and delivery of CHW educational programs. Interest was strongly sought in the validation of core competencies and in entry-level recognition for CHWs as an emerging and growing workforce; the CHW workforce desired to gain national recognition “as important members of a nation’s health care team.”

The project searched for educational institutions, mostly community colleges, which expressed interest in aligning with identified core technical assistance institutions regionally to serve as “**Adapter Institutions.**” These institutions were selected based upon letters of high level administrative and institutional commitments to assign and support their staff to fully engage in the initiative.

The Project partnership so emerged as follows:

- Six (6) geographically and strategically located Core TA Institutions
- 15 Adapter Institutions
- 5 Expert Consultants, and most importantly
- A National Advisory Council of 15 members primarily made of 10 active/seasoned CHWs, including promotores and Native American tribal CHRs

The following are the participating institutions, advisors, and project consultants:

Core Technical Assistance Institutions:

1. **Arizona:** The University of Arizona and Pima Community College (Tucson)
2. **Connecticut:** Southwestern Connecticut AHEC (Bridgeport)
3. **Florida:** University of South Florida’s Lawton and Rhea Chiles Center (Tampa)
4. **Minnesota:** Minnesota State Colleges and Universities System (Mankato)
5. **Oregon:** Multnomah County Health Department’s Community Capacitation Center (Portland)
6. **Texas:** El Paso Community College (El Paso)

Adapter Institutions:

1. **Arizona/New Mexico:** Diné College
- 2-3. **Connecticut/New Jersey:** Housatonic Community College and Essex County College/Camden AHEC
- 4-6. **Florida:** St. Petersburg College, Hillsborough Community College, and Central Florida Community College
- 7-8. **Hawaii:** Maui Community College and Kapi’olani Community College
- 9-12. **Minnesota/Indiana:** Minneapolis Community Technical College, South Central Technical College at Mankato, Ridgewater College (MN), and Ivy Tech State College (IN)
13. **Oregon:** Portland State University
- 11-15. **Texas:** El Centro College and South Texas Community College

Expert Consultants

1. Sergio Matos (New York)
2. Sarah Redding (Ohio)
3. Carl Rush (Texas)
4. Cindy Tsai (California)
5. Ann Withorn (Massachusetts)

CHW-NEC National Advisory Council CHW Members:

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9. Kimbro Talk (Diné Nation)
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Non-CHW Members:

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2. Melinda Cordero (California)
3. Teresa Hines (Texas)
4. Agnes Hinton (Mississippi)
5. Cathy Stueckemann (Maryland)

1. INTRODUCTION

C. Purpose of the Guidebook

This guidebook was developed to offer lessons learned and recommendations made by the “Community Health Worker National Education Collaborative” (2004-2008) for college responsive programs. The CHW-NEC was funded from September 30, 2004 through September 29, 2008 by the Fund for the Improvement of Postsecondary Education (FIPSE) of the U.S. Department of Education. The University of Arizona in Tucson was the grantee. Arizona’s Area Health Education Centers (AHEC) Program Associate Director, Donald E. Proulx, MEd, served as the principal investigator and project director. E. Lee Rosenthal, PhD, of the University of Texas at El Paso served as co-director and Nancy E. Collyer of The University of Arizona served as the project senior program coordinator.

The overall purpose of this national initiative was to establish a “National Community of Practice for College Responsive Educational Programs and Services” for the community health worker (CHW) workforce. Community health workers are culturally and linguistically competent members of the nation’s public health and health care delivery workforce. They are particularly effective in reaching minority and socioeconomically disadvantaged populations in resource-poor neighborhoods, where they help the nation to address health disparities in both urban and rural settings. The project’s purpose was not to set “national standards for the accreditation of CHW educational programs” nor to establish a set of “standards for the national credentialing” of CHWs. History and tradition tells us that accreditation and credentialing standards are only adopted when a critical mass of CHWs are represented by their own “national association” similar to those developed for nursing (NLN and ANA) and for many allied health professional associations like ARRT for radiologic technology. The American Association of CHWs only just began formally organizing in 2007.

This guidebook not only shares the work, findings and recommendations of the CHW-NEC initiative, it also serves to connect interested individuals, institutions of higher education and related agencies with a project website: www.chw-nec.org and an extensive set of national expert advisors and project collaborators. These collaborators offer important recommendations for the development of CHW educational materials, curricula, services, and promising practice delivery strategies, which are particularly responsive to CHWs of all types and job titles. Community health workers across the

U.S. have become important members of the nation’s health and human services delivery team.


The emphasis in the project’s methodology was to invite, fully engage, and “**listen**” to the important voices of active, experienced, and seasoned CHWs in the identification, validation, training and dissemination of the most promising practices for the educational preparation, deployment, and continuing development of competent CHWs. This initiative focused on the development of a “core competency-based basic entry-level of education” for workers in community health.

While this project did not attempt to define a standardized curriculum or to make recommendations for

certification or other forms of credentialing for CHWs, these topics are very important and are reviewed within the scope of the project’s dissemination of findings and materials. **DVDs have been produced to disseminate regional technical assistance and training sessions provided by the project extending from Florida to Hawaii.** Project workshops and training agendas focused on national and regional topical areas of interest; presentations were made by members of the project’s national collaborators and by other invited expert consultants. Some of the referenced CHW-NEC DVDs include a

review of the national status of CHW certification/credentialing...a 101 type presentation as of 2007 (*See Carl Rush’s Review on Credentialing on the CHW-NEC website*).

Project materials are well described and accessible on the CHW-NEC website: www.chw-nec.org. This website offers video clips, technical assistance training agendas, speaker/presenter profiles, session handouts, and PowerPoint presentations. The website also provides a directory of suggested literature, a listing of national presentations made by the project team, access to important recent research publications about the CHW workforce, and studies on outcome/impact measures and cost-benefit analyses.



“The emphasis in the project’s methodology was to invite, fully engage, and “listen” to the important voices of active, experienced, and seasoned CHWs. . .”

1. INTRODUCTION

D. The CHW Field: Historic Trends

CHWs represent a vital emerging *force* in public health. In a recent assessment of health disparities, the Institute of Medicine's *Unequal Treatment* reported that the incorporation of CHWs into health programs can help improve the health of those who are not well served by the current health care system (Smedley, Stith, and Nelson, 2002). In its 2002 report *Community Health Workers/Promotores de Salud: Critical Connections in Communities*, the Centers for Disease Control's (CDC's) Division of Diabetes Translation and Division of Adult and Community Health noted that, in CDC-funded programs, "a common thread [is] community members [serving or acting] in the role of CHWs." An evidentiary study funded by the Centers for Medicare and Medicaid Services on approaches to cancer prevention among elders of color found that CHWs were the "primary mechanism for cultural tailoring" (U.S. Department of Health and Human Services, 2003). In 2007 the Health and Human Resources Administration released the Community Health Worker National Workforce Study <http://bhpr.hrsa.gov/healthworkforce/chw/default.htm#preface>. These reports reflect a growing recognition of the important role CHWs can play in ensuring the delivery of quality and culturally competent medical care and health promotion services.

1. Community Health Worker Training, Education, and Capacity Building

CHW training and capacity building programs are critical to the support of CHW workforce development. With no formal training, CHWs bring important insights and abilities to the classroom regarding work gained through shared experiences within the communities where they serve. Beyond this, many important skills and capacities can be developed. The best CHW training or capacity building embraces an adult education philosophy to enhance CHWs' existing knowledge and skills. "Popular education" builds on this philosophy (Freire, 1970) and is successfully used in many CHW programs, particularly in Spanish-speaking communities.

Many different skills and topics are addressed in CHW initial and ongoing training. Early in their training, CHWs typically learn about their multiple roles and responsibilities; about resources available in their base agency and about other area health and human services, as well as about health information related to the issues they address in their service program. The National Community Health Advisor Study, <http://www.rho.arizona.edu/Resources/Studies/cha-study/default.aspx> (Rosenthal, Wiggins, Brownstein, et al., 1998) identified core skills common among CHWs; these are frequently among the cornerstone of CHW training programs. They are: communication skills, interpersonal skills, service coordination skills, capacity-building skills, advocacy skills, teaching skills, organizational skills, and knowledge of community needs, services, and health issues. Many curricula integrating these skills are utilized in CHW training and capacity building.

In the last several decades, CHWs received training mostly through training on-the-job, usually developed and facilitated by a program coordinator. On-the-job training is still an important cornerstone of CHW training and capacity building both in formal and informal settings, such as CHW conferences. Since the 1990s, a number of CHW education and training centers have developed; some of these programs offer credit-bearing options for CHWs versus on-the-job training. In the new millennium, community colleges are clearly becoming an important source of initial and on-going education for CHWs. In response to this, the CHW-NEC was formed to help bring greater unity to how the field approaches CHW capacity building. Specifically, the CHW-NEC project worked to develop promising practices guidelines to support college-based CHW educational programs; these are presented later in this guidebook. These guidelines are in lieu of educational program standards that may eventually be established by a CHW-led group such as the newly formed AACHW.

2. CHW Credentialing

A separate but related issue to college -supported CHW education and related certificates, is the establishment of CHW credentialing programs. There is an ongoing debate among CHWs themselves and among CHW supporters as well about the value and the risks of CHW certification (Rosenthal, Wiggins, Brownstein, et al., 1998; Keane, Nielsen, and Dower, 2004). There is concern that credentialing might limit access to the field for some potential CHWs, such as those with limited English language proficiency and/or with little formal schooling. At the same time, many believe credentialing could improve chances of sustainable funding sources for CHWs and could further national recognition for CHWs. Today, most CHWs no longer wish to be referred to as "lay health workers," and, indeed, this is important with two-thirds of the CHW workforce now being paid for their service (HRSA, 2007).

Several states have begun to explore how they can establish CHW certification; two states have already adopted credentialing. Texas was the first, beginning with activities in 1999 that ultimately recommended the state establish CHW certification standards for individual CHWs and for CHW educational programs. Early work in developing a state credential was criticized for the lack of CHW involvement. In response, the state established a nine-person committee, including four certified CHWs, to oversee the implementation process.

Ohio has also adopted a credentialing program in which the state Board of Nursing regulates the CHW certification process. A few other states including Minnesota, Indiana, and Alaska, have linked use of certain curriculum to state requirements or benefits and still other states are exploring and/or implementing possible credentialing of varying types and at various levels, including credentialing individual CHWs, their trainers and/or

1. INTRODUCTION

curricula, and CHW programs themselves. A key in this exploration is ensuring CHW leadership is involved in guiding any developments in this direction. (See *Carl Rush's Review on CHW Credentialing on the CHW-NEC website.*)

3. CHW Evaluation and Research

As the CHW field has grown, there has been increasing evaluation and research in the field assessing processes and outcomes of CHW programs. CHW contributions were explored in a study of CHWs funded by the Pew Health Professions Commission; the study identified that CHWs have been found to contribute to increasing access to health care; improving quality of care; reducing the costs of care, particularly by reducing unnecessary utilization of emergency medical services; community empowerment and growth; and providing a new entry point into the labor market for people who traditionally had difficulty entering the paid workforce (Witmer, Seifer, Finocchio, Leslie, and O'Neil, 1995).

In a subsequent analysis of the literature on CHW research and evaluations in the U.S., Swider (2002) added "improving health status" and "promoting behavior change" to the list of outcomes found in some CHW programs. The cost effectiveness of CHW programs is difficult to document conclusively; programs may indeed be cost effective, but there has been limited evaluation in this area. Swider's review (2002) found that many peer-reviewed journal articles were inconclusive. However, there have been some promising findings in this area. For example, a study in Baltimore (Fedder, Chang, Curry, and Nichols, 1999) identified cost savings from the utilization of CHWs. The study found that with CHW involvement, emergency room visits went down by 40%, emergency room admissions to hospitals declined by 33%, and Medicaid reimbursements declined by 27%. The study reported that the CHW program resulted in an average savings of \$2,245 per patient per year, with a total savings of \$262,665 for the 117 patients served.

From 1994-1998, the University of Arizona conducted The National Community Health Advisor Study (NCHAS), noted previously in this guidebook, with funding from the Annie E. Casey Foundation. This was a first nationwide study of CHWs. The study explored four areas including analysis of CHW core roles and competencies (Wiggins, in Rosenthal, 1998). A decade after the foundation-funded NCHAS (1998), the federal government sponsored the Community Health Worker National Workforce Study under the auspices of the Bureau of Health Professions (2007). The study estimated that in the year 2000 there were approximately 85,000 CHWs serving individuals and families throughout the U.S. The national workforce study estimated that approximately 33% of CHWs were volunteers with other CHWs serving in part and full-time employment as CHWs.

In 2007, recognizing gaps in CHW research to date, a research agenda-setting conference, funded initially by the California Endowment, was held in January 2007, allowing for an interdisciplinary dialogue about what research is needed in the future to better document CHW contributions. At the two-day invitational conference, "Focus on the Future: Building a National Research Agenda for the Community Health Worker Field," CHWs and others came together to define research, practice, and policy issues confronting the field. The participants engaged in a consensus building process to develop a CHW research agenda. Among the top areas prioritized by the meeting participants were the need for CHW research on "CHW Funding Options, CHWs as Capacity Builders, and CHWs Promoting Real Access to Care."

4. CHW Networks/Associations

Regional, state and several national CHW organizations are helping to strengthen the CHW field and provide opportunities for CHW leadership in the field. Active national networks in the CHW field include (2008):

1. The American Public Health Association (www.apha.org/membergroups/primary/) CHW Special Primary Interest Group, led by CHWs and representing CHWs in public health;
2. The National Association of Community Health Representatives (www.nachr.net/), an association of Native American CHW programs, funded in large part by the Indian Health Service;
3. National Hispanic Association of Community Health and Outreach Workers, Inc., formerly the *Red Nacional de Promotores*, bringing together CHWs from across the country, especially Spanish-speaking *Promotores(as)*; and
4. The American Association of CHWs ([www.aachw.org - forthcoming website](http://www.aachw.org-forthcoming-website)) formally established in 2007 to bring together state, regional, and national networks.

In addition to national CHW networks, numerous regional and state networks have played significant roles in the CHW field over the past decade. One example is the Community Health Advisor Network, predominantly made up of volunteer CHWs in the southeastern U.S. One of the first formal state networks of CHWs in the U.S. was the New Mexico Community Health Worker Association formed in the mid 1990s. The Oregon Public Health Association has a special committee on CHWs, chaired by CHWs, that provides leadership at the state level and also leverages national influence. Over time, several states, including Maryland, Mississippi, Virginia, California, Massachusetts, Arizona, and Minnesota have established statewide associations or centers to bring CHWs together. A current list of CHW networks can be obtained through APHA and the AACHW.

2. PROMISING PRACTICES

A. Introduction to Promising Practices: The CHW-NEC Framework

The CHW-NEC partnership developed a framework for understanding educational program development consisting of seven components grouped under four main categorical areas. The framework, illustrated by a triangle (see below), provides a stepwise ladder of investigation for new program development and/or for strengthening existing programs.

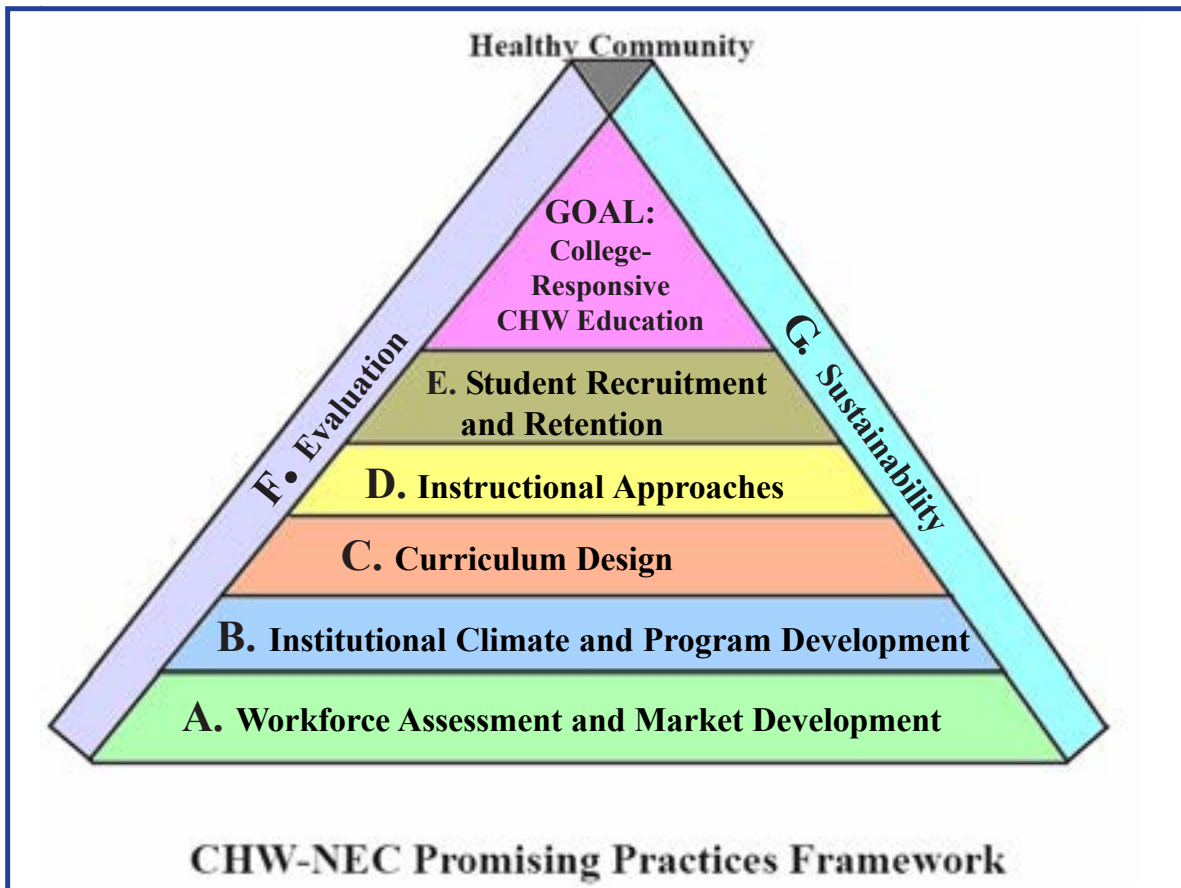
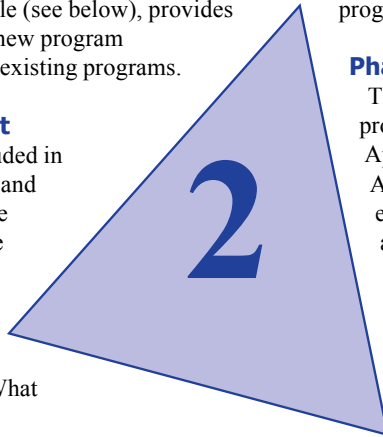
Phase I: Program Development

There were two components included in this phase: (1) Workforce Assessment and Market Development, in which college faculty and staff need to play an active role in examining the employment opportunity landscape for CHW in their service region. This phase also included (2) Institutional Climate and Program Development. What

support is presented by institutions of higher education for developing a curriculum or educational program track for CHWs? Will the institution build a CHW educational program that is responsive to existing and future needs?

Phase II: Program Implementation

There were three components in this phase of the project: (1) Curriculum Design, (2) Instructional Approaches, and (3) Student Recruitment and Retention. A primary consideration in all these components was to examine how to meet the needs of the non-traditional adult learners. The last two Phases – III: Program Evaluation and IV: Sustainability held only a single component for the project's inquiry. The promising practices that the project identified are each grouped under these areas of the framework in this guidebook.



2. PROMISING PRACTICES

B. Defining Promising Practices

Promoting “Promising Practices” is a part of a quality movement that encourages the concept of “doing our best;” in fact, it is modeling what we want those we serve to do as well. Based on a review of selected public health literature discussing promising practices, the following areas were adopted as key characteristics for any promising practices adopted by the CHW-NEC partnership:

1. There are measurable objectives
2. They are participant-driven (empowering)
3. They are evolutionary-with continuous practice improvement in mind
4. They reflect tested theories and beliefs
5. The processes and strategies utilized reflect relevant evidence *
6. They express an environmental understanding of the “climate,” both internal and external for success.

*Evidentiary sources might be:

Published and unpublished literature; staff experience; community/client/student feedback; the experiences of other organizations; expert opinions inside and outside the field; Internet sites; funder impressions; evaluation findings; and subjective and objective data. “Promising Practice” is suggested as an alternative term, when clear empirical evidence does not validate something is a “Best Practice.”

The CHW-NEC team also acknowledges that there are some risks associated with the adoption of “Postsecondary Promising Practices.” Pursuing such practices may promote a movement toward developing guidelines, standards, and norms that can be utilized to **control** services or, in this case, educational programs that are not compatible with community needs. At times promising practices may place a higher value on cost efficiency vs. people-oriented values. The CHW-NEC partners believe that critical on-going reflection regarding promising practices can serve as a remedy to counter these risks. The CHW-NEC also acknowledges the term “useful practice” as suggesting that the context of a practice will determine what is best.

1. How are the promising practices identified for CHW education?

- A program design that “Works” is constructed using Promising Practices!
- If students/CHWs enroll and successfully complete the curriculum, it’s because the curriculum and the instruction are properly tailored to meet the competencies, character and learning style needs of the students/CHWs.
- If the instruction is taken to the student, rather than the student, by imperative, being taught on a campus, then the program is student-centered, not campus-centered. This is a CHW “best practice.”

- If unrealistic academic prerequisites are not put up as barriers to enrollment, then the program is constructed on the basis of serving the needs of non-traditional adult students, who are likely not high school graduates or GED completers.
- Student success is based upon an interactive adult learner-based format...oral work is as highly regarded as written work.
- A curriculum that is responsive to the needs of students to demonstrate performance is working to promote student success.
- A postsecondary program that serves employers effectively is based upon the needs of the workforce. A program that graduates successful students who serve as CHWs in the field utilizing their newly acquired education skills and knowledge is a promising practices program.

2. Some suggested evidenced-based support for Promising Practices:

- Adult Learning Theory applies (see pages 15-16 of the University of Arizona Core Curriculum Guidebook).
- Stimulus-response behaviorist theory (B.F. Skinner and others), including “reinforcement theory” applies. That is, student success begets an enhancement of learner self-confidence, which is reinforcing to further success for students new to postsecondary education.
- John Dewey’s educational philosophy applies: “Education as Experience!” That is, what the learner brings with them (their direct experience and prior training/education/learning) is as important as what they may newly experience in the postsecondary environment.
- Paulo Freire’s (Brazilian Educator) “Popular Education Pedagogy” applies to non-traditional adult learners, with limited literacy/language skills...learning to read and write through discussion...education of, by, and for the people...problem-centered learning.
- Maslow’s “Hierarchy of Needs” theory applies. Start with the simple and grow to the complex.

1. Brownson R, Gurney J, and Land G. Evidence-based decision making in public health. *J. Public Health Management Practice*. 1999, 5(5), 86-97.
2. Cameron, R., et al. Linking science and practice toward a system for enabling communities to adopt promising practices for chronic disease. *Prevention Health Promotion Practice*, January 2001, 2 (1), 35-42.
3. Kahan B and Goodstadt M. The interactive domain model of best practice in health promotion: developing and implementing a promising practices approach to health promotion. *Health Promotion Practice*, January 2001, 2(1), 43-67.

2. PROMISING PRACTICES

C. Promising Practices Identified by the CHW-NEC

This section poses questions for guidebook readers who may be in some phase of CHW educational program development, including those who are attempting to start new programs and those who are already offering educational programs.

During the life of this project, the CHW-NEC partners identified many promising practices that have relevance to CHW education and training programs. In exploring those practices spanning the life of a CHW educational program, CHW-NEC partners have articulated key issues pertaining to each promising practice that should be examined in the process of starting or strengthening a CHW capacity building program, particularly within, or in coordination with, formal academic institutions.

Accordingly, this section of the guidebook poses questions for the readers that the project investigated. Postsecondary institutions should work to address these questions if engaging in the development of CHW educational and training programs. The "Key Considerations" outlined in this section set the stage for these questions. This questioning process offers program developers a framework and some insight for considering important decision points along the way to delivering successful and responsive educational program options.

In order to develop a successful CHW educational program there are many steps in the process and many questions to address. Readers may walk through the phases of CHW educational program development, wherein this guidebook highlights the promising practices identified by the CHW-NEC. Within each of the promising practices presented, there are important questions for consideration in achieving institutional success.

Community Health Worker National Education Collaborative Promising Practices Menu Overview List

A. Workforce Assessment and Market Development:

1. Completing Labor Market Assessments; the First Step in a Program Feasibility Study
2. Carrying Out Employment Market Development
3. Promoting CHW Leadership – CHW Association Development
4. Addressing State and Related Certification Requirements
5. Supporting and Developing CHW Fieldwork Preceptors

B. Program Development and Institutional Climate:

1. Identifying a Program Home/Best Fit Within the Institution
2. Engaging Active/ Experienced CHWs and Employers as Advisors to Program Development
3. Starting with an Entry-Level Basic Certificate Program
4. Avoiding Pre-Requisite Requirements for Admission to an Entry-Level Basic Course of Study
5. Evaluating Existing College Courses to Support the CHW Curriculum
6. Marketing the Program

C. Curriculum Design:

1. Implementing a Competency-Based and Basic Core Skills Curriculum
2. Integrating a Performance-Driven Assessment Process
3. Selecting Appropriate Elective Courses for CHW Students
4. Developing Specialty Health Track Modules
5. Including Health Issues Content for a Broad Student Orientation to First Aid/

CPR, General Health Issues, and Bio/
Social Determinants of Health

D. Instructional Approaches:

1. Using Flexible Scheduling Like Block Scheduling and Weekend Classes
2. Providing Instruction Which is Student-Centered
3. Addressing Institutional Requirements for Instructor Credentials
4. Selecting and Developing Direct Employment Community-Based Teaching Sites
5. Integrating Popular Education/Adult Learning Approaches into Instruction
6. Assessing Prior Learning for Credit



2. PROMISING PRACTICES

Community Health Worker National Education Collaborative Promising Practices Menu Overview List

(continued)

E. Recruiting and Retaining Students:

1. Using Proactive Student Recruitment Strategies Suitable for Adult Non-Traditional Students
2. Providing Entry-Level Counseling for Students Regarding the CHW Field
3. Addressing Student Participation Barriers (child care, transportation, academics, technology access)
4. Assessing and Addressing Financial Aid and Funding Needs
5. Using Lessons Learned from CHWs in Navigating College Systems
6. Addressing Literacy and Language Issues in the Classroom, Including Computer Literacy
7. Providing Tutors and Mentors

F. Evaluation

1. Evaluating the Effectiveness of the CHW Educational Program
2. Assessing the Comprehensiveness of the Curriculum
3. Conducting Performance-based Evaluation of Instructional Approaches
4. Gathering Student Feedback/Satisfaction Surveying
5. Soliciting Employer Feedback /Survey
6. Doing Student Follow-up
7. Conducting Client Follow-up
8. Assessing Student Learning
9. Evaluating Community Impact



A CHW-NEC Advisory Council member discusses evaluation with the project evaluator.

G. Sustainability:

1. Developing a Community/Employer/CHW Advisory Group
2. Cultivating Workforce Development /Education Funds
3. Sustaining Efforts to Match Student Needs to Relevant Financial Aid Programs and Private Support
4. Publicizing and Celebrating Student Successes
5. Integrating Alumni into Teaching and Mentoring Students
6. Sustaining Faculty Contact with Experienced CHWs
7. Exposing Administration to the CHW Field, Classes, and Publicity
8. Providing Specialty Training Linked to Payers (Medicaid/ CHIP, WIC, Chronic Disease Management, etc.)
9. Creating Curriculum Exchange Opportunities
10. Documenting Student Contributions and Cost-Effectiveness of CHWs in General
11. Establishing Educational Programs as a Point of Entry into Employment and/or Advancement

2. PROMISING PRACTICES

I. Program Development

A. Workforce Assessment and Market Development



CHW-NEC Promising Practices Framework

ELEMENT 1. Completing Labor Market Assessments; the First Step in the Program Feasibility Study

College faculty and staff considering a CHW program need to evaluate the current and potential job market for CHWs in their service area to assure that there is an adequate level of interest, workforce, and employer demand for an entry-level college responsive curriculum and instructional program.

Questions:

- Does your college require documentation of an adequate workforce demand before adopting any new programs of study or courses?
- What is considered “adequate?”
- Is there institutional support for an “environmental scan” of need for the program?
- How will you know who the employers are for CHWs; can you contact a local CHW network?
- Can local CHWs help to define the extent of their workforce and by whom they are employed?
- Would local and county governments help to define the employers and the titles of CHWs working in the educational institution’s service region?

ELEMENT 2. Carrying Out Employment Market Development

In collaboration with local area CHWs and CHW advocates, college staff can participate in developing CHW employment, volunteer, and internship opportunities for CHW students.

Questions:

- Is there employer demand for college-supported entry-level education OR would employers prefer to orient their staff through employer designed in-service training?

Key Consideration: Workforce assessment and market development includes exploring the current employment market, workforce policy, and financial climate for CHWs as well as identifying and developing volunteer and paid CHW positions in the college service area. College-supported CHW educational programs must play an active role in assessing the availability of and opportunities for CHW jobs in their service area. Program faculty and staff can anticipate playing an active role in the development of the CHW field overall into a more sustainable component of the health and human services workforce. College staff must also explore ways to link education to employment promotion opportunities within existing CHW employment sites.

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2. PROMISING PRACTICES

A. Workforce Assessment and Market Development (continued)

- How do you promote the efficacy for college-supported entry-level training to remove the burden of on-the-job training from current and future employers?
- Is the employer aware that core basic competency training can improve the performance and confidence of their employees?
- Would the “community of employers” be willing to collaborate to achieve an adequate class size for the college program?
- Would the community employers see the advantage of the transferability of core skills for CHWs to work in focused public health interest areas such as domestic violence, HIV-AIDS, substance abuse, tobacco use, diabetes, obesity, and other chronic disease issue areas?
- Is there access to care support for outreach programs for neighborhood residents—adults and kids?
- Does your state have a KidsCare or equivalent Program?
- Is there a Healthy Start Program to serve pregnant women and their infants to improve prenatal and post-partum care and to reduce the incidence of low-birth-weight babies?

ELEMENT 3. Promoting CHW Leadership – CHW Association Development

College faculty and staff are encouraged to support the development of CHW networks through their experience and knowledge of organizational and community development, by making their own direct contributions, and by promoting student participation in emerging workforce networks.

Questions:

- Can you invite CHW leaders and seasoned workers to offer their direct practical experiences in the instruction?
- Will you allow CHW classroom visitors to speak about CHW organizational developments and growing networks?
- Does your institution have policies regarding the role of faculty or staff as advocates for public policy and organizations representing particular workgroups or other groups in the community, in the state, or in the nation?
- How can you balance these institutional policies with your personal views as a member of the communities that the college serves?
- How can you integrate advocacy discussions in the classroom; what level of activism is appropriate?
- What about students in fieldwork experiences participating in public issues as advocates?

ELEMENT 4. Addressing State and Related Certification Requirements

College faculty and staff and the CHW students should contribute to the debate about state and nationally- related CHW certification requirements and work to assure that, as needed, the CHW curriculum is contributing to students acquiring the competencies to meet the requirements for any identified certifications.



CHWs participate as instructors.

Notes: _____

2. PROMISING PRACTICES

A. Workforce Assessment and Market Development (continued)

Questions:

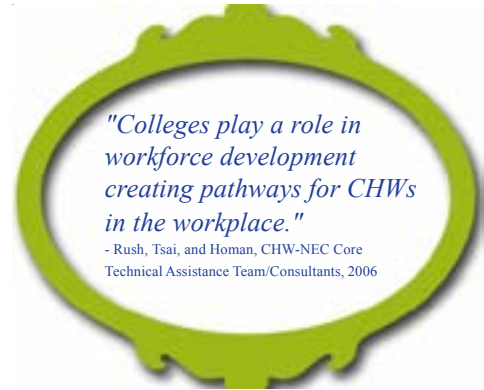
- Will you include examples of state certification systems for CHWs and/or for state approved instructional programs in the instruction?
- Will you compare and contrast these examples for their efficacy and responsiveness to the unique character and scope of service of CHWs?
- Will you include an examination of the pros and cons for credentialing of CHWs in the U.S.?
- Will you include learning activities regarding Medicare and Medicaid reimbursements to employers for the health-related services provided by community health workers?

ELEMENT 5. Supporting and Developing CHW Fieldwork Preceptors

College faculty and staff should work to develop CHW preceptors as adjunct faculty in the community, potentially opening up new work settings for CHWs and solid learning opportunities for students.

Questions:

- Will you include a practicum requirement in the curriculum to validate the competence of your students?
- Will you invite employers and working/seasoned CHWs to serve on a program advisory committee?
- Will you use a college program advisory committee to support continuous program improvement?
- How will you identify “qualified” practicum preceptors?
- Will you utilize CHWs in the field as preceptors?
- Will you develop and provide an instrument for preceptors to check off the completion of fieldwork competencies for your students during the practicum?
- Will you invite the input of employers for the development of a practicum competency checklist? Will you offer an adjunct faculty development orientation for preceptors?
- Will you clearly differentiate the preceptor role in instruction and student evaluations versus the college’s responsibility as the educational institution of record for grading students and issuing college program certificates of completion?



Notes: _____

2. PROMISING PRACTICES

B. Institutional Climate and Program Development



Key Consideration: Program development and institutional climate includes a comprehensive set of activities to aid in refining overall CHW educational program development, implementation, and evaluation at the educational institution. It is important that every college-supported CHW educational program integrate involvement from experienced CHWs in their program at every stage through inclusion of CHWs as planners, faculty, and student mentors to meet their institution’s and community’s needs.

ELEMENT 1. Identifying a Program Home/Best Fit Within the Institution

Identify a department (social work, nursing, allied health, public health, etc.) within the college that will be most interested and supportive in the development of a CHW program/curriculum. Some nationally successful CHW educational programs are located in nursing departments, some in social services departments, and some in allied health program departments. Program location success comes within educational units or departments that fully understand CHWs as unique health care team members who contribute to the health of disadvantaged, medically underserved, and special population communities within the college’s service region.

Questions:

- How will you communicate the character of CHWs and their unique workforce niche to your educational colleagues and administrators to help them determine the best fit within the educational discourse sections of the institution as already constituted?
- Will you orient college administrators and faculty to the character of the CHW workforce and the importance of developing a program of study that ensures the optimal engagement of CHWs as students and students as CHWs?

ELEMENT 2. Engaging Active/ Experienced CHWs and Employers as Advisors to Program Development

Experienced CHWs and employers in the service area of the college can help to guide faculty and others who are just now learning about the CHW workforce and their scope of responsibility.

Notes: _____

2. PROMISING PRACTICES

B. Institutional Climate and Program Development (continued)

Questions:

- Will the faculty exercise academic humility by inviting seasoned and actively employed CHWs and employers to help inform the curriculum development process and instructional delivery patterns which are compatible with the needs of the workforce?
- Will the faculty engage experienced CHWs as program advisors, as teachers, as guest lecturers, as fieldwork site leaders, supervisors and preceptors to aid the college in validating the competence of students?
- Will the college invite community CHWs as mentors and advisors for the students, offering help to “CHWs as students” in navigating the college?

ELEMENT 3. Starting with an Entry-Level Basic Certificate Program

Begin with the development of a basic curriculum that is well informed by practicing/experienced CHWs and which focuses on common entry-level CHW employment competencies.

Questions:

- Will the curriculum be **appropriate** to the unique socioeconomic character, culture, and prior mixed educational attainment levels and limited college readiness of this workforce?
- If the college develops a curriculum, will they come? Might the college take the program to the students where they live and work?
- Will it be **acceptable** to the neighborhoods served?
- Can it be **accessible** to adult non-traditional and disadvantaged students, where transportation, childcare, enrollment costs, and access to distance learning technology are all important potential barriers to matriculation?
- Will it be **adaptable**, language sensitive, and community evidence-based?
- Can instruction be scheduled in blocks of time like over weekends, and will faculty **accommodate** the student population by tailoring programs and educational services to address unique populations and neighborhood needs?

ELEMENT 4. Avoiding Pre-Requisite Requirements for Admission to an Entry-Level Basic Course of Study

Seek to develop a new “door-of entry” to the new CHW program that does not include academic prerequisites and the typical academic screenings for reading, writing, and math skills readiness for college.

Questions:

- Will the college honor oral work as much as written class work?
- Can the college provide entry-level credit by assessment which is validated through the presentation of prior learning/training and direct work experience?



Another door of entry for CHW Education

Notes: _____

2. PROMISING PRACTICES

B. Institutional Climate and Program Development (continued)

- Will the college allow the validation of a portfolio of competencies with the support of employers and previous trainers of CHWs?
- Will the college operate a basic certificate entry-level program that does not place unnecessary academic admissions assessment barriers on adult non-traditional students?

ELEMENT 5. Evaluating Existing College Courses to Support the CHW Curriculum

Carefully evaluate existing college courses that may or may not support an entry-level program of study that is competency defined.

Questions:

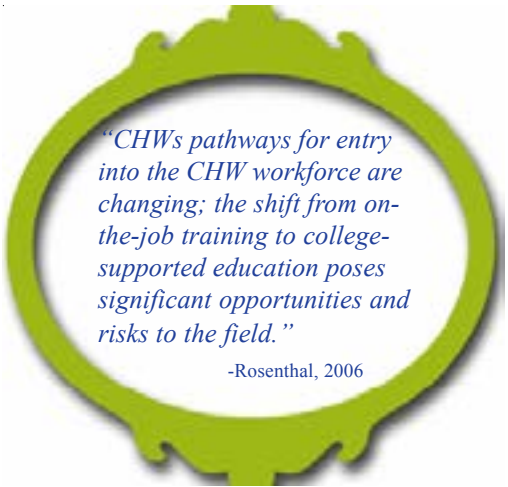
- Will the college avoid requiring college courses in this new program as a means for generating enrollments in courses that may not always fill at an adequate class size?
- By example, will the college avoid requiring enrollment in medical terminology, introduction to algebra, and anatomy and physiology courses when these are truly not needed for CHWs to achieve an entry-level core set of educational competencies that are needed to support the scope of their services in community health?

ELEMENT 6. Marketing the Program

Involve actively employed and seasoned community health workers and employers in the college’s service region to communicate and share the new college-supported curriculum widely within the health and human services industry.

Questions:

- What types of media releases might aid in announcing the new program?
- Where can recruitment of students be most lucrative?
- Will you invite community health workers in the service region to communicate the program accurately?
- What community agencies might be helpful in supporting the enrollment costs of students? Would this be an incentive for students to enroll?
- Can the college do “contract education” with several collaborating CHW employers to support small class sizes? Contract education engages employers in a manner that assures the full time student equivalent (FTSE) funding will be adequate to support the class offering. Employers can agree to make up shortages in FTSE income to run a small class size for their staff.

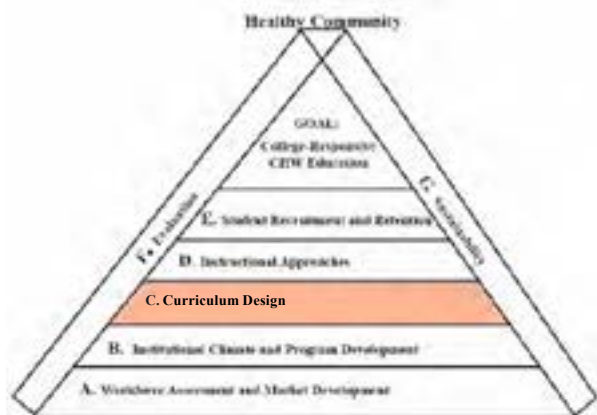


Notes: _____

2. PROMISING PRACTICES

II. Program Implementation

C. Curriculum Design



CHW-NEC Promising Practices Framework

ELEMENT 1. Implementing a Competency-Based and Basic Core Skills Curriculum

Begin with the development of a simple entry-level curriculum that focuses on core CHW competencies and, as possible, create career ladder and career lattice articulations to related fields of study building upon the entry-level basic core certificate of study.

Questions:

- Does your program already have a curriculum?
- Is it competency-based?
- How do you know if a curriculum is competency-based?
- Have you worked with area agencies to advise them about the educational program you are offering?
- Have you helped to stimulate a career ladder that will recognize the education CHWs will obtain in your program?

ELEMENT 2. Integrating a Performance-Driven Assessment Process

Include fieldwork as a part of assessing CHW learning and validating competence. CHWs are frequently adult learners who will best demonstrate their skills through interactive methods.

Questions:

- How will you assess learning in your program?
- Will your assessment strategies accommodate lower literacy levels that students may bring with them to the institution allowing them to adequately demonstrate their proficiency?
- Will the institution recognize that some lower literacy skills are not a barrier to the success that CHWs have when working in neighborhoods where their own socioeconomic and cultural character is indigenous to the area?

Key Consideration: Curriculum design relates to the overall course structure (i.e., number of credits, elective courses, etc.) and course content that is utilized in a CHW educational program. Intimate knowledge of one’s community is an essential part of being a CHW. It is essential that all individualized community educational methods and individualized classroom experiences take into account the local community and cultural context, tailoring the curriculum to the community in order to enhance CHW knowledge and skills needed in the field.

Notes:

2. PROMISING PRACTICES

C. Curriculum Design (continued)

ELEMENT 3. Selecting Appropriate Elective Courses for CHW Students

Allow students freedom to select elective courses that may lead them to understanding other related career tracks.

Questions:

- Do you plan for students to have electives in their course of study?
- If yes, does it offer them a chance to distinguish themselves in some way as a CHW student who is, for example, proficient in computer skills or in using sign language?
- Do you plan to offer open communication electives?
- Does your CHW program offer career lattice mobility into other health-related programs?

ELEMENT 4. Developing Specialty Health Track Modules

Create specialty educational/training tracks responsive to the health needs and job opportunities in the CHW workforce arena.

Questions:

- Will your program of study address community health and human services needs unique to your service region?
- Will health specialty areas be taught in your program?
- Will these be offered as advanced course modules that build upon the entry-level core program of study and/or might these be treated as CHW program ladder electives?
- Will the curriculum emphasize health literacy promotion and disease prevention and primary care services?

ELEMENT 5. Including Health Issues Content for a Broad Student Orientation to First Aid/CPR, General Health Issues, and Biological and Social Determinants of Health

Create CHW courses that orient students to basic health concepts as well as the biological and social determinants of health. Some health information is core to CHWs such as a basic understanding of primary care issues and issues related to community health promotion and community capacity building.

Questions:

- How will your program address these areas of basic core competence?
- What sources are easy for students to access for this information?
- Will you allow students to draw upon their own experiences to explore the biological and social determinates of health?
- Will learning activities be reinforced in some fieldwork practicum, or internship experiences?

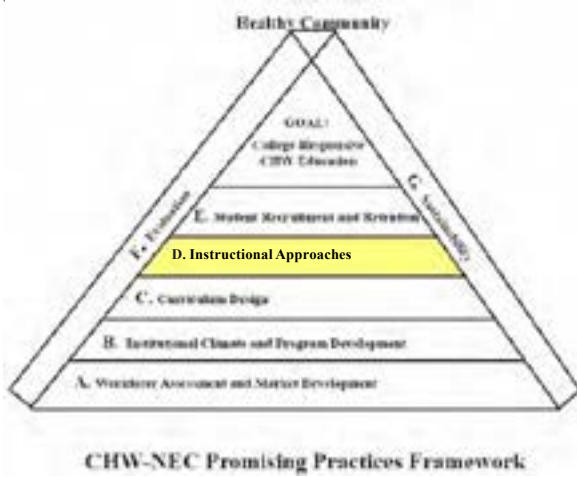


CHWs interact with their peers in an educational setting.

Notes: _____

2. PROMISING PRACTICES

D. Instructional Approaches



ELEMENT 1. Using Flexible Scheduling like Block Scheduling and Weekend Classes

Use flexible scheduling to reach the students where they live and work. CHW students, like other adult learners, have many competing demands on their time.

Questions:

- Can the scheduling of courses include input from students about proposed schedules and locations?
- Can classes take advantage of evening and weekend times allowing for longer educational sessions and fewer trips to attend class.
- Can your institution use videoconferencing distance learning technologies and Internet-based learning for students?
- Will students have the necessary resources where they live and work to use these distance learning modalities?

ELEMENT 2. Providing Instruction which is Student-Centered

Deliver the instruction to limited English speakers, if this is needed within the service region of the institution.

Questions:

- Does your approach to learning begin with what the student already knows, constructed to advance their knowledge and skills in their field of work/service?
- Are practical hands-on learning opportunities extensively used?
- Do you address the needs of “English as a Second Language” students by allowing for frequent team work and student team collaborations in the class room where assignments can be communicated and mentored by bilingual class peers?

Key Consideration: Instructional approaches include the methods that are utilized in the capacity building/teaching process including assessment of competence for college credit, interactive classroom activities (role plays, etc) and fieldwork. College-supported educational programs must not lose focus when working with two keys groups—CHWs becoming students and students becoming CHWs. Experienced CHWs are the change agents of their communities. New students have the capacity to impact the delivery of health in their communities and to grow as CHWs. The knowledge of both groups and their experience in the educational system will impact their approach in their own community education efforts.

Notes: _____

2. PROMISING PRACTICES

D. Instructional Approaches (continued)

- Do you allow for simultaneous translation of information in classes with mixed populations of language and culture?
- Are class members who translate given any incentives such as earning extra credit?

ELEMENT 3. Addressing Institutional Requirements for Instructor Credentials

Provide Adjunct and Associate Faculty status for experienced and expert CHWs, CHW program coordinators, and CHW employers so they can participate in providing relevant learning activities, fieldwork, and classroom instruction in your college-sponsored program. Those who teach, learn the material even better.

Questions:

- Does your program work to team CHWs with non-CHWs to teach in the classroom?
- Do CHWs lead some class sessions and learning activities?

ELEMENT 4. Selecting and Developing Direct Employment Community-Based Teaching Sites

Develop and/or utilize community sites that offer opportunities for students to practice and demonstrate their CHW skills.

Question:

- Will you be proactive in identifying fieldwork sites where some CHW students are already employed or sites where they might be welcomed to practice and demonstrate their proficiency in another practice or service delivery environment?

ELEMENT 5. Integrating Popular Education/Adult Learning Approaches into Instruction

Integrate adult learning approaches that are “liberating” and “participatory” (“popular”) to foster optimal learning, including interactive activity skills.

Questions:

- Do you understand the techniques of problem posing that can help draw the student into defining the problem and finding the solution?
- Do you have students lead the classroom discussion at times?

ELEMENT 6. Assessing Prior Learning for Credit

Create systems that allow CHWs to document and/or demonstrate relevant prior experience in serving the community so they can receive advanced college placement and credits by assessment in a college-responsive CHW educational program.

Questions:

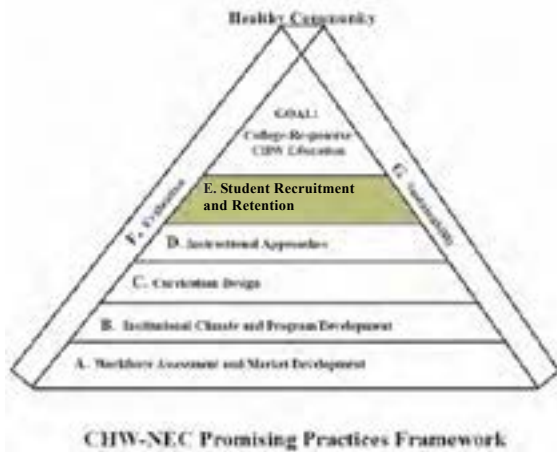
- Has your program explored credit for prior learning approaches such as utilizing a portfolio to document prior employment competency and community service experience?
- What does the institution allow in terms of advanced placements, competency assessment for college credits, etc.?
- Is there faculty experience in doing this effectively, which preserves academic and institutional integrity, and which does not affect the status of the institution’s accreditation?

(There is more discussion on Credit by Assessment by Ann Withorn of Boston University on the CHW-NEC website.)

Notes: _____

2. PROMISING PRACTICES

E. Student Recruitment and Retention



Key Considerations: Recruiting and retaining students refers to strategies utilized by a CHW educational program to ensure that students/CHWs enter and stay enrolled in a CHW educational program. Recruitment and retention strategies must be carried out by CHW college-supported educational programs which are successful in breaking down traditional academic barriers to admission and matriculation and which develop appropriate and relevant systems that will support CHW efforts in furthering their learning.

Element 1. Using Proactive Student Recruitment Strategies Suitable for Adult Non-Traditional Students

Work actively to recruit potential and existing CHWs to participate in the CHW educational program.

Questions:

- Have you contacted local employers who hire CHWs to encourage them to support staff enrollment in the program?
- Have you prepared a brochure explaining the role of a CHW in health and human service agencies to be distributed to potential employers (i.e. county health departments, community health centers, local neighborhood community centers, etc.)?
- Do you plan to advertise your program in the local newspapers, school newspapers, bulletin boards, etc.?
- Do you invite CHW alumni to help recruit new students?

Element 2. Providing Entry-Level Counseling for Students Regarding the CHW Field

Ensure that incoming students fully understand the broad scope of the CHW practice model and options for paid and volunteer work in the local service area.

Questions:

- Do you plan to offer an entry-level course for students to explore the CHW field?
- How do you help students new to the field to understand CHW work?
- Will your course include information regarding potential employment opportunities in the local community after graduation?

Notes: _____

2. PROMISING PRACTICES

E. Student Recruitment and Retention (continued)

Element 3. Addressing Student Participation Barriers (childcare, transportation, academics, technology access, and other barriers)

Work to make the educational program accessible to students by providing needed support services to facilitate participation in classes and related assignments. Work with the administration to address the barriers and challenges of adult learners entering a postsecondary educational institution. Provide opportunities for assisting students in navigating the educational system.

Questions:

- Can your program/college offer alternative admission requirements?
- Will your program explore the barriers your students face and develop a plan with them and/or orient them to the resources that can help them overcome personal barriers to participate and succeed in college?
- How does your program/college address language barriers?
- Are you planning to provide or offer students childcare assistance?
- Will you use adult learner educational methods?
- How will you help CHW students understand the college environment and its expectations?

Element 4. Assessing and Addressing Financial Aid and Funding Needs

Work actively with students to determine financial needs and to help them secure needed financial assistance; as possible, work with community advocates to develop funding strategies that can be made available to students on an as needed and on emergency bases to support retention and completion rates.

Questions:

- Are you developing your curriculum with an adequate number of credit hours to qualify students for Federal Financial Aid?
- Does your institution provide assistance with researching scholarship and/or financial aid opportunities?
- Will you contact local CHW employers to explore if they might offer to pay the tuition of their CHW staff to participate in the program?



A CHW shares her story as a non-traditional adult learner.

Notes: _____

2. PROMISING PRACTICES

E. Student Recruitment and Retention (continued)

Element 5. Using Lessons Learned from CHWs in Navigating College Systems

Based on input from CHW students in existing educational programs, include alumni where possible as mentors and develop guides for new students to effectively navigate the college system.

Questions:

- Does your institution offer an orientation or guide on “how to navigate the world of college life” for new students?
- How does your program plan to integrate its alumni into your program?
- Could alumni serve as instructors or guest speakers in the classroom?
- Will they be involved in assisting with internships in the field?

Element 6. Addressing Literacy and Language Issues in the Classroom Including Computer Literacy

Create a teaching/learning environment where students support each other in verbal and written communication through activities such as simultaneous or consecutive translation and through assigning cooperative learning opportunities. To the extent feasible “bilingual materials” should be utilized.

Questions:

- Will you offer classes in more than one language and provide bilingual opportunities in real time?
- Will you conduct classes using Adult Learner techniques (i.e. Popular Education)?
- Do you offer a mechanism to address “fear of failure” issues for new students?
- Are your institution’s policies flexible in dealing with adult non-traditional learners?

Element 7. Providing Tutors and Mentors

Work to assure that CHW students have access to experienced, active, working CHWs and other mentors and tutors to support their success in coursework.

Questions:

- Does your college offer remedial classes in reading and writing skills?
- Does your college offer credit for life experiences and on-the-job training?
- Do you plan to provide tutors for first-time students?
- Will some of these tutors and mentors be CHWs?
- Can students enroll in the CHW curriculum concurrent with development skills classes?



CHWs attend a college class.

Notes: _____

2. PROMISING PRACTICES

F. Evaluation



ELEMENT 1. Assessing the Comprehensiveness of the Curriculum

The first element in evaluation promising practices is to assess the comprehensiveness of your curriculum. The purpose of this is to assess the content in your courses assuring that the information taught adequately addresses the core roles and competencies needed in CHW work and service. This is an item that needs continuous feedback to assure the curriculum content meets the needs of the students, their employers and the community members they serve.

Questions:

- What core competencies will you use or are you now using in your curriculum?
- How were they developed?
- Are they a good fit based on CHW, employer, and expressed community needs?
- Have you examined other curricula across the country?

ELEMENT 2. Conducting Performance-based Evaluation of Instructional Approaches

This element is important to assure the effectiveness of the teaching style in its fit with CHW student learning styles. This can be accomplished through regular input from students, from active CHWs, from instructors in related community service disciplines, and from those teaching in successful programs across the U.S.

Questions:

- What instructional approaches do you use now?
- Why do you use them?
- Are they appropriate for CHWs?
- How might you find out if they are the best methods for CHWs in your college’s service region?

Key Consideration: Evaluation of the CHW educational program includes evaluating a wide range of variables including student outcomes in the classroom and workplace, curriculum content, staff and faculty development, field placements, and the institutional climate. Assessing the program’s successes and challenges is a key obligation of those coordinating or directing CHW college-supported education programs.

Notes: _____

2. PROMISING PRACTICES

F. Evaluation (continued)

ELEMENT 3. Gathering Student Feedback/Satisfaction Surveying

As in other college courses, it is important to routinely gather feedback from students regarding their satisfaction with what they are learning in the classroom, as well as feedback on the program/curriculum overall. This is different than assessing teacher ability or student satisfaction with the teacher, although the two are undeniably linked. Evaluation can not be solely focused on the content of the course(s) and the overall curriculum. It is essential to link the information gathered for evaluation with employer feedback as described in Element 4.

Questions:

- How and when will you collect student feedback on course satisfaction?
- On curriculum satisfaction?
- On instructional delivery satisfaction?
- On student performance...student success?
- What has the institution learned?
- What else would you like to know for continuous program improvement?

ELEMENT 4. Soliciting Employer Feedback /Survey

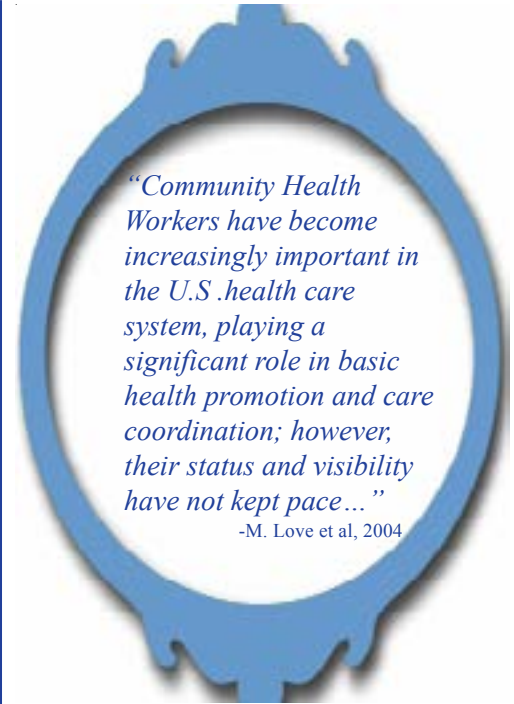
Solicit input from employers about their assessment of both the appropriateness of the CHW curriculum and CHW student performance on the job. This element gets to the core reason for CHW educational programs – whether or not CHWs are obtaining and retaining knowledge and learning skills that are vital to job performance. If not, then the educational program needs to address these issues, and if so, is there anyway (time and resources permitting) to improve course and/or curriculum content and instruction?

Questions:

- Are CHWs obtaining and retaining knowledge and learning skills that are vital to job performance?
- What CHW education related knowledge and skills are employers desiring for their employees?

ELEMENT 5. Doing Student Follow-up

Follow-up should be made with students who complete (or leave) CHW educational programs. It is important to review how they believe the curriculum contributed to their experience/success in their current work and to document any “rewards” associated with their participation in the program such as salary increases, higher position rank, promotion in grade, as well as to evaluate changes in self-perception and self-efficacy. This information can help with recruiting and retaining future students.



Notes: _____

2. PROMISING PRACTICES

F. Evaluation (continued)

Questions:

- Why did students leave the program (non-completion)?
- Is there anything that the college might do to help retain these students?
- How did your CHW educational program contribute to the students' experiences and success in their jobs?
- Have students reported any "rewards" (improved self-efficacy, salary increases, higher position rank, promotion in grade) for completing the program of study?

ELEMENT 6. Conducting Client Follow-up

Create opportunities for CHW clients to give feedback to students and to faculty about the preparedness and performance of CHW students. This is particularly useful when a CHW educational program requires fieldwork or an internship during the program. Particularly, feedback can be obtained from clients with whom the CHW as student is directly working.

Questions:

- What did the clients like most and least about their interactions with the CHW student?
- How did the knowledge and skills that the CHW learned in the program translate into effective client services and client satisfaction during the fieldwork practicum?
- How will you develop tools to measure these outcomes?
- Might you look at existing effective tools from other programs?

ELEMENT 7. Assessing Student Learning

Use creative adult performance appraisal approaches to assess growth in student knowledge and skills. Typical standard academic assessment tools may not accurately judge knowledge and skill acquisition of students in your CHW educational program. CHW students are typically older adults who may or may not have vast experience with usual college testing methods. Creative adult learning-based approaches may help teachers and trainers better evaluate student knowledge and skill retention.

Questions:

- How does your college usually test knowledge and skill? Are they effective?
- Could other methods be used and still be in compliance with your college's policies?
- Might you want to look at the experience and tools of other colleges with successful CHW training programs?

ELEMENT 8. Evaluating Community Impact

Participate in assessing the impact of CHW students on the community and on policy change. This is the hardest and the most time consuming evaluation to perform. This type of evaluation needs to be conducted over many years, if not decades, and takes much dedication to recording detail and following the CHW movement and its effect on the community at large.

Questions:

- Given your CHW and regional needs, how would you anticipate CHWs might be impacting the community?
- What community impact measures would validate the deployment of college-prepared CHWs? How could you track the changes in the health of communities served by CHWs?
- What resources will you need in terms of both time and money?
- Might you best look at other college evaluations and the tools used to measure community impact?

Notes: _____

2. PROMISING PRACTICES

G. Sustainability



Key Consideration: Sustainability
 efforts should be targeted to support and sustain all aspects and phases of a CHW educational program, and it should include goals for sustaining all contributors to the program including students, staff, faculty, and field partners. It is important that every college-supported CHW program work on issues of sustainability.

ELEMENT 1. Developing a Community/Employer/CHW Advisory Group

Integrate a community-based advisory group, including active and experienced CHWs into the program to assist in both start-up activities and efforts to sustain the program.

Questions:

- Will you invite employers to the table early to serve on a program advisory committee?
- Do you plan to include a representative number of CHWs on the advisory group?
- Will you meet regularly to keep everyone informed of progress and to continue obtaining broad input?
- Have you included representation from community organizations that can assist with ongoing funding?

ELEMENT 2. Cultivating Workforce Development/Education Funds

Develop diverse funding streams that can help to address student financial needs.

Questions:

- Might you encourage participating employers to help pay for tuition, fees, and books for their CHW staff to participate?
- Will you contact local service organizations (Rotary, Kiwanis, Lions Clubs, etc.) to solicit support for students in terms of scholarships, textbooks, transportation needs and/or childcare services?

Notes: _____

2. PROMISING PRACTICES

G. Sustainability (continued)

ELEMENT 3. Sustaining Efforts to Match Student Needs to Relevant Financial Aid Programs and Private Support

Assure that the educational program is designed to maximize student access to Federal Financial Aid and other funding sources.

Questions:

- Are you developing your curriculum with the adequate number of credit hours to support Federal Financial Aid criteria?
- Does your institution offer assistance with filling out Financial Aid forms?
- Does your institution provide assistance with researching other scholarship and/or financial aid opportunities? Assure that the educational program is designed to maximize student access to Federal Financial Aid and related funding sources.

ELEMENT 4. Publicizing and Celebrating Student Successes

Share student and program success with others including the students' families, college administrators, policymakers, employers, and the community at-large.

Questions:

- Can your program/college use its website to highlight CHW student successes?
- Does your program/college have a newsletter to share CHW student successes?
- Could this be distributed widely to employers, policymakers and the community at large?

ELEMENT 5. Integrating Alumni into Teaching and Mentoring Students

Involve CHW graduates in the on-going life of the program.

Questions:

- Will you consider including active and seasoned CHWs as supporting faculty for your program?
- Will you plan to invite CHW graduates to serve as mentors for new students?
- Do you plan to continue having CHWs on your advisory group?

ELEMENT 6. Sustaining Faculty Contact with Experienced CHWs

Work to build CHW educational program faculty capacity and understanding of the CHW field.

Legislation begins to appear at the state and national level to support CHW services; Patient Navigation bills in the new millennium begin to offer hope for funding CHWs.

Notes: _____

2. PROMISING PRACTICES

G. Sustainability (continued)

Questions:

- Can your college/program faculty develop a program that tracks CHW graduates in order to invite them to serve as faculty and mentors in the future?
- Does your institution provide support for faculty with assigned teaching assistants and research assistants to allow them to spend more time with student development?
- Can your program offer incentives for CHW students to come back as faculty?

ELEMENT 7. Exposing Administration to the CHW Field, Classes, and Publicity

Assure that college administrators and policymakers understand the contributions CHWs make and the overall dynamics of the CHW field.

Questions:

- Will you invite administrators and policymakers to participate in welcoming new CHWs to your institution?
- Will you include college administrators and policymakers on your program advisory group?
- How might you offer orientation of the CHW field for students, administrators, and policymakers alike?

ELEMENT 8. Providing Specialty Training Linked to Payers (Medicaid/Children’s Health Insurance (CHIP), Women, Infants, and Children (WIC), and Chronic Disease Management Programs)

Integrate current health plan payers, who might pay for CHW services, into the planning of CHW educational programs; integrate healthcare payer information into the learning activities.

Questions:

- Do you plan to use guest speakers from third-party payers to offer information regarding their programs, organizations, and services?
- Will you offer opportunities for the CHW students to role-play approaching a third-party payer for reimbursement of CHW services?

ELEMENT 9. Creating Curriculum Exchange Opportunities

Seek out opportunities to share curricula and review other CHW educational and training strategies and methodologies to ensure that the program is taking advantage of the best available approaches and materials.



College administrators and faculty discuss the CHW field.

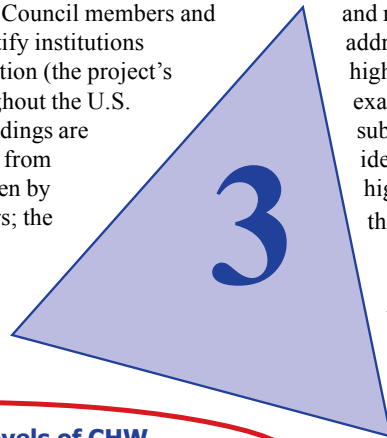
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3. KEY CONSIDERATIONS

KEY CONSIDERATIONS IN ACTION - HIGHLIGHTS

As a part of their contribution to the CHW-NEC project, CHW-NEC Advisory Council members led an effort to document promising practices in CHW education and capacity building throughout the U.S. Council members and all project partners were asked to identify institutions carrying out Key Considerations in Action (the project's prioritized promising practices) throughout the U.S. Highlights of the council members' findings are shared below. These notes are adapted from newsletter stories researched and written by participating advisory council members; the names of the original author and interviewee are listed at the end of each highlighted summary. For

more information, see the CHW-NEC final newsletter where the original stories are featured; the newsletter can be found on the website at www.chw-nec.org. Note that in the interviews and related summaries, External Support for Students is addressed throughout the stories and is not separately highlighted. Also, at the time of original interviewing no example of Credit for Prior Learning was identified, but subsequently developing efforts in Massachusetts were identified; notes on this key consideration are highlighted in the newsletter (Vol.3, No.1) available on the CHW-NEC website.



CHW Leadership at All Levels of CHW Educational Programs

The Central Massachusetts Outreach Worker Training Institute (OWTI) was identified by advisory council members and others in the field as a credit-bearing CHW program that puts issues of CHW leadership front and center. Notably, Tatyana Gorodetsky, a CHW herself, is the director of the OWTI. As this key consideration focusing on CHW leadership is also a central recommendation of the advisory council, the review of Key Considerations in Action begins with this Institute.

The OWTI was developed to address area CHW training needs; it is based at Central Massachusetts Area Health Education Center, Inc. The OWTI collaborates with many groups including area colleges, where in some cases they have cooperative agreements creating links between OWTI and the colleges. The mission of the OWTI is to provide career-focused, college-supported education for CHWs and their supervisors in health and social services.

CHW Leadership in CHW Education:

- At OWTI, CHW leadership was a priority. The director is a CHW with a strong link to the state CHW association, the Massachusetts Association of Community Health Workers (MACHW). The strong bond between the OWTI and MACHW creates synergy in CHW leadership and workforce development movements in Massachusetts.
- The OWTI was designed with leadership and input from CHWs. The model includes CHWs participating as part of faculty/instructor teams for every learning session. For each session, the CHW trainer is paired with a college/university faculty member or an administrator in

the field of health or public health. Staying connected to CHWs, MACHW and community organizations provide OWTI a constant pool of potential CHWs who can participate as students and faculty. This helps sustain the program by already having faculty and students in the pipeline.

- The OWTI's Annual CHW Recognition Day and Graduation is a forum where the CHWs are acknowledged, recognized, and inspired, and it offers a public arena to speak about themselves, community workforce development, and educational advancement. It has become a tradition to have CHWs, who are OWTI graduates and who became the OWTI faculty members, speak at the annual recognition events.
- CHW empowerment, validation, and knowledge-based skills development are all successes the director has observed within the training program. Many CHWs report gaining a new sense of pride, respect, and value. Learning itself has resulted in successfully shifting some CHWs from being reactive to proactive, being empowered with knowledge enabling them to stand up for community needs, and helping them in their efforts to represent the community while working in health and human services agencies and systems.

Sustainability: A state regulation made by the Massachusetts Department of Public Health on CHWs could assist with the sustainability of OWTI, if enforced. The policy states that CHW programs supported with state funding provide or facilitate opportunity for CHWs to participate in at least 28 hours of training per year. OWTI is also looking to employers as potential supporters of sustainability; currently there is a fee of \$150 for CHW training.

This highlighted summary is based on an interview with Tatyana Gorodetsky of the Outreach Worker Training Institute, Worcester, MA; the interviewer was Advisory Council Co-Chair Durrell Fox of the New England HIV Education Consortium, Boston, MA.

3. KEY CONSIDERATIONS

Integrating Policies and Advocacy Activities and External Support for Students

The Minnesota Community Health Worker Project and the Health Care Education Industry Partnership was chosen by CHW-NEC partners to exemplify policy and advocacy activities combined with the development of college-supported CHW education. The partnership is staffed by Anne Willaert based in Mankato, Minnesota. The project and related partnership have worked together to address changing workforce issues confronting Minnesota, and in so doing, they have developed a model of policy change aimed at Centers for Medicare and Medicaid Services that allows for reimbursement of some CHWs in their state. They have also helped to support research that has provided valuable guidance not only for their own state but for the U.S. overall.

Advocacy for CHWs and CHW Education:

- The Minnesota Project and Partnerships' focus on the development of CHW college-based educational programs provided a launching point for innovative CHW advocacy activities, wherein community college faculty and others played a role in helping to develop the CHW workplace.
- A policy council, including many academic partners, met regularly to coordinate statewide CHW activities. This ensured the development of opportunities to communicate the CHW role in promoting public policy to support cost reimbursements for CHW services.
- The Minnesota CHW Project has a long list of funding and supporting institutions and partners including college faculty, CHWs, community agency funders, and other community stakeholders.
- The project's director shares that: "Having community health workers at the table through the entire curriculum development and design process ensured that the learning objectives and curriculum would fully support the role of Minnesota's CHWs. CHWs help bridge the gap in services to the underserved and are vital in creating healthy communities and assisting in the provision of equal access to healthcare for everyone."
- Six course components in the state's curriculum reflect entry-level core competencies, and they incorporate policy and advocacy content. The six components include: (1) the CHW Role, Advocacy, and Outreach; (2) Organization and Resources (Community and Personal Strategies); (3) Teaching and Capacity Building; (4) Legal and Ethical Responsibilities, (5) Coordination, Documentation, and Reporting; and (6) Communication and Cultural Competence.

Sustainability: The Minnesota college programs working collaboratively have helped to build and sustain college-supported CHW training. Together with a CHW-led association, Minnesota collaborators have worked to promote the availability of money to fund CHW services. Through this effort they have helped to create the employment market to sustain them as CHW educators and, most importantly, to help sustain the community work of CHWs.

This highlighted summary is based on an interview with Anne Willaert of the Minnesota State Colleges and Universities System, Mankato, MN; the interviewer was Advisory Council Member Valerie Starkey of the Na Pu'uwai Native Hawaiian Health Care System, Kaunakakai, HI.



CHWs review a proposed curriculum.

3. KEY CONSIDERATIONS

Responding to Diverse Participant Backgrounds

The CHW program at Minneapolis Community and Technical College (MCTC) serves an ethnically and internationally diverse student body. Jane Foote explains that their CHW program is a part of the statewide Minnesota Community Health Worker Project. CHW educational programs at the college were developed to address gaps in the job industry in terms of what colleges had to offer.

Serving a diverse student population:

- In the U.S., tensions existed among immigrant students dating back to struggles in their countries of origin. Students and instructors can overcome some of these historical tensions by putting the theories from the communication module of the Minnesota CHW curriculum into action.
- The Minnesota 11-credit curriculum created seven modules tailoring training to the communities in which CHWs live and work and for the populations they serve. The theme of diversity is woven throughout the curriculum with many opportunities for applying health literacy exercises within the community. One example from the curriculum is the task of mapping the resources available in the neighborhoods where the CHWs serve. In this exercise, the CHW must examine their community from an assets perspective as it relates to the services that are available to the diverse populations living there.
- The curriculum's attention to building student skills and empowering the students with richly diverse presentations, discussions, and assignments, all geared to adult learners, has made this program successful. MCTC has found that all of this, as well as working to build a multi-cultural and international respectful community within the classroom, has helped to ensure that the CHW students achieve their goal of graduating and being prepared to move forward in the pursuit of their goals for the future.

Sustainability: Minneapolis Community and Technical College CHW students from the initial enrollment cohort have already stepped into leadership roles at the school and in their community. Several students from the first class have become mentors, tutors, and teacher aides for other CHW students now participating in the program. The overall sustainability of the program relies on having strong ties to the health and human services industry. To assure the success of students, the Minnesota CHW project worked hard to give the students as much assistance as needed including supporting students in getting financial aid and scholarships, English tutoring, and finding internship site placements.

This highlighted summary is based on an interview with Jane Foote of Minnesota Community and Technical College, Minneapolis, MN; the interviewer was Advisory Council Member Kimberly Brown-Williams of All Children's Hospital, St. Petersburg, FL.



CHWs participate in a cultural competency exercise.

3. KEY CONSIDERATIONS

Integrating Diverse Curriculum and Teaching Styles and Offering Innovative Approaches to External Support for CHW Students

It is clear at Pima Community College in Tucson, Arizona, that CHW students have an investment in shaping their own education. In part this is because of the way that the CHW program director, Mark Homan, decided to “create a sense of ownership for the students in the program and their education.” To help foster this ownership, the initial CHW course in the college’s 16-credit CHW basic certificate program is tailored to what CHW students would like to learn and how that learning relates to the goal of the overall program. The course and the curriculum can by design shift to meet the needs of the students for any given CHW cohort, including meeting students where they are; often holding class off campus in a community location chosen by the class.

A Responsive CHW Curriculum:

The Pima Community College CHW Program employs many strategies for creating a curriculum that responds effectively to the needs of CHW students, including addressing the fact that many students have not been engaged within traditional postsecondary education environments at all or, at least, not for many years.

The curriculum embraces an adult-centered teaching style accompanied by a proactive approach to supporting unique adult learner needs. The college’s innovative strategies included:

- **Language Translation in Real Time:** Students come from many cultural backgrounds and speak many languages. Mark Homan shares: “I try to assure that every student, regardless of whatever languages they may speak, are able to fully engage.” To address this, he created a multi-language classroom with student translators. For some students, providing translation services can even earn them some internship time for college credit.
- **Small Group Work:** Learning activities are also completed in small groups to address language and learning barriers. These groups take turns leading the class through various activities such as a community development scavenger hunt, where students go out around the classroom and gather materials related to community development. They then create a sculpture of all the things they have gathered symbolizing the important elements related to the community development process.
- **Guest Speakers:** Students enjoy contact with professionals from the community with whom they may work in their CHW jobs. Guest speakers present on topics like Social Security and AHCCCS (Arizona Health Care Cost Containment System), which is the Arizona’s Medicaid program. All presentations are

bilingual or are translated just as other class discussions are translated in real time.

- **Daycare:** When classes are held in a local community center it is easier to offer childcare support. One selected community center for CHW classes has a classroom on one side and a daycare room on the other side of the center. Daycare for the CHW students is provided by a group of grandmothers linked to the center called “the Nanas Group.” These nanas work with the small children helping to teach them about the culture of their own neighborhoods. These services are usually coordinated with the community center staff. The community center is one of seven Family Wellness and Resource Centers in the local area school district.
- **Community Change Course Content:** CHWs take a course that is supported by the textbook: “Promoting Community Change” by Mark Homan. Students are responsible for participating in certain types of community events, such as a conference about working with young people; the students work at the conference to help with its activities.

Sustainability: In addition to the college’s creative approaches for supporting non-traditional adult students, external support for students is important to the program. Effort is given to generating financial support for students’ academic enrollment costs, and unpaid internships are solicited from various community service groups including: the Tucson Unified School District, Rotary Clubs, the United Way, and other organizations within and outside the college environment.

Sustainability student-style: Students help develop their own financial support mechanisms as well. They have volunteered their services in local school districts and with the Tucson water company. In one case, they participated in trainings around health and water conservation. Following this, they went from door-to-door to let the public know about Tucson water issues. They were paid by the water company for their help, but most notably, they decided to not take the monies for themselves. Instead they put the funds earned into a communal pot called the “*olla*” (pronounced: *oya*), and they then put these funds into the Pima College Foundation account.



3. KEY CONSIDERATIONS

The funds that they generate by helping the water utility communicate with the public about water conservation are then used to support CHW students in need. In order to be eligible for this support, applicants go through a student board of directors where they set up their own eligibility requirements. This is a unique means developed by the CHW students, themselves, to support all needy members of the CHW student community. Some CHW students are also linked to local community centers, where students who have completed the college program serve as mentors for the students coming after them. These organized student groups, have also developed important relationships with local area policymakers. For example, the County Board of Supervisors awards the students a certificate upon completing the CHW educational program, county monies are provided to support a CHW community-based training program. This is not a Pima Community College program per se, but it follows the 16-credit basic certificate curriculum. Finally, the Pima Community College supported program has learned about one tried and true way of sustaining students – “food” is made available in the night classes, and students take turns in preparing and offering these foods.



CHW students participating in a “community development scavenger hunt” prepare to create their sculpture.

This highlighted summary is based on an interview with Mark Homan of Pima Community College, Tucson, AZ; the interview team was comprised of Advisory Council Members Valerie Starkey of the Na Pu’uwai Native Hawaiian Health Care System, Kaunakakai, HI; Mae Gilene Begay of Navajo Division of Health, Window Rock, AZ; and Cathy Stueckemann of the Indian Health Service, Rockville, MD.

3. KEY CONSIDERATIONS

Innovative Instructional Approaches

Cornell University was selected as a model institution to exemplify innovative instructional approaches in CHW education. As a part of their work with adult-learners, Cornell not only offers innovative approaches to teaching, they also emphasize the importance of preparing the student for success before they join a student cohort. Cornell stresses the importance of engaging the employer as a true supporter of student success. The Cornell program is known nationwide for offering a competency-based approach to educating “family support workers” serving at the frontlines of health and human services. Quite a number of CHW programs have found this curriculum meets their needs for entry-level prepared CHWs. The program does not require any formal educational prerequisites to enroll.

Innovative Instructional Approaches:

- The program has a unique way by which it delivers the training for participants: “The program is designed for adult learners who learn by practicing and doing,” states Meryl Jones, director of Family Development at the New York City Department of Youth and Community Development. Enrolled individuals develop skills for both work and life.
- Popular education is at the center of this curriculum. The curriculum integrates interactive role plays and analysis of triggers, such as pictures which highlight typical families served. For example, students may be asked to study a drawing to identify the strengths of the family in the drawing. Participants are encouraged to develop confidence in assessing family and system strengths and needs; they are encouraged through problem-solving to build critical thinking skills.
- Curriculum modules are structured to challenge participants to acquire new skill sets and enhance those that they already have. Techniques such as brainstorming, partner work, and small and large group projects are all used; participants learn through discovery. The student/participant-centered learning approaches support student success; and this cooperative approach to education also ultimately prepares students in their approach with their community clients in the same way.
- The program emphasizes preparing participants for their own learning experiences. There is an orientation for applicants to the program, which includes a discussion of expectations, program structure, student preparedness, and suggestions for success. The orientation addresses many myths about barriers to success and offers examples of student support that are

in place by the program at Cornell to address barriers. Participants are encouraged to get employer approval and buy-in for their enrollment, even to the extent that employers may support the costs of their enrollment.

- The family development approach helps families develop the capacity to solve problems and achieve long-lasting self-reliance. Services provided by family workers are more focused on helping families use their own strengths and skills to reach their own goals.
- Those who enroll in the Cornell program often report changes in their behavior from being very quiet and reserved to having the confidence to be vocal advocates for the underserved. Ultimately, employers and related community-based organizations gain more competent workers who help to improve community program outcomes, and wherein overall organizational cultures improve.

Sustainability: Cornell’s curriculum is implemented in collaboration with the New York Department of Youth and Community Development. This training program is available in all 62 counties of New York State and in 16 other states. To date (in 2008), there are 3,500 graduates in New York State and more than 10,000 graduates overall.

This highlighted summary is based on an interview with Meryl Jones of the New York City Department of Youth and Community Development, New York, New York; the interviewer was Advisory Council Member Romeila Rodriguez of Woodhull Medical Center, Brooklyn, NY.



CHW students engage in role playing as part of the “popular education” training model.

3. KEY CONSIDERATIONS

Addressing Personal Barriers to Participation

Maui and Kapi'olani Community Colleges in Hawaii offer a place where natural leaders can continue their education and earn college credit to support their work as CHWs. These graduates become the next generation of Hawaii's health professional workforce. According to Napualani Spock, director for the Community Health Workforce of the Hawaii Primary Care Association, "getting in the door to start the program is not easy for many potential students." Through collaborations between the colleges, workforce development staff, and advisory councils, the programs conducted community assessments and surveys so they would have information about the needs and interests of the future student body in the community health worker programs.

Personal barriers to mainstream education identified by CHWs varied; they include:

- the unknown process of taking college courses
- past due book fines from a previous college experience affecting the current application
- non-established residence in Hawaii
- high tuition costs
- non-existent immunization records
- lack of or limited access to transportation
- child care costs and options
- finding a balance between work, family, and classes

Brainstorming to eliminate personal barriers: Hawaii's educational program works to address the issues identified as barriers to access. Through open conversations and work groups among the students, the identified barriers are reviewed and the groups brainstorm about ways to eliminate the barriers. In the process:

- CHW student role models give hope to many students who experience bumps in the road as they navigate their way through the college experience.
- It is understood that a CHW's education does not start or end in a classroom. Community health workers continue to build leadership, communication, and other skills through their first-hand experiences in community settings, as well as in the classroom setting.

Sustainability: A community health worker program is as good as the foundation upon which it is built. Ms. Spock believes that the experiences of community health workers as students increase the success of the next enrollment group. Learning from prior mistakes and realistic approaches, builds the foundation of a strong and sustainable CHW educational program—one that continues to provide the support and knowledge base which complements the life experiences of CHWs throughout the islands of Hawaii.

This highlighted summary is based on an interview with Napualani Spock of the Hawaii Primary Care Association, Pu'unene, HI; the interviewer was Advisory Council Member Graciela Camarena of Migrant Health Promotion, Welasco, TX.

Creating Links between Education and Career Growth

Community Health Works was originally developed through a partnership of the Department of Health Education at San Francisco State University and the Health Science Department at City College of San Francisco. Representatives from many sectors came together early in the process of development; including state policymakers, hospital administrators, and local workforce agency staff. They discussed the growing health care industry and explored the skills needed by CHWs to serve effectively in that system. The first six years (1995-2001) of funding for the collaborative effort between the University and City College came from the U.S. Department of Education's Fund for Improvement of Postsecondary Education (FIPSE). Community Health Works is thought to be the first program to establish a credit-bearing certificate of education for CHWs in the United States.

Linking Education and Career Growth:

- During the course of implementing the program, the Community Health Works team modified how they linked education and career growth for their students. They expanded classes to meet demands from students and employers. At first, CHW instructors taught small class groups, but students and potential students pushed to have larger classes. Area hospitals and other agencies were always in need of more CHWs.
- Graduates are able to obtain good jobs. Some students have come back to the institution as presenters who talk about their experience both as CHW students and as CHWs in the workplace. This certificate program gives the students the experience and awareness of the community that supports their role as a CHW.

3. KEY CONSIDERATIONS

- The program conducts routine surveys in CHW work sites. Accordingly, courses are modified every year to address current needs in the workplace. CHW training is community-based and includes internship experiences for both working CHW students and new CHWs. The internships strengthen student opportunities to network for jobs and to learn both the skills and content that are on target for local area jobs.
- One of the challenges of “creating links between education and career growth” is funding for students’ education. The tuition costs in this California-based school are \$20 a unit for in-state students and \$150 a unit for out-of- state students. The program prefers to offer free tuition to their students and, they have largely been able to do that up to this point in time.

Sustainability: The Community Health Works program is responsive to its industry partners and its students. As staff member Alma Avila explains, “they are continually exploring ways to address area workforce capacity building needs.” Currently they are working to establish CHW educational programs for youth. By being responsive to the demands of the workplace and the community, this historic program has continued to sustain itself.

This highlighted summary is based on an interview with Alma Avila of City College of San Francisco, San Francisco, CA; the interviewer was Advisory Council Member Kimbro Talk of the Navajo Health Services (Diné Nation), Shiprock, NM.

Evaluating All Aspects of the Program for the Life of the Program

Several Florida community colleges started a collaboration as a part of an innovative research effort funded by the Centers for Disease Control known as the *Maternal and Child Services Workforce Development* (MCSWD) program. It was established to promote a stronger workforce, in this case, the CHW workforce. The program targeted core maternal and child health competencies, safe childbirth education, developmental disabilities, and intervention and family support systems available in the community.

The overall goal of the MCSWD program was to determine the most effective strategies, programs, and systems to build capacity among CHWs that would enable them to both reduce illness and death among mothers as well as to promote healthy lifestyles among childbearing families. The program developed a core curriculum offering 21 academic transferable

credits that articulated well with existing postsecondary human service, pre-health science, and health-related professions educational programs in the colleges. The program targeted existing workers who were providing outreach, support, and intervention services for childbearing families and their children (birth to age 5) in public health, child development, and family service settings.

The evaluation of this educational intervention had four levels:

1. The Individual Level - the individual family support worker/CHW students
2. The Agency/Program Level - the home agency of the participating CHW student
3. The Community/Client Level - the communities and clients served
4. The Educational Program Level - looking at the educational institution

The research team, coordinated by Darlene Shearer, collected evaluation information four times throughout the length of the program regarding CHW student learner outcomes. This included visiting the agency of each CHW student to determine if they had the same kind of duties and the same amount of work experience before, during, and after the program. They collected student profiles including such data as current job allocation and previous schooling.

Evaluating CHW student development:

- To understand academic achievement, individual colleges tracked student grades; their grades improved over time. Although there were a few students that dropped out due to family problems, no students failed.
- To evaluate student problem solving skills, students were asked to write narrative reports on different cases, for example, “what would they have done in a given situation?” Notably, with courses offered only in English, in some instances, the program had to provide tutoring for students in order to fully evaluate critical thinking skills in exercises such as this.
- Changes were noted in CHW self-confidence related to their knowledge of maternal and child health issues.

This highlighted summary is based on an interview with Darlene Shearer of the University of South Florida, Tampa, FL; the interviewer was Advisory Council Member Myrna Jarquin of Montgomery County Human Services Center, Rockville, MD.

3. KEY CONSIDERATIONS

Working to Sustain Students and the CHW Educational Program

The City of Denver compensates the University of Denver to coordinate a CHW educational program in local community colleges. The students and area residents are community members representing the cultural and linguistic diversity of the state. These individuals work in a variety of community-based locations including health, school, and community centers. Some other venues in which they work are going door to door to inform people of services. They work with clientele of various local shops and have made a link with a clinic to help students access pregnancy testing.

Sustaining Students:

- One of the greatest achievements for CHW students has been the opportunity to succeed in college. In many cases, these are first generation college students. They have 35 faculty members, all unique, who take great joy in seeing the individuals in this program succeed.
- The Denver Community College CHW program has been a win-win situation in many ways: there are new partnerships with new streams of business interested in CHWs. Career pathways are being developed from CHW outreach to patient navigation.
- CHWs are better prepared for the work they do, and the policymakers see this as a success because of the diversity of the workforce. In addition, the clients benefit from the CHW being better prepared.
- Helping support students to take courses in the communities where they live and work helps support CHW educational needs statewide. Recognizing this, Denver Community College enrolls students statewide. CHW students can go to their local community colleges for the first required CHW courses and then travel to Denver for some CHW core course requirements, necessitating only a short stay in the city.
- CHWs can become leaders and serve as mentors for new students coming into the program. The program seeks CHW feedback and responds to meet the needs of students in many different ways. For example, in response to student input, the students take the first set of three classes and then take a study break.
- One challenge the program staff notes is language barriers for many Spanish speakers. The college requires exams be completed in English. If a student has problems with English, they are referred to the *English as a Second Language* course.

Sustainability: The program addresses sustainability issues by assisting students with financial issues and personal choices. At present, when students apply for admission, they also apply for any grants or tuition reimbursements available through Denver Health Community Voices. To date, none of the students has had to pay for their courses. This sustainability is dependant upon a patchwork of funders that have worked well to cover students' needs. The program's director, Elizabeth Whitley, notes that to make the project and sustainability work, academic partners need to be flexible and committed to educating this type of non-traditional adult and often working student. Also, the program needs a broad base of community support including such groups as Sisters of Color, Planned Parenthood, and others. Funders need to include both government and private supporters. Institutions currently providing funding for the program include the W. K. Kellogg Foundation and the Colorado Department of Public Health and Environment. In addition, tobacco settlement money is provided from the State of Colorado.

This highlighted summary is based on an interview with Elizabeth Whitley of The Community College of Denver; the interviewer was Advisory Council Member Cynthia Thomas of the Arizona Community Health Outreach Workers Network (AzCHOW), Inc., Tucson, AZ.



See the CHW-NEC Newsletter Vol.3, No.1 on the website: www.chw-nec.org for the complete interview reports on "Key Considerations in Action."

4. CONCLUSIONS

In the overall perspective, the findings from the CHW-NEC project from October 1, 2004 through September 30, 2008 reveal there is no “one best system” for community health worker training—no ‘single silver bullet’ for a nationally adopted educational program. There is also no standard “curriculum size” that fits all regional needs. Rather it is clear that locally-responsive educational programs are needed to address community health worker capacity building needs.

Success can be realized in both postsecondary credit and non-credit-bearing training tracks. There are multiple postsecondary doors of entry that work and which can adequately serve differing workforce markets nationally. The initial critical step to successful curriculum development is to measure and properly understand regional workforce market demands and to participate in workforce market development by “doing” respectful and responsive training.

What the CHW-NEC particularly offers is a set of “Key Considerations” for a “national community of promising practices.” The national education collaborative recommends starting with training at an entry-level for community health workers of all titles and in all service settings across the United States. Grow from the simple to the more complex only as the workforce and market place invites or requests increasing levels of educational support.

The CHW National Education Collaborative also found the foundation for delivering “a successful national community of practice” comes with the invitation and respectful engagement of the voices of seasoned and active community health workers in curriculum design and instructional delivery processes. America’s institutions of higher education need to “exercise academic restraint and humility” to effectively hear the counsel of those who are already serving effectively in community health work. The Key Considerations rendered by the CHW-NEC National Advisory Council of ten active and seasoned CHW leaders and five experienced CHW program directors and advocates are illustrated and emphasized repeatedly in this guidebook as a central product of this collaborative. See the full “Key Considerations” document on the website at www.chw-nec.org

In every setting investigated by the CHW-NEC, community health workers—*promotores*, community health representatives, doulas, community health advisors, access to care advocates, patient care advocates, patient navigators, neighborhood outreach workers, health start mentors, and all those who do community health work under so many different titles—share “a common core set of competencies” to be effective in their communities and to be invaluable to their employers in reaching

populations who are most in need of culturally appropriate services. Those core competencies, still being affirmed by the field as it grows and develops, provide a critical starting point for curriculum development that is tailored to the local level. As the field further affirms these core competencies, those working in CHW education and capacity building will increasingly be able to contribute to growing a strong and united CHW workforce.

In addition to a core set of entry-level competencies, community health workers are often further prepared to successfully serve within many health and human service issue areas including:

- 1) In chronic disease issue areas, such as diabetes, obesity, HIV-AIDS, cancers of all types, asthma and other chronic obstructive pulmonary diseases, and many more;
- 2) In behavioral health, such as domestic violence, child abuse, bullying, substance abuse, sexual abuse, and many more; and
- 3) In human services such as food banks, homeless shelters, disaster preparedness settings, immigration services and many other issue areas.

Community health workers serve in all these issue areas and in many different settings, including hospitals, clinics, health departments, community health centers, tribal health and Indian Health Service units, and more.

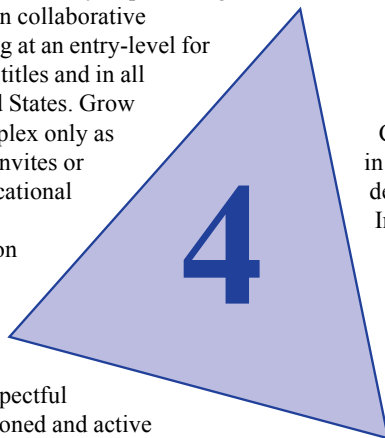
Final reflections on lessons learned in the long journey of the Community Health Worker National Education Collaborative bring to light several key considerations in their own right.

In starting and strengthening a CHW educational program, a broad partnership needs to be involved. Everyone needs to be at the table to plan, implement, and design a strong CHW educational program. Assure sufficient engagement of all partners in curriculum development, instructional delivery, evaluation, and program sustainability: employers, community health and human services agencies, students, faculty, administrators, and local, state, and national public and private funders. This is especially important for both CHWs and their current or potential employers/coordinators:

- CHW engagement is an imperative for educational institutional success.
- Employers and related stakeholders must be at the program feasibility study table.

The institutional climate must be taken into account from program initiation to sustainability:

- Institutional and faculty sensitivity for addressing barriers to student success is an imperative.
- Institutional support can be fickle and may fluctuate with changes in an institution’s administrative climate and where competing curricular demands are always present.



4. CONCLUSIONS

- “Small is Beautiful”...Start with a Bite-size Entry-Level Certificate of training.

Approaches to education and capacity building must reflect approaches that CHWs need to utilize in the field to inform and empower those they serve:

- Adult learning pedagogy is an imperative for adult non-traditional student success.
- Offering orientations for students new to higher education to navigate the college is important to successful matriculation, retention, and completion rates.
- Core competencies set the initial stage for training to be responsive to the CHW field of work.
- CHW training in common core competencies across the country is important, but programs of study must also be uniquely tailored to regional needs.
- Offering a CHW curriculum, which is responsive to the unique character and needs of the workforce becomes a college program development ‘labor of love’ when external grant incentive support is absent.
- Offering recognition for the competencies that CHWs bring with them to the college is important, but it takes a lot of work to design a credit by assessment system.
- The attributes of direct experience which CHWs bring to the educational program are an invaluable resource to the learning activities in any program of study; trainers and faculty need to take advantage of these attributes.

Understanding the dynamics of the local marketplace in terms of the current status and potential long-range demand for CHWs is critical to the educational institution decision-making process on whether to start a new program/curriculum.

- Workforce market assessment and employment market development are both important. These are critically important first steps in the program’s feasibility study.
- Service agency support for students to complete a program of study and preparation for work can save on-the-job training costs for employers.

Finally, it is clear that the developmental nature of the field contributes to an ongoing need for those engaged in CHW educational program development. It is important for postsecondary institutions to keep apprised of the CHW leadership in the field and changes occurring at the state and national levels, particularly regarding accessibility of educational resources for CHW programs and related training standards. Many institutions have found they need to play a role in being a part of this dialogue. Among the bigger issues in this area are the growing interests in and initiation of CHW credentialing which in some ways can muddy clarity and create delays in educational design and instructional delivery. Ongoing dialogue with CHWs and other leaders in this area is imperative.



Some postsecondary institutions offer distance learning classes in order to meet the needs of its CHW students: this also addresses small class sizes.

4. CONCLUSIONS

TIPS FROM THE FIELD

1. The first Rule is “KISS IT.” Keep it simple and salient from the start. Begin with an entry-level core competency-based basic certificate curriculum, which is CHW informed and employer validated.
2. Avoid unrealistic and unnecessary academic admissions barriers for a basic entry-level program; avoid unnecessary pre-requisites.
3. Take it to the students...to the community. Try to make it student-centered not campus-centered.
4. Built it from the Outside In not from the Inside Out. Build the curriculum from the perspective of community-based CHW practice sites. Consider a curriculum constructed from the perspective of where CHWs work and serve in their communities.
5. Exercise Academic Humility. Invite seasoned and active CHWs and employers to inform and validate the curriculum and instruction which the college offers. Engage CHWs as program advisors, as teachers, as teacher aides, as guest lecturers, as fieldwork site leaders, supervisors, and preceptors (to help validate the competence of students), as mentors and advisors for students (offering help for CHWs as students to navigate the college). In other words, fully engage the leadership of experienced, seasoned, and successful CHWs to support the college’s development and delivery of a CHW responsive program.
6. Make sure it meets a 4 As Test:
 - Is it Appropriate? Is it entry-level, welcoming to adult learners, liberating, language-sensitive, competency-based, and culturally appropriate?
 - Is it Acceptable? Is it at a content level of acceptability? For example, don’t require pharmacology, anatomy and physiology, or even full blown medical terminology courses, when this is truly not needed. Do the training in the context of the unique character and need of the community (ies) being served.
 - Is it Accessible? Avoid barriers to matriculation, like academic screenings which make non-traditional learners feel fearful. Offer the instruction where students live and work in the college’s service region. Consider student transportation issues and options (for example, student car pools, and public transportation options); can childcare alternatives be explored to assist these adult students as parents?
 - Is it Adaptable? Is it “community evidence-based?” Is it tailored to unique population and neighborhood needs? Can instruction be scheduled in blocks of time, like over weekends? Can distance learning technology reach students in multiple sites...is this technology user friendly...will resource-poor communities and disadvantaged students have access to the college’s distance learning technologies?

4. CONCLUSIONS

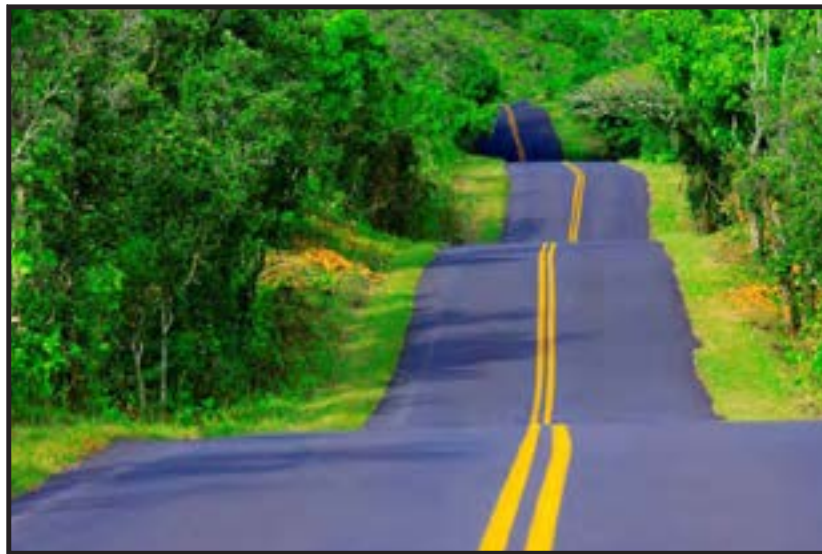
The CHW-NEC Journey

This project was conceptualized in an era when community colleges were just beginning to define their roles in community health worker education. They were the maverick institutions that stepped in with a variety of instructional responses to address the expressed needs of CHWs and their employers. As the CHW-NEC project was funded over a four year period from 2004 through 2008, it became increasingly common to hear and connect with community colleges that were exploring their educational roles in this field. Today, while CHW college-supported programs are not yet widespread, it is clear that the growth in interest and in actual programs is now moving like a small wildfire. Community health workers are here to stay; as evidenced by the 2007 release of the HRSA CHW National Workforce Study, the CHW workforce is estimated to be more than 100,000 with approximately one third of that workforce playing a role in volunteer programming. The question is no longer should colleges and credit-bearing education be a part of the field, but how must it be done?

In the years ahead, it will be important to watch the signals from the American Association of CHWs and other national CHW leadership groups including the CHW group within the American Public Health Association, now moving to Section status, with its special Committee on CHW Education y *Capacitacion*. These groups will help set the stage for endorsing core competencies in the community health services field and to define acceptable credentialing which will impact educational programming. The Key Considerations for promising practices

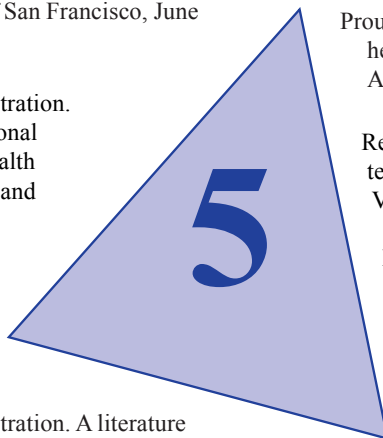
in CHW education identified by the CHW-NEC Advisory Council can also offer some directions for colleges and other institutions working to develop programs; like the community health services field, the Key Considerations will also continue to evolve. The CHW-NEC website is offered as a venue to capture and track that evolution.

The CHW-NEC offers a starting point for the field in creating a national infrastructure and set of overarching values related to CHW education and capacity building. During its four years, the collaborative partners were like canaries in the coal mine—institutions developing new programs in a still evolving field. Each program amalgamated its programming to the shape of the local landscape. The CHW-NEC was successful in providing acceptable, appropriate, adaptable, and accessible technical assistance to help with local and regional landscapes responsively. For educationally responsive postsecondary programs to continue growing and developing curricular doors of entry for the CHW workforce, the educational institutions always need to reach for the best guides in the field—the seasoned CHWs who bring a long and honorable tradition of standing in two worlds and making them connect.



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APPENDIX G

List of AIDS Education and Training Centers⁷

AETC Name	General Contact Information	Contact Information	States Covered
National Coordinating Resource Center	François-Xavier Bagnoud Center School of Nursing, Rutgers, The State University of New Jersey 65 Bergen Street, 8th floor Newark, NJ 07101 phone: (973) 972-5141 fax: (973) 972-0397 email: info@aidsetc.org	n/a	n/a
Mid Atlantic	University of Pittsburgh Graduate School of Public Health 130 DeSoto Street A427 Crabtree Hall Pittsburgh, PA 15261 phone: (412) 624-1895 fax: (412) 624-4767	Linda Rose Frank, PhD, MSN, ACRN, FAAN Principal Investigator and Executive Director email: frankie@pitt.edu phone: (412) 624-9118 fax: (412) 624-4767	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Midwest	University of Illinois at Chicago, College of Medicine Department of Family Medicine 1919 West Taylor, 8th Floor (M/C 779) Chicago, IL 60612	Teresa Haro Regional Assistant Director email: tharo@uic.edu phone: (312) 996-3160	Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, Wisconsin
Mountain West	Harborview Medical Center Mail Stop: 359932 325 Ninth Avenue Seattle, WA 98104 phone: (206) 543-2704	Becky Karschney Program/Training Coordinator email: karschne@uw.edu	Alaska, Colorado, Idaho, Montana, Oregon, North Dakota, South Dakota, Utah, Washington, Wyoming
New England	University of Massachusetts Medical School 333 South Street Shrewsbury, MA 01545 phone: (617) 262-5657 fax: (617) 262-5667 email: aidsed@neatc.org	Vanessa J. Sasso, MSW Senior Project Director email: vanessa.sasso@umassmed.edu phone: (508) 723-4012 fax: (508) 856-5294	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

⁷ AETC National Coordinating Resource Center. Directory of AIDS Education and Training Centers. Accessed at <https://aidsetc.org/directory>.

AETC Name	General Contact Information	Contact Information	States Covered
Northeast/ Caribbean	Columbia University, Department of Psychiatry HIV Center 601 West 168th St #46 New York, NY 10032 phone: (646) 774-6978 fax: (212) 568-3060 email: nynjaetc@columbia.edu	Gracine S. Lewis, BS email: gs2375@cumc.columbia.edu phone: (646) 774-6978 fax: (212) 568-3060 Nadine Nader email: nn69@cumc.columbia.edu phone: (646) 774-6981 fax: (212) 568-3060	New Jersey, New York, Puerto Rico, U.S. Virgin Islands
Pacific	University of California San Francisco 550 16th Street, 3rd Floor UCSF Mail Code 0661 San Francisco, CA 94158-2549	Prescott Chow Email: prescott.chow@ucsf.edu	Arizona, California, Hawaii, Nevada, and 6 U.S. affiliated Pacific Jurisdictions
South Central	Parkland Health & Hospital System 8435 N. Stemmons Freeway 11th Floor, Suite 1125 Dallas, TX 75247	Debbie Watts Administrative Assistant email: debbie.watts@phhs.org phone: (214) 590-2181 fax: (214) 590-2184	Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Southeast	Vanderbilt Comprehensive Care Clinic Vanderbilt Health at One Hundred Oaks 719 Thompson Lane, Suite 37189 Nashville, TN 37204	Jennifer Burdge, Med Project Director email: Jennifer.Burdge@vanderbilt.edu phone: (615) 875-7873 fax: (615) 875-5115	Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

APPENDIX H

Sample CHW Program Tools and Forms⁸

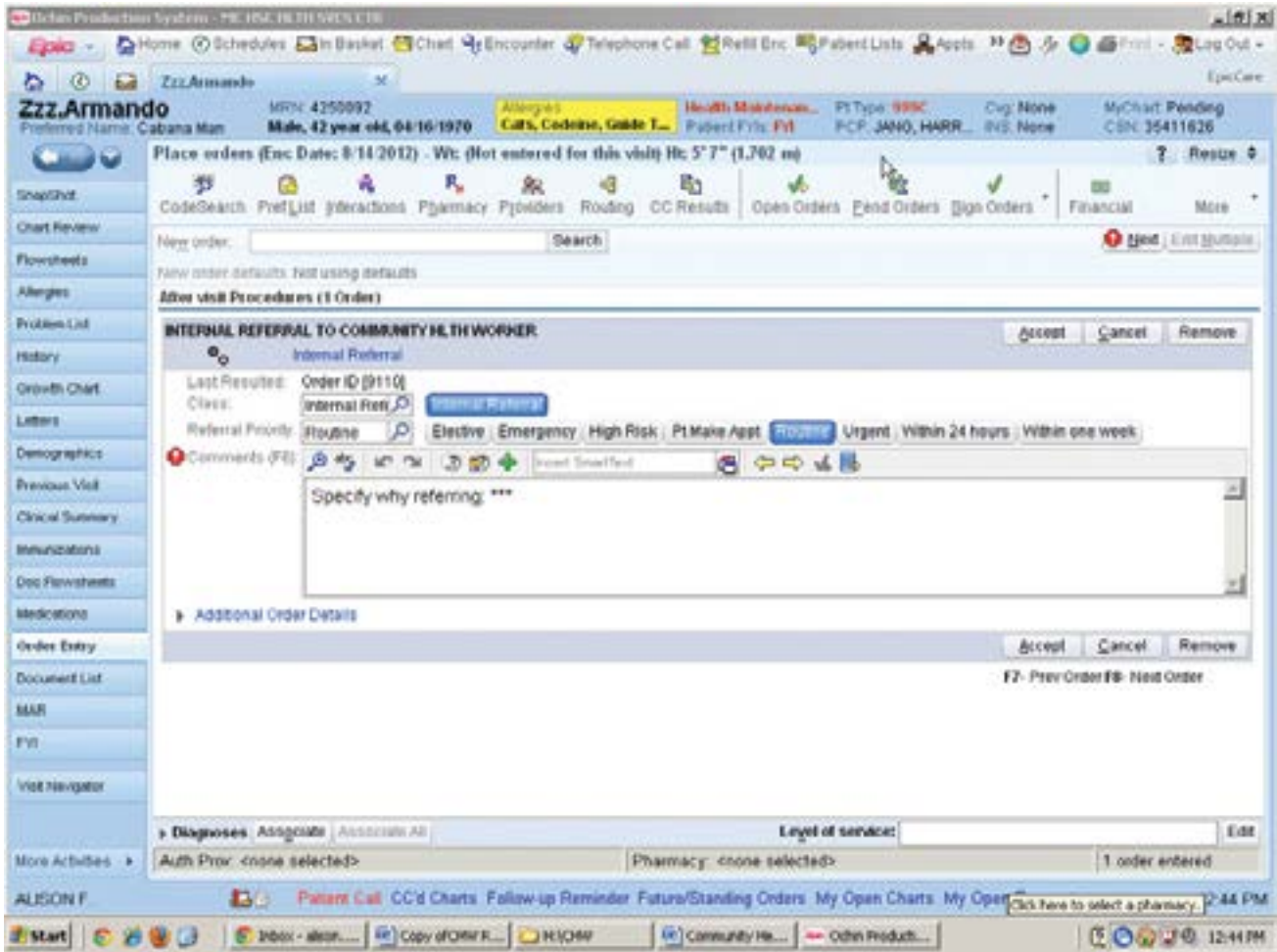
Multnomah County Health Department (MCHD) Referral Process

Step 1: Team identifies a patient in need of CHW support during huddles, team meetings, visits, etc. for:

- Care Coordination/Engagement in Primary Care Home
- Health Promotion (Education)
- Individual and Family Support Services
- Referral to Community and Social Support Services

Step 2: Provider or other team member creates a referral "Internal Referral to Community Health Worker". During the morning huddle, during a visit, or at other appropriate times the team can identify patients that they think would benefit from individual or family CHW support for areas described above. If possible, a "warm-hand" off should occur simultaneously. Referral reports will be checked daily in the morning and afternoon by the CHW. For referrals that come directly from the front desk (self-referrals) The CHWs themselves will input the referral.

⁸ A Frye, J Davich, and E Borke. Multnomah County Health Department, Portland, Oregon. 2012.



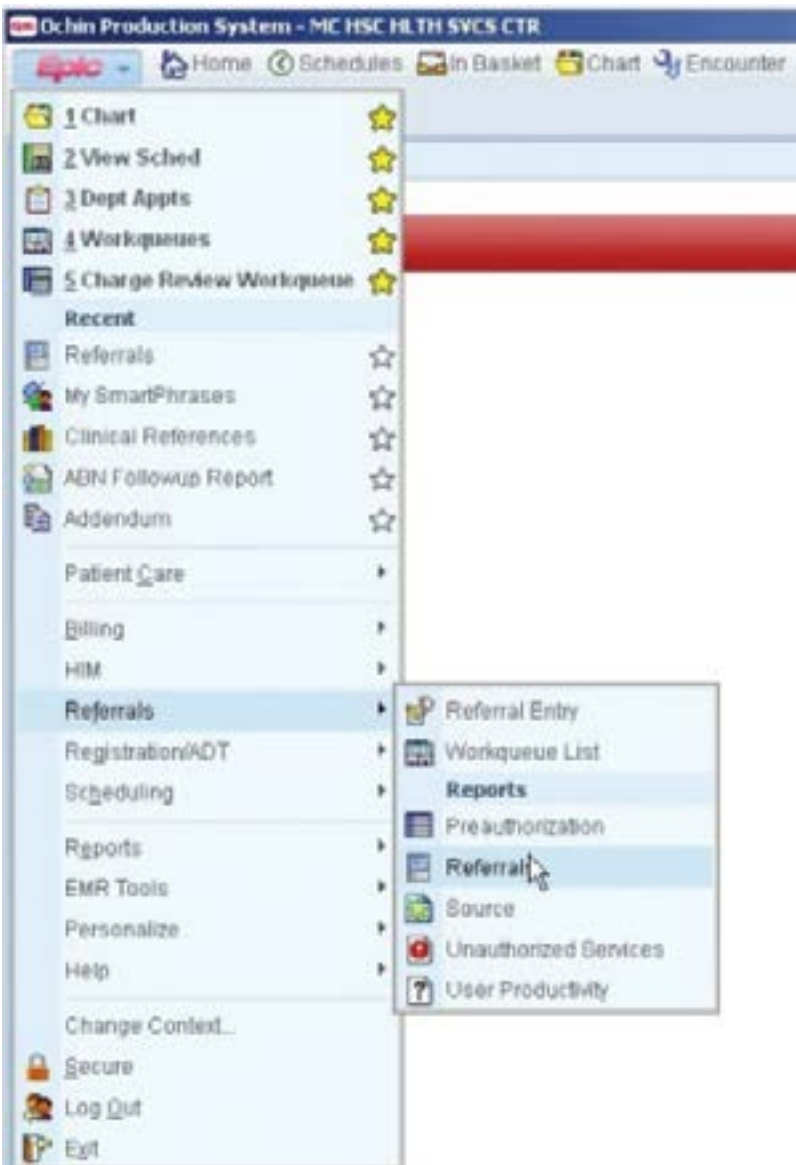
OR

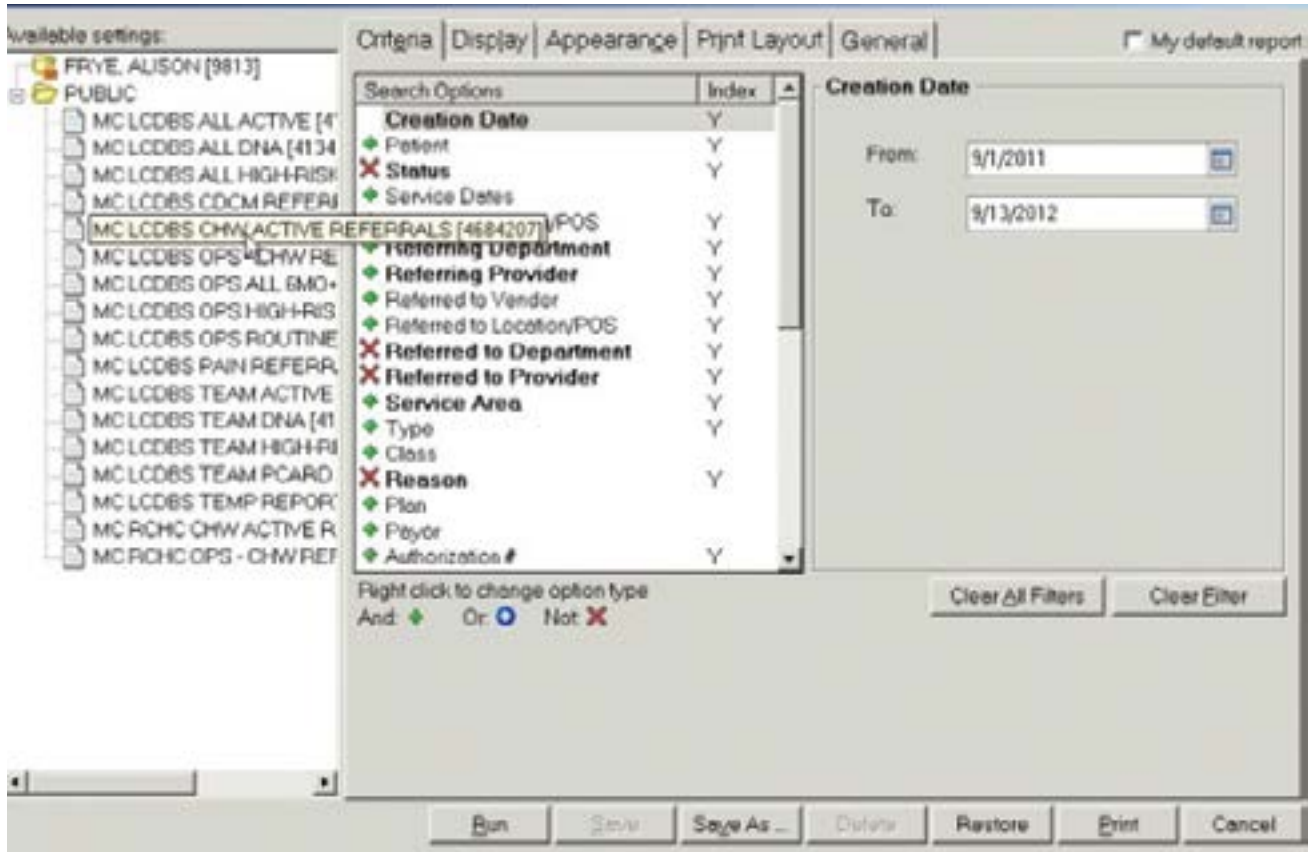


Step 3: Choose the referral type. Specify the reason for the referral in the comments. For example, if the client is referred because they need "Referral to Community and Social Support Services" specify the kind of services the client or family needs.



Step 4: CHW receives referral. At a minimum, each day in the morning and the afternoon, the CHW reviews their referral report. This will provide you with a list of referrals that have been sent to the CHW by Provider teams. To run referral reports go to the Epic menu and scroll down to Referrals, under the report menu, click on Referrals again and this will take you to the referral report menu.





Click on the referral to open it and to review details in the comments section towards the bottom of the window.

The screenshot shows a medical software interface with a referral form for 'Zee Tester'. The patient ID is 4299170 and the referral number is 1241143. The status is 'New Request'. The form includes sections for 'General', 'Referred by', 'Referred to', and 'Visits'. The 'Referred by' section shows 'MC PRIMARY CARE' and 'MC LCDBS PC'. The 'Referred to' section has several empty fields with red error icons. The 'Visits' section has a table with columns for 'Requested', 'Authorized', 'Visits', 'Per period', 'Periods', and 'Total'. The 'Requested' and 'Authorized' rows both show a value of 1. The interface also shows a taskbar at the bottom with various application icons and a system clock.

The screenshot shows the same medical software interface, but with the 'Referral Details' section expanded. It displays 'Patient Demographics for Zzzmchdonly,Zee Tester [4299170]' and 'Order Information'. The patient demographics include birth date (3/22/1976), age (36 yrs), sex (Female), and address (50 PANDA BEAR BLVD, PORTLAND OR 97232). The order information includes order number (27512673), procedure (INTERNAL REFERRAL TO COMMUNITY HLTH WORKER), and ordering user (Zita Borgen [3300]).

Patient Demographics for Zzzmchdonly,Zee Tester [4299170]				
Birth date:	3/22/1976	SSN:	999-99-9999	
Age:	36 yrs	Sex:	Female	
Home phone:	503-688-3653	Work phone:		
Address:	50 PANDA BEAR BLVD PORTLAND OR 97232		E-mail:	zta.g.borgen@multco.us
Permanent comments:				

Order Information			
Order #:	27512673	Procedure:	INTERNAL REFERRAL TO COMMUNITY HLTH WORKER
Order Date:	9/6/2012	Proc Category:	Referral
Priority:	Routine	Class:	Internal Referral
Ordering User:	Zita Borgen [3300]	Department:	Mc Lcdbs Pc
Auth Provider:	FIX, MCHD	Enc Provider:	Rubilia Ibarra, COMMUNITY HE
Referred to Provider:	No Referred to Provider Information		
Diagnosis:	COMMUNITY HEALTH EDUCATION		
Sched Instruct:			
Comment:	Specify why referring: edu		

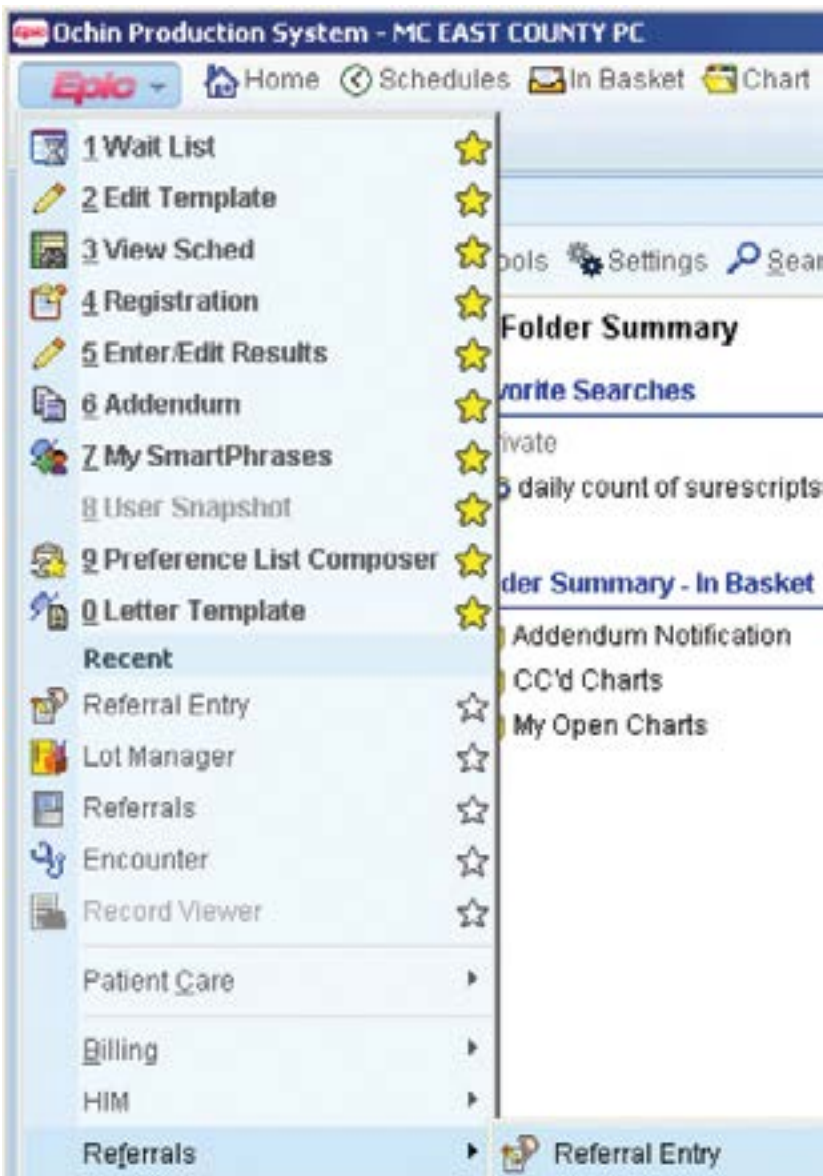
For High Risk referrals, follow-up is required within 24 hours. For Routine referrals follow-up is required within 5 business days.

Step 5: CHW contacts the client and schedules a time to complete a needs assessment using the assessment in the SMART phrase.CHWASSESS.

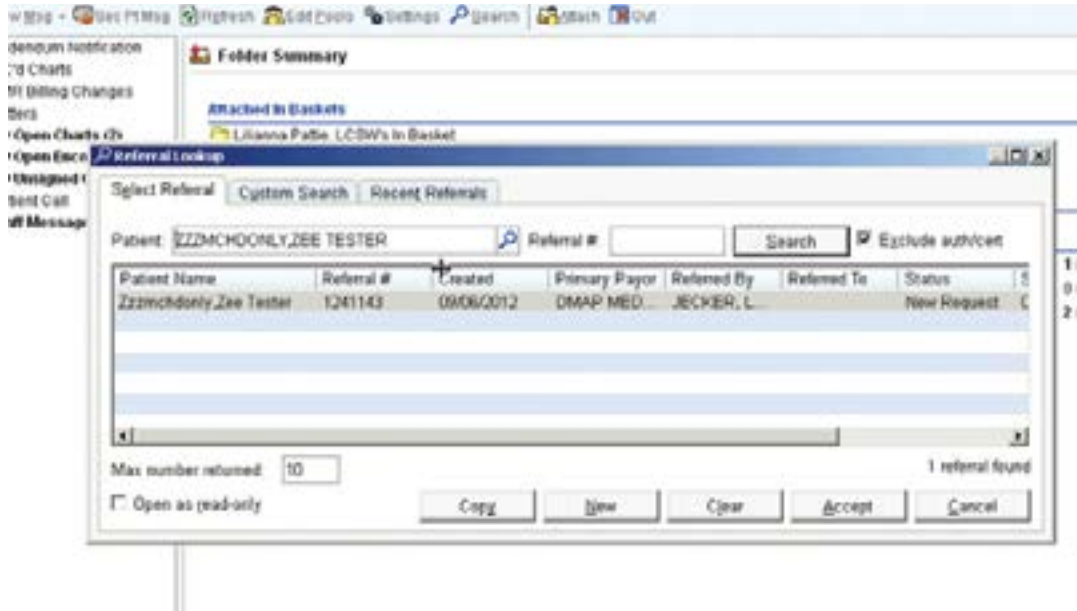
Step 6: Once CHW has made contact with the client, they close the referral using the

Go to the Epic menu.

Scroll down to Referrals, and go over to Referral Entry.



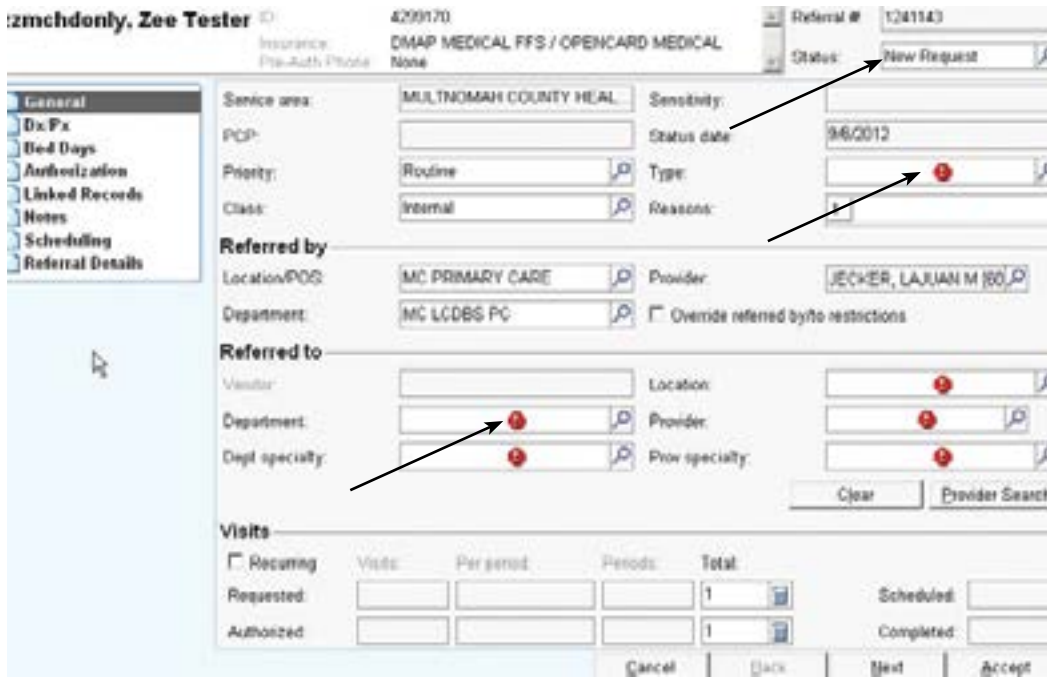
Search for the patient by name or referral number.



Choose the referral and click 'Accept'

Find the box labeled 'Status'. MCHD uses these labels in a standardized way so that providers know what happened to the referral. This may change throughout the process. (see status definitions below*)

Next the CHW adds the referral type "Community Health Worker." Next add the appropriate department in the referred to section. This would be the clinic where the CHW works.



Step 7: Once the CHW completes an assessment and creates a plan to address clients' resource, education, care coordination and support needs CHW services are documented in interim and telephone encounters as outlined in the CHW documentation guidelines. The initial assessment note is CCed to the referring provider. If the CHW does not complete an assessment and the referral is closed for any other reason, attempts to contact or refusal of service should be documented in an interim note and CCed to the referring provider.

***Referral Status Codes**

Status Name in EPIC	Definition
New Request	<ul style="list-style-type: none"> Referring Provider creates new referral. Referral is new and no activity has been done.
In Process	<ul style="list-style-type: none"> "In Process" means: <ul style="list-style-type: none"> documented attempts to contact client to make a specialty appointment, OR an appointment with the specialist/service is made and communicated to the client OR documentation that client will schedule own appointment OR the specialist clinic will contact patient to schedule.
Refused service	<ul style="list-style-type: none"> Patient refuses the referral.
Patient Cancelled	<ul style="list-style-type: none"> Patient cancels the appointment with the CHW.
Unable to Locate	<ul style="list-style-type: none"> Cannot locate the client. Has tried at minimum two phone call and one letter to reach the client.
Closed	<ul style="list-style-type: none"> The CHW makes contact with the patient to complete assessment or initial visit
Closed–Patient Cancelled	<ul style="list-style-type: none"> The patient cancels the referral. Individual working on the referral at the health center sends a staff message to the referring provider. Wait for approval from the referring provider before changing to this status.
Close–Patient No Show	<ul style="list-style-type: none"> The patient no showed for the scheduled appointment. Individual working on the referral at the health center sends a staff message to the referring provider. Wait for approval from the referring provider before changing to this status.
Canceled	<ul style="list-style-type: none"> The referring provider cancels the referral. Individual working on the referral at the health center waits for approval from the referring provider before changing to this status.

Treatment Adherence Program Referral Form—Kansas City CARE Clinic⁹

ATTN: _____

Phone: _____ Fax: _____ Email: _____

Please complete all pertinent referral information below

Client Name: _____ Date referred to peer: _____

Date of Birth: _____ Race: _____ Gender: Male Female Other

Client Phone: _____

May we leave a message at this number? Yes No

Referred By: _____

Organization: _____

Phone: _____ Fax: _____

Reason for Referral (check all that apply):

Initial assessment	SHP/Peer counseling
New diagnosis	Patient request peer counselor
New patient	Peer support
Encourage adherence	Complex regimen
Reminder phone calls	Rescue/salvage therapy
Adherence evaluation	Change in therapy
Recurring missed appointments	Starting first line regimen
Help patient prepare to start TX	Provide patient education

Additional comments:

Peer Treatment Supervisor Information:

Date Received: _____

Peer Counselor: _____

Peer follow up: _____

⁹Kansas City CARE Clinic. Treatment Adherence Referral Form. Treatment Adherence Program. Kansas City, MO.

Referral Form—Kansas City CARE Clinic¹⁰

Referred by: _____ Agency: _____

Referrer phone number: _____ Referrer Email: _____

Program Referral

Client Name: _____ Date of Birth: _____

Address: City: _____ State: _____ Zip Code: _____

May we send client mail at this address? Yes No

Phone Number: _____ Cell Phone: _____

Is it okay to leave a message on client's phone? Yes No

Age: _____ Race: _____

Is client currently receiving HIV care? Yes No

Please list the barriers this client is or has experienced with regard to staying in care:

How should the program coordinator(s) follow up with the client?

Assessment of Client Needs	Yes	No
English Proficient		
Adequate Support Systems		
Adequate Coping Mechanisms		
Mental Health Stability		
Substance Use		
Adherent to Treatment Recommendations		

¹⁰ Kansas City CARE Clinic. Treatment Adherence Referral Form. Treatment Adherence Program. Kansas City, MO.

Referral Flow Sheet–Southwest Louisiana AIDS Council (SLAC)



HIV REFERRAL FLOW SHEET

OR OLDDXNCCC OR OOC PT

PROVIDER

Physician: _____

NP: _____

SUPPORT SERVICES

Linkage Care Coordinator

FACT Intake (Part One): _____/_____/_____

Screening Completion: _____/_____/_____

Lab Work Completion: _____/_____/_____

Date of Medical Appointment: _____/_____/_____

Signature: _____

Community Health Worker

Meet/Greet Appointment: _____/_____/_____

Intake/Evaluation Appointment: _____/_____/_____

Signature: _____

Peer Advocate: Accepted Declined

MEDICAL CASE MANAGEMENT SERVICES

FACT Intake (Part Two): _____/_____/_____

SLAC Referral: _____/_____/_____

TA Counseling Session: _____/_____/_____

BH/MH Referral: _____/_____/_____

Signature: _____

SPECIALIZED SERVICES

Psychiatric Services

Medication Management: _____/_____/_____

Behavioral Health (BH)

Mental Health/BHS: _____/_____/_____

Substance Use: _____/_____/_____

Signature: _____

Intensive Case Management (INCAM)

Provider's Order to INCAM Received: _____/_____/_____

Signature: _____

NURSE

Signature: _____/_____/_____

PATIENT NAME: _____

DOB: _____

Referral Request for Services–SLAC



W.O. Moss Memorial
HEALTH CLINIC

Comprehensive Care Clinic

1000 Walters Street Lake Charles, LA 70607
Phone: 337.480.8153 Fax: 337.480.8064

Referral Request for Services

Date: _____

MRN: _____

Patient Name: _____

DOB: _____

_____ Behavioral Health Specialist

_____ Linkage Care Coordinator

_____ Community Health Worker

_____ Medical Case Manager

_____ Dental Care

_____ Medication Assistance

_____ Eye Exam

_____ Nursing Home

_____ Food Pantry

_____ Nutritionist/Nutritional Supplements

_____ HIV/AIDS Education

_____ SLAC Intake/Case Manager

_____ Home Health

_____ Substance Use Counseling

_____ Hospice

_____ Transportation Assistance

_____ Housing Assistance

_____ Treatment Adherence Counseling

_____ Insurance Assistance

_____ Other (explain below)

Explanation/Comments: _____

CCC Staff Requesting Services: _____

To be completed by recipient:

Notes/Follow-up:

Signature: _____

Sample CHW Policy and Procedure–SLAC



POLICY NUMBER: MMHC-CCC

PAGE NUMBER: 1 of 2

EFFECTIVE DATE: 07/25/18

POLICY DESCRIPTION: CCC-CHW

DEPARTMENT: W. O. Moss Memorial Health Clinic

Policy and Procedure

Approved By: _____
Director of Clinics

TITLE: CCC COMMUNITY HEALTH WORKER (CHW)

Purpose:

- To provide an added layer of support for HIV+ patients and their families
- To increase linkage and retention in care
- Provide an additional resource to assist patients in achieving patient goals
- Decrease gaps in services along the continuum of care

Policy:

- The departments within the Comprehensive Care Clinic and SWLA AIDS Council will utilize the services of the Community Health Worker for on-going or episodic engagement to increase patient health outcomes and decrease gaps in care.

Protocol:

- Staff members will complete a referral form and submit it to the CHW by fax or in hand
- CHW will process the referral and follow up with submitter of referral and provide information as is appropriate according to request
- CHW will determine if the patient requires on-going assistance. If further assistance is needed, the frequency will be determined and followed until patient is successfully equipped to be self-sufficient with or without Medical Case Manager.
- CHW will update staff regarding patients

Frequency:

- Patients may receive episodic CHW services according to the request of any staff member or at the CHW's discretion
- On-going CHW services may be provided at the following frequencies over the course of 90-days or as deemed necessary by providers and CHW:
 - One Week
 - Two Weeks
 - Monthly

Responsible Parties:

- Providers, Supervisors/Evaluators, Behavioral Health Specialist, Medical Case Managers, Non-Medical Case Managers, Navigation department (to include Linkage Care Coordinator, Peer Advocates, other CHWs)

Community Health Worker (CHW) Procedures

Title: CCC Community Health Worker

Purpose: To increase linkage and retention in care by providing support to the following departments within the Comprehensive Care Clinic and SWLA AIDS Council:

- Linkage Care Coordinator
- Medical Case Management
- Non-Medical Case Management
- Behavioral Health Services

Policy: The community health worker will receive referrals from CCC staff to aid patients accessing and maintaining medical care services.

Procedures:

Absence: the CHW will notify clinic and administrative supervisors of absence; complete outgoing case conferencing; and instruct patients to contact case managers (medical/non-medical as is appropriate) during CHW absence. Upon return, CHW will complete incoming case conferencing.

Acuity of Needs: the CHW will complete an Acuity of Needs assessment (for non-SLAC clients only) to gauge priority of needs when processing referrals and/or patient requests. For SLAC clients, CHW will refer to completed Acuity of Needs scale or complete a referral requesting completion of this assessment.

Case Conferencing: in an effort to increase positive health outcomes, the CHW is expected to participate in case conferencing with team members to ensure care coordination and/or resolution of barriers to care.

Community Health Worker (CHW) Procedures

Care Coordination: the CHW is expected to perform duties as deemed necessary within scope to aid patients in accomplishing goals established in written plan of care or as is necessary for retention in care, viral suppression, and/or addressing social service needs.

Chart Reviews: for CCC, the CHW is expected to complete five patient chart reviews per month from the OOC list, referrals from aforementioned departments, and /or from reports submitted by CHW. Written plan of Care, Mental Health Screening (if applicable), documentation of all encounters, and patient goals achieved will serve as the focal point. For BU project, CHW will complete chart audits as instructed by project guidelines at baseline, six months, and twelve months.

Consultation: the Clinic Manager is available to the CHW to provide guidance and instruction regarding patients when deemed necessary.

External Case Conferencing: the CHW will remain as a clinic contact representative for the Nursing Home and/or Hospice care teams on behalf of acute patients.

Home Visits: the CHW will complete home visits as directed for linkage to care purposes and /or per staff request through the referral form. The non-medical case manager may serve as a “buddy” to the CHW for home visits. An update will be provided to the staff member who requested the home visit as soon as possible or within three days. Following the home visit, the CHW must complete the response portion of the referral form and submit to the requester of service.

Incoming Case Conferencing: upon returning from an absence, the CHW will follow up with the Lead Medical Case Manager and/or the Medical Case Manager to receive an update regarding patient needs communicated prior to CHW’s absence.

Community Health Worker (CHW) Procedures

Leave Requests: the CHW will complete a leave request form and submit it to immediate supervisor for approval. Upon approval, the CHW will notify clinic and administrative supervisors of absences (i.e. flex, sick, and vacation).

Meetings: the CHW will participate in weekly Huddle meetings, MCM and Support Services meetings, Monthly CCC Team meetings, SLAC CM Meetings, Clinic Staff meetings, and department meetings (as scheduled). During this time, patient staffing will occur and all team members will receive updates regarding CHW's progress with patients. During department meetings, the CHW may share challenges regarding patients, ideas, concerns regarding CHW role, and/or program integration.

Mental Health Screening: per the request of the Behavioral Health Services, a Mental Health Screening (taken from the FACT Intake Assessment) will be completed during a home visit for the purpose of linkage and retention in care. The screening should be completed and submitted to the Behavioral Health Services for further follow up and/or services. If a patient reports suicidal/homicidal ideations, the CHW is expected to call 911 immediately. Any other actions and/or counseling regarding this area is prohibited as it would be outside of the CHW's scope.

Outgoing Case Conferencing: the CHW will submit a report to the Lead Medical Case Manager of patients who will need assistance in the CHW's absence to ensure staff is aware of patient needs and those needs are met during CHW's absence.

Referrals: the CHW is expected to receive and process referrals in a timely fashion. All referrals require a written response on the bottom of the form to be submitted to the person requesting the referral. This referral and the CHW's work regarding the referral must be documented on a progress note in the patient's file/chart.

Community Health Worker (CHW) Procedures

- Linkage Care Coordinator Referrals- process as quickly as the situation requires or within three days.

OOO List- the monthly Out of Care list is expected to be processed within 30-days with an update provided to both the CCC Clinic team during monthly team meeting as well as to the SLAC Case Management team during meetings (two per month).

- Medical Case Management/Non-Medical CM Referral- process as quickly as possible or within three days.
- Behavioral Health Services Referral- process as quickly as possible or within three days.

Reports: the CHW will provide the following reports with the frequency cited.

Community Health Worker (CHW) Procedures

Requests: all issues and or challenges that may hinder completion of duties should be communicated to appropriate persons by email, letter, or text message to ensure that issue is addressed.

Trainings: the CHW will be notified regarding trainings and is expected to attend and participate with a positive attitude and willing active engagement.

Transportation: the CHW is expected to provide transportation, as a last resort, for patients who are scheduled for linkage care coordination, medical, and/or mental health appointments for linkage and retention in care. The CHW is NOT a permanent resource for transportation and should only be used if other resources are unavailable.

“Warm Hand-Off”: upon receiving the patient referral, the CHW and/or Evaluators follow up with the patient within three days for program participant consent and linkage.

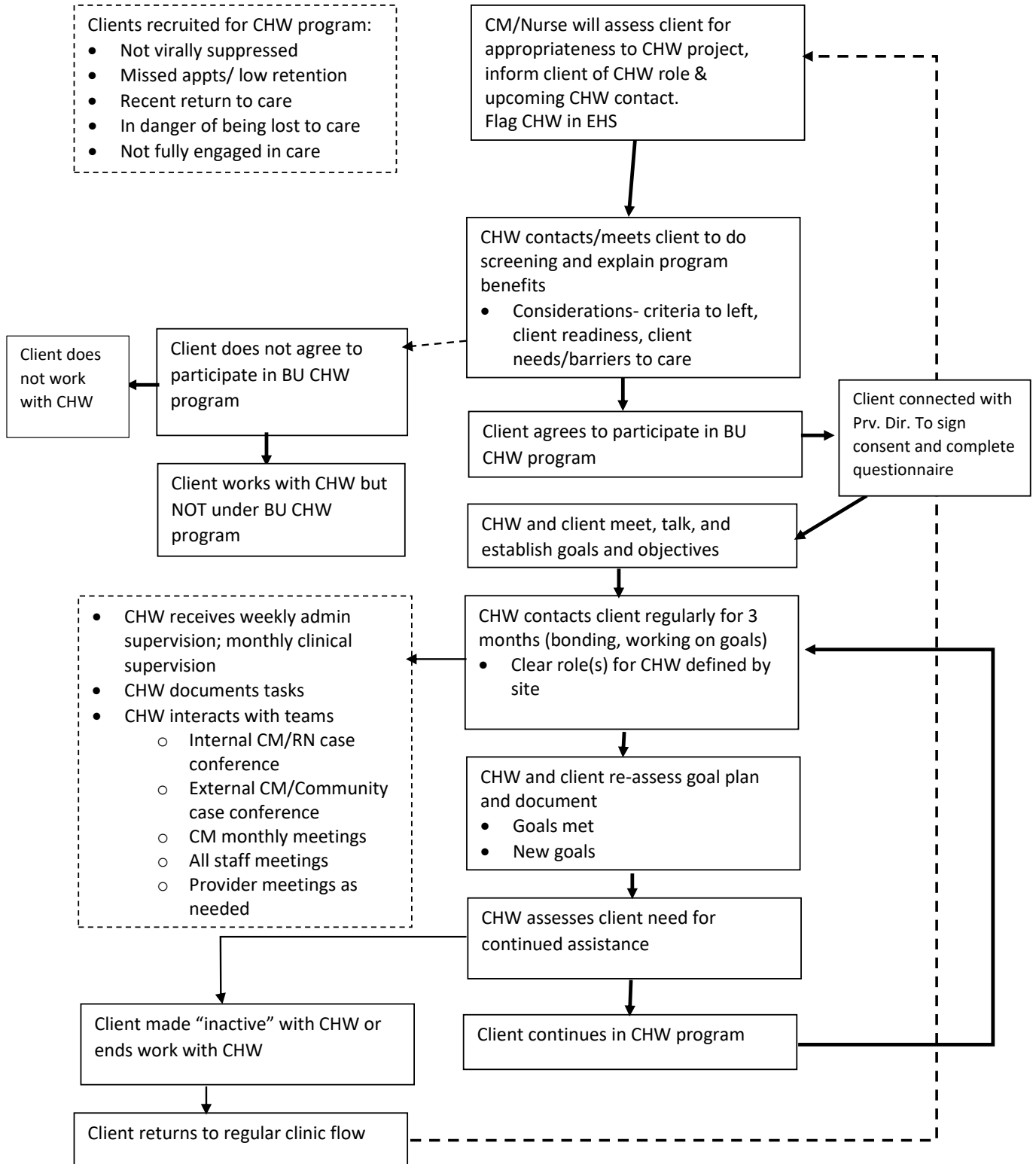
Written Plan of Care: the CHW will work with the following departments to support patients in accomplishing the goals developed during the patients’ meeting with the staff:

- Linkage Care Coordinator- Risk Reduction Plan
- Medical Case Management- Written Plan of Care
- Non-Medical Case Management- Care Plan
- Behavioral Health Services- Care Plan

From these tools, the CHW will work with the patient to establish a realistic list of short-term goals that demonstrate progress toward meeting the goals outlined in the documents cited above.

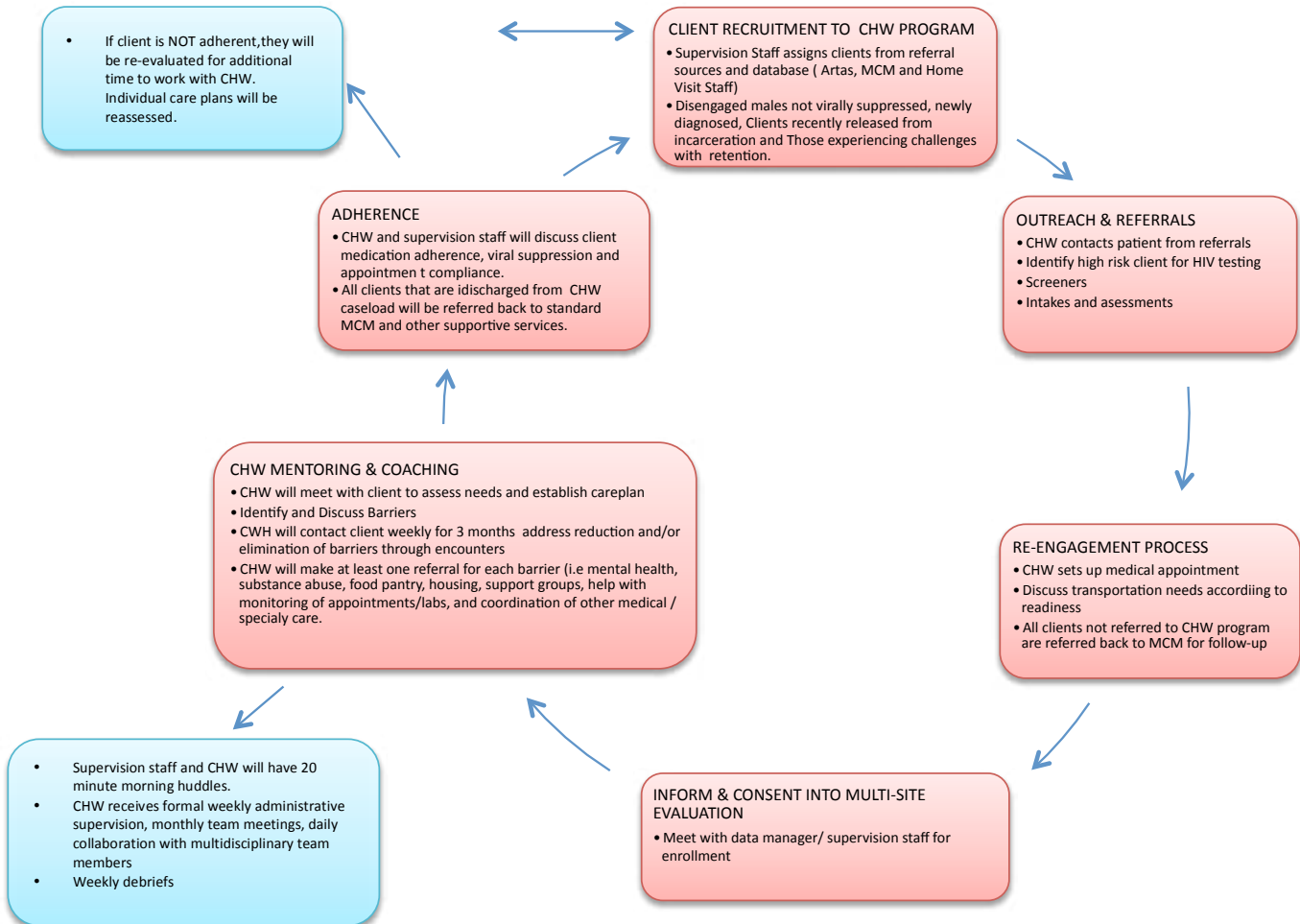
CHW Program Flowchart–The McGregor Clinic

Community Health Worker in McGregor HIV Care Program



CHW Program Flowchart–Newark Beth Israel Medical Center, Family Treatment Center

NEWARK BETH ISRAEL MEDICAL CENTER –CHW FLOWCHART



CHW Program Forms—Southern Nevada Health District



**COMMUNITY
HEALTH
WORKERS**

*Building Bridges in the
Community with Compassion,
Respect, and Accountability*

Viral Suppression

Retention in Care

**Medication
Adherence**

Peer Navigation



FOR REFERRAL

CALL OR EMAIL
Program Coordinator
MERYLYN YEGON, CHN
(702) 759-1646
yegon@snhd.org

OR VISIT
**SOUTHERN NEVADA
HEALTH DISTRICT**
280 S. Decatur Blvd.
Las Vegas, NV 89107

RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize any of the agencies listed below who participate in the community based Ryan White All Parts (ABCD) Programs in the State of Nevada to release and/or share information concerning my eligibility, medical record status, and information concerning my HIV screening, diagnosis, and treatment. The following agencies/programs authorized are:

- ❖ Access Community Cultural Education Programs & Trainings
- ❖ AIDS Healthcare Foundation
- ❖ Access to Healthcare Network
- ❖ Aid for AIDS of Nevada
- ❖ Carson City Health and Human Services
- ❖ Community Counseling Center
- ❖ Community Outreach Medical Center
- ❖ Clark County Social Service
- ❖ Dignity Health
- ❖ Division of Public and Behavioral Health HIV Surveillance
- ❖ Golden Rainbow
- ❖ HELP of Southern Nevada
- ❖ Horizon Ridge Clinic
- ❖ Huntridge Family Clinic
- ❖ Las Vegas Urban League
- ❖ Nevada Division of Welfare and Supportive Services
- ❖ Nevada Medicaid
- ❖ Medicare
- ❖ Nevada AIDS Research & Education Society
- ❖ Nevada Legal Services
- ❖ Nevada Office of HIV/AIDS
- ❖ North County Healthcare
- ❖ Northern Nevada HOPES
- ❖ Nye County Health & Human Services
- ❖ Planned Parenthood of the Rocky Mountains
- ❖ Ramsell Corp. – Pharmacy Benefits Manager
- ❖ Southern Nevada Health District
- ❖ The Gay & Lesbian Center of Southern Nevada
- ❖ University Medical Center- Wellness Center
- ❖ University Nevada, Las Vegas - College of Medicine - Maternal and Child Wellness Program
- ❖ University Nevada, Las Vegas School of Dental Medicine
- ❖ Washoe County Health District
- ❖ Your Health Insurance Company
- ❖ Your Physician: _____
- ❖ Partner/Spouse/Other: _____

Information may be released between the above listed agencies throughout the duration of my active enrollment in the Ryan White All Parts (ABCD) program. I may withdraw this consent by notifying, in writing, the Ryan White agency where my eligibility was completed. I understand that my records are protected under federal HIPAA regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this consent in writing any time, except to the extent that any action has been taken while it is still in force. This consent expires automatically one (1) year from registration or previously signed consent.

AFFIDAVIT

I fully understand that by applying for this program, I am divulging personal information that will be used to assist me with benefits associated with the Nevada Ryan White Parts A, B, C, D Programs. I understand this information will be kept confidential, but will be used by staff to review my eligibility for this program. Also, by signing this form, I understand that the information contained within may be used to verify all application information provided. By applying for this program, I understand that this does not mean that my application will be accepted, as funds are limited and eligibility requirements must be met.

I fully acknowledge:

1. It is my responsibility to renew my eligibility every 6 months on or before my birth month and 6 months following (half-birth month).
2. It is my responsibility to report any changes to my household income, my address, my contact information, my health insurance, or any other information that may affect my eligibility or services.
3. If I fail to recertify, my eligibility and benefits will be terminated.

I certify that the information provided in this application is true and accurate as of the date below and acknowledge that any intentional or negligent misrepresentation of the information may result in nullification of this application and a termination of benefits.

Printed NameSignatureDate



Fax completed form to (702) 759-1412 Attn: Legal

Authorization to Disclose Patient Health Information

For Office Use Only:
Approved: _____
Date: _____

Southern Nevada Health District - PO Box 3902 - Las Vegas, NV 89127 - Tele: 702-759-1364

Patient/Client Name (please print): _____ Male/Female (circle one) Birthdate: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____

I authorize the disclosure of the above named individual's Protected Health Information (PHI) and request the Southern Nevada Health District to release the requested information to: (Note: There is a \$0.60 per page photocopy fee)

Name (please print): _____
 Address: _____

Release of information may be (indicate one): _____ Mailed; Faxed to a secure Fax #: _____
 _____ Call for in-person pickup; Emailed encrypted to: _____

The purpose for this requested information is:
 Continuity of Care Personal use Consultation School Transfer Attorney Insurance
 Other, specify: _____

The following information is requested:
 Immunization records Sexual Health Clinic
 TB Clinic Records HIV Case Management
 Lab Test (specify type of test) _____ Family Planning Records
 Refugee Clinic Records Outreach HIV/STD screening
 Food handler/Health Card Testing Healthy Kids Exam/Maternal Child Health Records
 Other, specify: _____
 Specify dates of services, if known: _____

I acknowledge and hereby understand that releasing my health records may contain information relating to HIV or AIDS, treatment for alcohol and/or drug abuse, and/or sexually transmitted disease.
Consent to release: HIV or AIDS, treatment for alcohol and/or drug abuse, and/or sexually transmitted disease. _____ (INITIALS).

This authorization will expire on the following date or event _____ or 180 days from date of signature.

- I understand that:
1. Authorizing this release of information is voluntary and I may refuse to sign this authorization.
 2. My treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization except where the treatment is for the purpose of research or solely for purpose of creating a health record for disclosure to a third party.
 3. I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance upon it.
 4. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy regulations.

The Southern Nevada Health District, its employees and healthcare providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

 Signature of Patient or Patient's Legal Representative Today's Date

 Print Name of Legal Representative (if applicable) Relationship to Patient (if not the Patient)

Note: Guardians and Durable Power of Attorney designees should include a copy of the applicable paperwork



REFERRAL TO SOUTHERN NEVADA HEALTH DISTRICT RYAN WHITE PROGRAMS

Fax the completed referral form to 702-759-1433 (secure line)

PLEASE NOTE NEW Fax #

Preferred referral method is via CAREWare. Complete this form if client is not in CAREWare or a referral cannot be completed in CAREWare. Call 702-759-0930 for questions.

Referring Agency Information Section

Date _____ Referring Agency _____

Person making referral _____ Phone _____

Email address: _____

Referral to: Nurse Case Manager Eligibility EIS/Linkage MD Other _____

Patient Information Section (Client in CAREWare A _____ CAREWare B _____)

Patient name: _____ DOB _____ Age _____

Phone _____ Address _____ ZIP Code _____

Race: Black White American Indian/Alaskan native Island Pacific Asian Other _____

Ethnicity: Non-Hispanic/Latino Hispanic/Latino Unknown _____

PMD: _____ Insurance: _____ Hospital DC date: _____

Reason for Referral (this will help expedite the referral process for clients referred to NCM)

Priority 1: (Assigned within 1 working day): Pregnant Newborn Child ≤ 18 yrs

Priority 2: Opportunistic infections Chronic non-adherence High acuity score (>31)

Newly diagnosed (<1 yr & was never in care) Viral Load _____ CD4 _____

Uploaded in CAREWare: Labs Proof of Diagnosis

Comments:

Is patient aware of referral? Yes No OK to contact client at the number listed above? Y N

Primary Language: English Spanish Other _____ Best time to call: _____

(SNHD Use ONLY)

Reply Date:

Staff Assigned: _____ Date Assigned: _____

Wait-listed, date: _____

Summary of attempts to contact (NCM must initiate contact within 1-7 days of assigned date)

Date: _____ Contact Outcome: Unable to contact Relocated Declined Accepted

Date: _____ Contact Outcome: Unable to contact Relocated Declined Accepted

Date: _____ Contact Outcome: Unable to contact Relocated Declined Accepted

04/11/2016 LY

Sample Home Visit Protocol–Southern Nevada Health District

SOUTHERN NEVADA HEALTH DISTRICT PROTOCOL/ STANDARD OPERATING PROCEDURE

DEPARTMENT: Sexual Health Clinic MANUAL: Case Management SECTION: Administrative	Number:
TITLE: Home Visit Safety For Case Managers and other staff in SHC	Origination Date: 10/2013
DESCRIPTION: Safety is a primary concern for all staff at the SHC and will be considered as integral for home visits done by the Case Managers, Social Workers and DIIS staff.	Effective:
	Next Review: 01/2015
APPROVED BY: <i>[Signature]</i> <i>Bonnie Aronson RN. DPH NSG</i>	Last Revision: 1/2014

I. PURPOSE / SCOPE

Safety is a consideration for all as work place violence episodes are increasing across the nation. This is especially important for case managers and other Sexual Health Clinic staff as they do home visits with clients to perform assessments and assist in care. The risk of violence toward staff members during these visits can be mitigated with some careful precautions.

Home visits are associated with potential for violence related to the fact that the home environment is not under the control of the employer as it is in other healthcare settings. Home visit related risks include those similar to clinic ones of mental illness, substance abuse, history of violence or exposure to diseases but also have other risks. These risks include safety risks from family members, animals and community crime. These may encompass the geographic area being visited, high crime areas, hostile animals, and many gang or surveillance issues that are common in this field.

II. PROTOCOL/STANDARD OPERATING PROCEDURE

The Home Visitation Leadership Advisory Coalition (Washington State Public Health) has developed a manual Safety Guideline Manual for Home visitors that has been modified and will be used as a resource before any home visits by SHC staff. When necessary and deemed an appropriate safety measure, two staff members shall be assigned to make a home visit.

Prior to doing a home visit with a family, the following should be performed.

1. Assess the case record information and other information sources, as appropriate, to determine whether there are any risk factors associated with the family, home, or neighborhood. Ask if there are animals there and if so, can they be placed in a

bedroom or backyard during the visit. If a Family Case Manager (FCM) believes that the home visit cannot be safely made alone, he or she should consult with the Supervisor to determine how to proceed.

2. If possible, call to confirm that the participating parent and/or any other people are home for the visit prior to leaving the office.
3. If traveling to a high crime area or other questionable area, schedule visits early in the day. Avoid visits after dark without supervisor approval. Avoid scheduling late afternoon visits on Fridays or before a holiday.
4. If traveling to an area that is new to the Home Visitor, before the scheduled visit, drive by to become familiar with the neighborhood.
 - a. Notify office staff when leaving or returning. If the worker plans to go home after the last field visit, Case office or a designated Supervisor via phone call or text message after the last visit is finished, and
 - b. Keep agency issued cellular phone powered on at all times while working in the field. Supervisors should keep all case management numbers in the SNHD issued cell phone.

When approaching the home:

1. When you leave your vehicle, know where you are going. Be aware of your surroundings. Carry yourself assertively. Keep your head up, posture erect, and make brief eye contact with others on the street.
2. If you are approached, be brief with the person and continue moving. Do not be drawn into conversations. Be neither friendly nor rude. Do not make the person angry. Wear a blank but firm expression. If the person continues to talk, say that you are in a hurry right now. If a person persists, follows you, or if you believe that you are in danger, yell for help as loudly as you can. Run to the nearest place where there are people.
3. Observe the outside of the home, surrounding homes, animals and/or unfamiliar vehicles.
4. Be aware of smells associated with substance use.
5. Look and listen for signs of someone at home and assess whether there is any sign of danger involving the occupants of the home.
6. Staff will always carry cell phone for all home visits.

When entering the home:

1. Go to the door that is in plain sight of the street and stand to the side of the door when knocking.
2. Do not enter the home if an unseen person calls for you to enter.
3. When door is opened, quickly observe inside to determine if there are any threats to your safety.
4. Do not enter the home if an adult is not present. If there are children in the home who may be unable to care for themselves, contact DCFS or call 1-800-992-5757 and contact local police. If the parent or caregiver with whom you normally work is unexpectedly not at home and the child is staying with someone who is a stranger to you, indicate that you will contact the parent/caregiver to reschedule for another time.

5. Observe the caregiver(s) or other adults within the household for suspicious behavior.
6. If the parent(s) refuse to let you enter the home, do not attempt to persuade them. If denied entrance, leave and return to the office. Consult with your supervisor.
7. Leave the residence if you feel unsafe entering the home.

When in the home:

1. Stay near an exit. Remain alert and observant.
2. Pay attention to unusual smells, particularly those associated with the manufacture or use of drugs.
3. Remain aware of the possibility of other persons in the home and inquire about anyone who appears to be in another room.
4. Limit the amount of personal information shared with families.
5. Do not go into any other parts of the home without the parent's permission. Proceed with caution when entering any room.
6. Do not accept food or beverages.
7. When there is a choice, sit in a hard chair rather than upholstered furniture. (If a family is startled by the knock or doorbell, family members may stick items such as syringes into the upholstered furniture.)
8. Leave immediately if you feel unsafe, encounter harassing behavior or a threat of violence, observe signs of substance abuse or if violence occurs. Consult with your supervisor.

If on a home visit and a threat to safety occurs, the employee should immediately terminate the visit and immediately leave the scene. After ensuring safe exit from the area, contact the necessary people such as law enforcement or CPS. Contact your supervisor immediately if the threat level does not warrant law enforcement but was enough to abort the visit.

a. To ensure immediate safety, if you are in a home and feel there is an imminent danger to you or to anyone in the house:

- Leave immediately.
- Call 911 or your local emergency number.
- Call the local Nevada Division of Child and Family Services (DCFS) at 702-399-0081 or the Child Abuse/Neglect Hotline at 1-800-992-5757 if children are in danger.
- Call your supervisor to advise him or her of the situation.
- Upon return to the office, debrief with your supervisor regarding what was observed during the visit.
- Contact the family as safety permits (in consultation with your supervisor) to ensure that everyone is safe. Assure the parents that you will continue to work with them (if possible) within program guidelines.

b. If you believe someone is in danger during a telephone call:

- Get as much information about his/her location as possible.
- Tell the person you are calling 911 or other emergency services, unless you fear doing so may worsen the situation or cause the caller to hang up. Try to

keep the caller on the line by using another telephone or asking someone else to make the call to 911 or other emergency services.

- If possible consult with supervisor during the call or immediately after the call.
- Stay in contact with family as safety permits.

c. If in doubt about any unusual situation, consult with your supervisor immediately. If a child is in danger, report to the Nevada DCFS immediately, and then consult with your supervisor. In a mental health crisis, do not transport families or individuals.

If you are threatened during a home visit:

1. Monitor signs of impending violence such as facial expression, verbal threats, and increase in breathing rate.
2. Summon help if needed.
3. Remain calm and speak slowly and softly.
4. Do not move closer to the customer
5. Avoid body language such as crossed arms, hands on hips, or shaking fingers
6. Avoid direct eye contact
7. If you can leave, step back slowly and leave the premises
8. If you are injured seek medical attention, notify your supervisor and contact
9. the police

Specific guidelines (see visitor manual for more specific information)

Know that there are many dangerous situations such as:

- Known abusers in the home
- Weapons are present and accessible
- People are under the influence of alcohol or other drugs
- People in the home start fighting
- Unrestrained animals (maybe aggressive)
- Holes in the walls that appear to be from fists
- Signs of drug use or manufacture:
- Smell of cat urine or ether
- Excessive security (guard dogs, covering of windows, etc)
- Paraphernalia (special ventilation, garden hose in window, lab equipment, glass pipes)
- Open sores on customer
- Large amounts of chemicals (cold tablets, lithium batteries, starter fluid, drain cleaner, camping fuel, acetone, paint thinner, brake cleaner, matchbooks, coffee filters, propane tanks)

Specific situations: See the Visitor home guide for definitions and explanations of both the signs and interventions for each.

Domestic violence

If there is a history of domestic violence

- Is the customer looking forward to the home visit or are they frightened or concerned about the visit.
- Has the customer indicated that it is not safe (abuser in home or recent violence).

Mental illness

- Determine if there is imminent danger to you, the child(ren) or any adult in the home, including the person with the mental illness
- Red flags of possible risk to the client and home visitor:
- Suicidal plans, threats and/or attempts
- Homicidal plans, threats and/or attempts

Drug Abuse

- Is there a history of drug abuse?
- Is the customer actively using?
- Have there been convictions related to use or abuse of drugs?
- Presence of drug paraphernalia
- Be aware of Red flags of intoxication
- Any indication of violent behavior?
- Any indication of manufacturing?

Firearms

- If you view firearms, assume there is an imminent danger to you, the child (ren) and/or other adults in the home leave immediately.
- If not in view, determine their whereabouts.

Criminal History

- There is a criminal history of the customer or anyone living in the home?
- Was the conviction for a crime against a person or a property crime?
- If the convicted person has a probation officer, check with them before going on the home visit

Threats of Harm, Violence Related to Gang Involvement

If entering a home and finding threats of harm, violence related to gang involvement, the home visitor must terminate the visit and call their supervisor immediately.

III. REFERENCES

Guidelines for Preventing Workplace Violence for Health Care and Social Service workers. Obtain at <https://www.osha.gov/Publications/OSHA3148/osh3148.html>

A Framework for Translating Workplace Violence Intervention Research into Evidence-Based Programs by K. McPhaul, M. London, J. Lipscomb, *Online J Issues Nursing*. 2013;18

American Nurses Association. Workplace violence
<http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-WorkplaceViolence>

Targeted Home Safety
<http://www.aging.ks.gov/TCM/Tools/Safety%20Tips%20for%20TCMs.pdf>

Washington State Public Health- Home Visitation Leadership Advisory Coalition.
Manual for Home visitors 2008

SNHD policy on Child Abuse and Neglect

IV. ATTACHMENT(S)

Safety Tips

SAFETY TIPS

- Have a game plan for the visit and let the office know exactly where and when you are going on the visit.
- Be aware of your audience when placing items inside your trunk of car, under the seats or floorboards.
- Use an excuse to leave if another family member enters the room and is dressed inappropriately.
- If a home visit presents significant safety risks- consider alternative meeting sites for visiting with the customer or take another co-worker with you.
- Do not walk around the residence looking in windows if no one answers the door,
- Look and listen for signs of disturbance involving or affecting people inside or outside of the residence. For example, is there fighting, crying, dog barking, etc?
- Trust your instincts about safety and impending danger- if you feel the need to leave, do.
- Dress casually, do not wear excessive jewelry.
- Make sure your identification is readily available. Do not wear around neck as this may be a choking hazard.
- Be aware of your surroundings, note entry to the house, exits, animals, cars or other suspicious activity.
- Leave the car and contact someone for alternative transportation, if you believe that you may not be able to return to or enter the vehicle without risk of harm.
- Park your car so you can pull out quickly if needed and cannot be obstructed from leaving. Back into space or back into driveway. Lock your car when traveling and when you return to it after the visit. Check inside and under your vehicle before entering it.
- Park with the driver's side door easily accessible,
- Locate the client's building prior to exiting the vehicle if the residence is in an apartment complex
- Carry car keys in your hand for accessibility as well as a means of protecting yourself.
- Leave valuable possessions including computers at the office.
- Always move to the side of the door after you knock, never stand in front of the door.
- Ask or wait for permission to enter the home.
- Familiarize yourself with your surroundings as you enter the premises; make sure you remember the way back to the exit/entrance.
- Do not enter the residence if no adult is present. Contact CPS if children requiring adult supervision are unattended in the home,
- You may sit in the home, but do not sit back and relax. Sit in a place where you can view the room and any doorways.
- Keep a close eye on the angry or upset customer. Stay at least arm's length away.
- Do not get between family members who are angrily confronting each other. Ask for a glass of water to give upset family member time to "cool off"
- Remove yourself from the situation as soon as possible if you feel threatened,

- Show respect and sincerity,
- Do not tell the client what to do, or how you would handle a situation if you were them,
- Make sure your body language is non-threatening. Remain calm, do not become defensive.
- Use good listening skills.
- Do not reveal any personal information about you or your family.
- Concealed weapons may not be carried or used for SNHD business.
- Staff may request animals are restrained during home visits.
- Know and follow the DCS local office procedures regarding vehicle safety, (what to do in case of an accident, breakdown, flat tire, or other mechanical problem with the vehicle),
- Become aware of the areas in the neighborhood where help could be obtained if an emergency occurs (i.e., 24-hour stores, gas stations, restaurants, and other public facilities) prior to parking the vehicle, if the home is in an unfamiliar area,
- Have enough gas in the car at all times

APPENDIX I

Sample Care Plan Forms¹¹

Peer Linkage and Re-engagement Care Plan

Client Name: _____

Client Record Number: _____

Date Created _____

Section 1: Coordination of Care

1a. First PCP Visit Attendance:

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	

¹¹ AIDS United & Boston University School of Public Health. Peer Linkage & Re-engagement of HIV-positive Women of Color. (2016) HRSA SPNS Project Dissemination of Evidence Informed Interventions.

1b. Case management visit attendance:

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	

1c: Second PCP visit attendance:

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	

Section 2: Patient identified goals

2a: Patient identified goal

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	

2b: Patient identified goal

Date Resolved:

Action Steps	Responsible Party	Target Date	Outcome	Outcome Date
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	
	<input type="checkbox"/> PCP <input type="checkbox"/> Peer <input type="checkbox"/> Patient <input type="checkbox"/> Other:		Completed? Y/N/ Other Notes:	

	Printed Name	Signature	Date
Client			
Peer			
PCP			

KC CARE Clinic Service Plan¹²

Client Name: _____ Date of Birth: _____

CHW Name: _____

Start Date:	Goal 1:	Client Will:	Date Completed:
60 Day Date:		CHW Will:	
Start Date:	Goal 2:	Client Will:	Date Completed:
60 Day Date:		CHW Will:	
Start Date:	Goal 3:	Client Will:	Date Completed:
60 Day Date:		CHW Will:	

¹² Adapted from Service Plan. Kansas City CARE Clinic. Community Health Worker Program. Kansas City, MO.

Written Plan of Care–SLAC



WRITTEN PLAN OF CARE (WPC)

Patient Name:				MRN:	DOB:
Indicated Needs		Start Date	Completion Date	Person Responsible for Action	Activity Commitment / Goal
1	Clinical/Medical				
2	Medication/Treatment Adherence				
3	Patient Information Update				
4	Cultural/Linguistic				
5	Employment/Financial				
6	Legal Needs				
7	Insurance Benefits				
8	Basic Necessities/ADL (Activities of Daily Living)				
9	Housing/Living Situation				
10	Transportation				
11	Women’s Health Assessment				
12	Support Services (CHW services, Peer Advocate, etc.)				
13	MH/SU				
14	HIV/AIDS Education and Prevention				
15	Referral Needs				
16	Other				
Patient Signature:				Date:	Was patient offered a copy of the WPC? Yes <input type="checkbox"/> No <input type="checkbox"/>
Medical Case Manager Signature:				Date:	

APPENDIX J

Sample CHW Encounter Forms¹³

CHW Client Encounter Form

Client name: _____ Date of Contact: ____/____/____

Client ID: _____ Site: _____

Duration of Encounter (minutes): _____

Encounter Content:

*Drop down menu options specified on page 2.

For each activity that you completed with a client in the course of one day, use the columns below to enter the type of encounter, the location of the encounter, and who you collaborated with to complete the encounter.

Completed? (check all that apply)	Activity	Type (drop down)	Location (drop down)	Collaboration (check all that apply)
<input type="checkbox"/>	I updated my client's medical and/or case management records (check all that apply):			
<input type="checkbox"/>	Completed an initial intake, assessment, or re-assessment.			
<input type="checkbox"/>	Updated my client's medical individual care plan.			
<input type="checkbox"/>	Updated my client's non-medical goal plan.			
<input type="checkbox"/>	I accompanied my client to an appointment (check all that apply):			
<input type="checkbox"/>	Medical appointment for their HIV.			
<input type="checkbox"/>	Medical appointment for a non-HIV matter.			
<input type="checkbox"/>	Non-medical appointment (i.e. social service appointments).			
<input type="checkbox"/>	Behavioral health (i.e. substance use or mental health) appointment.			

¹³ Adapted from the Intervention Encounter Form used in the Med-HEART project. Accessed at <http://medheart.cahpp.org/>

Completed? (check all that apply)	Activity	Type (drop down)	Location (drop down)	Collaboration (check all that apply)
<input type="checkbox"/>	I referred my client to an appointment for a service (check all that apply):			
<input type="checkbox"/>	Medical appointment for HIV healthcare (i.e. linking newly diagnosed clients to first HIV medical appointment).			
<input type="checkbox"/>	Medical appointment for non-HIV health care.			
<input type="checkbox"/>	Non-medical appointment (i.e. social service appointments).			
<input type="checkbox"/>	Behavioral health (i.e. substance use or mental health) appointment.			
<input type="checkbox"/>	I reminded my client about an upcoming HIV health care, non-HIV health care, non-medical, or behavioral health (i.e. substance use or mental health) appointment.			
<input type="checkbox"/>	I arranged transportation for my client to get to an upcoming HIV health care, non-HIV health care, non-medical, or behavioral health (i.e. substance use or mental health) appointment.			
<input type="checkbox"/>	I assisted my client with obtaining concrete services, such as by assisting with completing applications for benefits, obtaining a cell phone, or other services.			
<input type="checkbox"/>	I provided coaching to my client regarding (check all that apply):			
<input type="checkbox"/>	Education about HIV disease management and/or HIV health services.			
<input type="checkbox"/>	Education about non-HIV disease management and non-HIV health services.			
<input type="checkbox"/>	Education about harm reduction.			
<input type="checkbox"/>	I provided my client with emotional support.			
<input type="checkbox"/>	Other (please specify): _____			

Drop Down Menu Options for Encounter Content

Type of Encounter (select one only):

- Face-to-face (Individual)
- Electronic (email, social media, text, phone, fax)
- Collateral (client not present/encounter done on behalf of client)
- Other (specify): _____

Location of Encounter(s) (select one only):

- Program site
- Streets, parks, open space
- Other social service agency
- Other community setting (Bar, Drop-In Center)
- Client residence (permanent or non-permanent residence)
- Medical, social service, or community-based organization setting (external to site)
- Correctional setting
- Other (specify): _____
- N/A (not face-to-face)

Collaboration:

- HIV primary care provider with prescribing privileges (MD, NP, PA)
- Nurse
- Case manager
- Supervisor
- Peer
- Other (specify): _____
- No collaboration

Client Tracking Form—Legacy Community Health

How to create a client spreadsheet

Why do you need a client spreadsheet?

- This may help you keep track of all your clients and their appointments in one place

Who needs a client spreadsheet?

- Anyone who is working with a large caseload or needs to keep careful track of clients

What should it include?

- **Client name and date of birth**
 - Depending on how your EMR system functions, you may just want to include the patient ID number, whatever is easiest for you!
- **Appointment dates and types:** I use a coded system illustrated below
- **Notes:** Include financial eligibility deadlines, any pertinent information to remember, client was referred by someone keep this information here, etc.
- **Others:** Important lab results, progress on a goal, color coded sections, outreach or home visit attempts

How do I use my spreadsheet for HIV care?


Here is an example:

Name	DOB	Appointment	Appointment2	Appointment3	Appointment4	Notes
John Doe	1/2/1991	4/15/2019 L	4/25/2019 M			RW/ADAP expire October, referred by Roxy case manager
Jane Smith	2/5/1990	3/26/2019 M	4/16/2019 L			Insurance, requests calls after 3pm

- **Name and date of birth:** keep track of each client and look them up in our EMR
 - My spreadsheet is password encrypted because of this
- **Red text:** indicates a missed appointment, which helps me remember to attempt to reschedule
- **Highlighted text:** indicates an appointment occurring that day so that I know who should be coming in for an appointment
- **Coded text:** L (lab) and M (medical) next to the dates to indicate appointment type

For questions reach out to Savi Bailey at sbailey@legacycommunityhealth.org!

Service Tracking Form–SLAC

		Southwest Louisiana AIDS Council 425 Kingsley Street Lake Charles, LA 70601			
Patient Units of Service Tracking Form					
Staff Name			Month		Page Number
	Date	Patient Name	Activity	F2F Units	Non-F2F Units
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

DO NOT ALTER THIS FORM

SLAC-CCC Revised 09.13.18

APPENDIX K

Sample Supervision Tools

One-on-One Meeting Agenda¹⁴

Name:

Date:

What has been the most challenging part of your week?

What has been the most rewarding part of your week?

Goals or planned actions for the week?

- 1 -
- 2 -
- 3 -

Progress on the goals or planned actions from last week?

- 1 -
- 2 -
- 3 -

Issues to review?

Resources needed?

Questions?

Next week's goals or planned actions?

- 1 -
- 2 -
- 3 -

Additional Discussion Points?

¹⁴ © 2013, Cy Wakeman, Inc., RealityBasedLeadership.com. Accessed at <http://www.realitybasedleadership.com/wp-content/uploads/2015/08/Ego-Bypass-Tool-One-on-One-Meeting-Agenda.pdf>

Trauma-Informed Supervision Guide—JACQUES Initiative

Trauma-Informed Supervision Guide

The Process of Supervision

A trauma-informed environment feels safe and welcoming to everyone. The way that staff members treat each other affects that environment and the people being served. Supervision should model the characteristics of a healthy empowering relationship so that staff members can develop similar relationships with the people being served.

A trauma-informed supervisor will attend to the supervisor-supervisee relationship by being aware of the impact of what they say and how they say it on their relationship with their supervisees. This includes:

Acknowledge Culture

The relationship between a supervisor and supervisee is influenced by the culture that each person comes from. By culture, we mean the attitudes, beliefs, values, assumptions and behaviors that a person has learned as result of their origins, social group and history. A trauma-informed supervisor maintains awareness of their own attitudes, beliefs, values, assumptions and behaviors as well as those of their supervisee, and pays attention to and acknowledges how these affect the relationship and the work.

Be Respectful, Honest, Kind and Fair

A supervision relationship is one in which the supervisor has more power than the supervisee. It is important to be aware of this fact. If a supervisee does not feel safe in the relationship, they will be unable to share their difficulties, doubts and struggles, and will instead try to make the supervisor think they are “on top of everything” even when they are not. It is therefore especially important to be respectful, that is to acknowledge and appreciate the supervisee’s experience and point of view even when it is different from that of the supervisor.

Supervisors must be honest as well so that trust can build in the relationship over time. However, honesty must be tempered with kindness. A supervisor will need to be able to speak directly to a supervisee about the areas of work in which they still have learning to do. However, a trauma-informed supervisor will communicate the expectation that the supervisee will improve over time. Supervisors must also be fair, giving all supervisees equal treatment, regardless of differences in *biability*.

Accentuate the Positive

A trauma-informed environment focuses on and builds on people’s strengths. In supervision, this means noticing and acknowledging what a supervisee is doing well, rather than addressing only the areas that need improvement.

Be Calm and Calming

When people are upset, they do not do their best thinking. When a crisis occurs or a supervisee makes a serious error, it is natural to become upset. A trauma-informed supervisor will take at least a moment to calm down before addressing a difficult situation. More time may be taken if an immediate response is not required. The goal is to be able to evaluate and discuss the situation in a calm manner. This is good modeling for the supervisee, and leads to better communication and more productive problem-solving.

Ask Questions

One goal of supervision is to encourage self-reflection and emotional self-awareness. This is sometimes called reflective supervision. We want staff members to be aware of what they are doing and why they are doing it. Asking questions and listening closely encourages people to self-reflect. In addition, asking questions prevents misunderstandings that result from mistaken assumptions.

Empower Others

The goal of supervision is to enhance the skills of the supervisee. For this reason, it is better practice to elicit solutions from the supervisee than to tell them what to do. If the supervisee cannot identify any potential solutions, it is good practice to brainstorm a number of solutions and then encourage the supervisee to select one by considering the pros and cons of each. A good supervisor allows a supervisee as much choice and control as possible.

Promote Self-Care

In the course of our work, we are exposed to painful circumstances and difficult situations that naturally stimulate feelings. Sometimes these feelings can accumulate and affect our attitudes, behavior and well-being. It is important for a supervisor to be aware of and acknowledge the impact that the work may have on all of us.

A trauma-informed supervisor models good self-care and supports supervisees in finding and implementing self-care strategies that work for them. Self-care strategies include but are not limited to healthy living; work/life balance; setting appropriate boundaries with co-workers and participants; and using peer and professional support.

Trauma-Informed Supervision Guide

Building Supervisee Competency

The process of supervision models the way we want employees to treat co-workers and the people we serve. A trauma-informed supervisor encourages supervisees to attend to the relationships they have with the people we serve by directing their awareness toward the impact of what they say and do on these relationships. Employees should also understand that they are the “face” of the agency and of treatment in general, and that the way they treat people has an impact of how people see them, the agency, and treatment as a whole.

A trauma-informed supervisor encourages supervisees to:

Work with people on the goals they set for themselves

People are motivated to work toward the goals that matter to them, not the goals that others have for them. We often think we know what is good for other people, and forget to ask what is important to them. This leads to many disappointments and misunderstandings. Supervisors can help supervisees avoid these mistakes by asking such questions as:

- What is important to this person?
- What achievement would make this person feel good about him/herself?
- What is this person trying to achieve?
- What does this person want?

Ask questions rather than make assumptions

Assumptions often keep us from coming to truly understand another person's point of view. Approaching others with openness and curiosity promotes understanding and empathy. Supervisors can encourage this attitude in supervisees by asking questions such as:

- Why do you believe that is what was intended?
- Have you asked them what is going on?
- Are there other possible explanations for what happened?

Be respectful, honest, kind and fair

For the most part, we all try to be respectful, honest, kind and fair. Usually, when we fail to achieve this, it is because of some feelings we have that we may not be aware of. The feelings may be due to some aspect of the situation or interaction we are responding to, or they may be feelings we brought with us to the workplace. Supervisors can assist supervisees by helping them to reflect on why they reacted the way they did, using such questions as:

- How do you feel about the way you handled that interaction?
- What about this particular situation made it difficult to handle?
- How were you feeling before the interaction?
- How did you feel in response to what occurred?
- How did you feel afterwards?
- What might have made things go more smoothly?

Acknowledge culture

Some of our attitudes, beliefs and assumptions come from our culture. Other people may have different attitudes, beliefs and assumptions because their background is different. Supervisors can help increase supervisees awareness of culture and cultural differences by asking questions such as:

- What in your background led to this value (or belief)?
- Do you think there are people who might see this differently?
- Can you imagine a reason why this person might see this differently than you do?

Focus on and build on strengths, abilities and interests

People coming for help are often very aware of their deficits and difficulties. In trying to help, we often ask about and focus on what is wrong, what is not working and what people have not been able to do. The result of this focus is that people do not feel good about themselves, and we miss important information about what is working. Supervisors can encourage supervisees to be more strengths-based by asking questions like:

- What does this person do well?
- What does this person like to do?
- Was there a time in their life that this person was doing better? What was happening then? What were they like during that time?

Encourage and support the people we serve to make choices and have as much control as possible

People feel respected and valued when they are allowed to make their own decisions. People also learn by making choices and noticing the outcomes of these choices. The people we serve have often had experiences in which choice was taken away from them and they felt helpless and powerless. We want the people we serve to have the opportunity to use and learn from their own power. Be aware of places where supervisors impose unnecessary rules, limits and restrictions rather than supporting others in making choices when they can and learning from their mistakes.

Explore situations with others and support them in coming up with their own solutions, when possible

The goal of trauma-informed treatment is to assist individuals in re-establishing a sense of choice and control. One way to do this is to support them in coming up with solutions to their own problems, rather than telling them what to do. Supervisors can encourage supervisees to use this approach by asking questions such as:

- Have you asked this person what s/he thinks could be done to improve this situation?
- Have you asked this person what they would like you to do to help with this?

Communicate hope

Often, the people we serve do not believe that their situation, whatever it is, can improve. This is a self-fulfilling prophecy. That is, people often give up too easily. In our work, it is our job to hold the hope for everyone, having faith that everyone can learn and grow and that eventually solutions to difficulties will emerge. It is important for supervisors to work with supervisees to maintain this hopeful attitude. Supervisors should notice when supervisees make statements that communicate a lack of belief in change and growth, and address the issue by asking questions such as:

- Do you really believe that there is no possibility that this situation (or person) will improve? Why do you believe that?
- Can you imagine circumstances under which this person would behave differently?

Remember that difficult behaviors often were developed as a result of trauma

Often, behaviors and symptoms are developed as the result of trauma. When we are aware of this, we have more empathy and patience with behaviors and symptoms that we do not like. Supervisors can help supervisees remember this by asking:

- How could this behavior (or symptom) have developed in response to trauma?
- How does this behavior help this person feel safer?

Encourage them to calm down before talking to a person who is upset

When someone is upset, being approached by a person who is also upset only makes the situation worse. People who are upset usually do not think clearly, and are less likely to come up with effective solutions to problems. Supervisors should, when possible, model “taking a moment” to calm down.

You can just say “Let’s take a moment to breathe before we go in” or something like, “Okay, let’s remember that nothing life-or-death is happening in this exact moment, I am sure we can find a way to work with this.” If a situation has already occurred and did not go well, the supervisor can ask:

- What were you feeling when you spoke with him (or her)?
- Do you think things might have gone better if you had taken a moment to ground yourself? What could you have said or done before you spoke with him (or her) that would have grounded you?

Identify triggers and calming strategies

Everyone has some things that “push their buttons”. We call those things “triggers”. A trigger can be a sight, sound, feeling or situation that reminds us of something bad that happened to us in the past. When we are “triggered”, feelings from our past add to the feelings we are experiencing in the moment and make them more intense than the present situation really calls for. It is important for everyone to learn what their “triggers” are and to have strategies for calming when they are triggered. A trauma-informed supervisor will help a supervisee identify their triggers and what calms them down. If someone becomes too caught up in talking about the past, a supervisor should redirect them to focus on this particular situation and what they might have done differently. We can help supervisees learn to identify their triggers and calming strategies by asking questions like:

- How did you feel when that happened?
- What about that situation got you so upset?
- Is this kind of situation “push your buttons”?
- When that button gets pushed, what helps you maintain your perspective?
- What do you think would have happened if you had used that strategy in this situation?

As supervisees learn to identify their triggers and use calming strategies, supervisors can suggest that supervisees help the people they serve identify their triggers and calming strategies. This can be done using the “Calmng Solutions Form” or can be done by using the same kinds of questions their supervisor is asking them.

Focus on creating a safe environment for everyone

The safer people feel in our facilities and programs, the more they will be able to grow and learn. People feel safe when an environment is calm and predictable, when there is clear communication about expectations, and when mistakes or difficulties are managed in a collaborative and supportive way. You can tell people feel safe when they are able to raise concerns and give input into what is going on.

In order to create a safe environment, supervisors must do what they say they are going to do and not make promises they cannot keep. They should answer questions and provide information in advance about changes or unexpected events. When a difficult event occurs, it should be acknowledged and discussed, and ways to prevent a recurrence should be developed collaboratively by the people involved. Supervisees should be encouraged to communicate with others directly and clearly.

Involve people being served in program planning, decision-making, and implementation

Part of our work is empowering the people we serve. The more we ask people what would be helpful to them, the more they feel respected and valued. The people we serve have valuable information that they have gathered just by being recipients of services. Asking the people we serve to help us make decisions has enormous benefits, but we often forget to do this. Supervisors can keep this in mind, and whenever any change is taking place, ask supervisees whether the people being served have been consulted for their input.

Supervisee Learning Review

Name of Supervisor: _____

Name of Supervisee: _____

Date: _____

	Outstanding	Good	Encourage	Don't Know
Considers the impact of what they do on relationships with others				
Attends to the strengths, abilities and interests of others				
Asks questions, rather than making assumptions				
Works with people on the goals they set for themselves				
Is respectful, honest, kind and fair				
Asks people being served for input				
Is aware of own feelings, beliefs and assumptions				
Considers the impact of culture on self and others				
Encourages others to come up with own solutions				
Considers the impact of trauma on behavior				
Remembers to calm down before approaching someone upset				
Is aware of own triggers and uses calming strategies				
Assists others in identifying triggers and calming strategies				
Pays attention to creating a safe environment				
Supports others in making choices and having as much control as possible				
Communicates the belief that others can learn and grow				

Comments:

Supervisor Self-Check

Name of Supervisor: _____

Name of Supervisee: _____

Date: _____

In working with this supervisee

	Yes	No	N/A
Did I remember to point out what the supervisee did well? Was I respectful, honest, kind and fair?			
Did I consider the impact of what I said and how I said it on our relationship?			
Did I ask questions and listen closely, rather than make assumptions?			
Did I remember to calm myself before I discussed difficult things?			
Did I consider the impact of culture on our relationship and on the way this supervisee works?			
Did I maintain awareness of my own feelings, attitudes, beliefs and assumptions?			
Did I try to help the supervisee come up with solutions, rather than tell them what to do?			
Did I try to give the supervisee as much choice and control as possible?			
Did I support the supervisee in using good self-care?			
Did I acknowledge that it is normal for the work to have an impact on us?			
Did I communicate my belief that the supervisee can learn and grow on the job?			

Comments: _____

Template for Developing a Trauma Integration Strategic Plan

Note: This assessment assumes an organization is already taking into account issues of culture, ethnicity, race, religion, gender, ability, sexual orientation, literacy, language and economic disadvantage in service design and delivery.

Name of Program:

Name of person completing this form:

1. Trauma Champion

Who would be a good person to serve as trauma champion, taking a leadership role in moving toward trauma-informed care?

2. Policy Statement

Have top managers drafted a policy statement or amended the organization's mission to state that services will be trauma-informed?

If not, write this as a goal statement.

Goal:

3. Trauma Strategic Planning Team

Who would be good people (various roles, including participants and/or family members) to invite to participate in a Trauma Strategic Planning Team?

List them:

4. Physical Environment

The Trauma Integration Planning Team (or a few members) might want to do a walk through of the program, asking themselves these questions:

- What would make this facility feel safer?
- What would make this facility feel more welcoming?
- What would make this facility feel more welcoming to the kinds of people we wish to serve?
- What would make this facility feel more calming?
- Are places and resources available for self-soothing?

If the answers to these questions can be developed into goal statements, write them below.

Goals:

5. Staffing

This section may be supplemented by the use of IHR's Staff Level Trauma-Informed Assessment or a focus group of staff. If you wish to do either of those, include them as goals.

- Does the program have either staff with specific trauma expertise or access to a trauma consultant?
- Does the program hire staff with lived experience similar to those being served or their family members?
- Do all staff have access to regular supervision?
- Do staff members have opportunities to talk about ways in which the work is affecting them?
- Is staff input taken into account in determining policies and practices?
- Do staff feel they have autonomy and choice and control in their work?

Please write below any Goals suggested by the above questions.

Goals:

6. Staff Competencies

Staff should have information about the topics listed below. Please check off those that staff, for the most part, do NOT have information about. Then develop a goal statement regarding providing training for those topics, listing them in priority order.

- Ways in which trauma, substance use and mental illness interact
- Impact of trauma on adults and children
- Impact of trauma on parenting
- Domestic violence
- Secondary trauma and self care
- Non-violent de-escalation techniques
- Mental illness
- Psychotropic medications
- Issues regarding record-keeping and domestic violence
- Special needs of women and men
- Triggers and calming strategies
- Empowerment and strength-based treatment
- Motivational Interviewing

Goal:

7. Safe Emotional Environment for Participants

- Are participants and family members treated respectfully at all times?
- Do staff talk about participants and family members in respectful ways?
- Are participants and family members informed about the limits of confidentiality?
- Is private information only discussed in private areas?
- Are participants treated in non-shaming and non-punitive ways even when they have broken a rule or exhibit difficult behavior?

Please write below any Goals suggested by the above questions.

Goals:

8. Safe Physical Environment for Participants

- Do all parts of the program/facility feel physically safe?
- Are participants and staff expected to act in a non-abusive manner?
- Are decorations and language non-violent, non-sexist and inclusive of diversity?
- Are procedures in place for keeping everyone safe if a perpetrator of a participant attempts to break in?
- Are procedures in place to keep perpetrators and victims separate? For example, if a perpetrator of a current participant applies for services?
- Are restraint and seclusion used only as a last resort when there is imminent danger?
- Is debriefing with the participant done after every restraint or seclusion?

Please write below any Goals suggested by the above questions.

Goals:

9. Empowerment Approach

- Are participants allowed as much choice and control as is feasible?
- Is flexibility with program rules permitted in order to meet needs of individual participants?
- Is participant and/or family member input sought and incorporated into program decisions?
- Do former participants or family members serve on the Board of Directors or Advisory Board?
- Are there women in leadership positions?

Please write below any Goals suggested by the above questions.

Goals:

10. Screening and Assessment of Participants

- Is screening and assessment done in a trauma-informed manner? (e.g., Are participants told why questions are asked? Is screening used for education? Are choice and control maximized?)

If not, write a goal about this.

Goal:

Please check off any of the following categories that are **NOT** currently included in screening.

- Strengths
- History of traumatic events-adults
 - Includes witnessing violence
 - includes domestic violence
 - includes childhood abuse
 - includes other forms of trauma
- History of traumatic events-children
 - includes witnessing violence
- Current safety from perpetrators
- Perpetrating violence
- Questions about children (even if unaccompanied)
- Triggers and calming strategies for all family members

Please write a goal about adding missing categories to your assessment.

Goal:

11. Psychoeducation for Participants

Please check off any of the topics below about which psychoeducation is **NOT** currently being provided for participants and/or family members.

- Ways in which trauma, substance use and mental illness interact
- Domestic violence
- Impact of trauma on adults
- Impact of trauma on children
- Safe coping skills such as grounding, self-soothing, making safe choices
- Intergenerational transmission of substance use, domestic violence, mental illness
- Impact of trauma on parenting

Please write a goal about adding psychoeducation on any missing topics that are appropriate given the population you serve.

Goal:

12. Service Planning for Adults and Children

Is service planning individualized?

Is service planning collaborative?

Do participants have choice and control over which services are received?

Do service plans address trauma, substance use, and mental illness, if appropriate?

Do participants have choice regarding the gender of their primary counselor?

Are participants permitted to change counselors if not satisfied?

When participants receive services from other providers, do staff contact those providers for coordination purposes?

Are participants asked about service needs of all family members?

Please write below any Goal's suggested by the above questions.

Goals:

13. Service Elements

Please place a check in front of any element not currently included in your program

Advance Directives

Wellness Recovery Action Plans

Planning regarding child if adult must move to another level of care

Crisis Prevention Plans for adults (triggers and calming strategies)

Crisis Prevention Plans for children (triggers and calming strategies)

Someone to help connect children with educational services

Please place a check in front of any element not currently available to participants, either by referral or on-site.

Parenting education that addresses impact of trauma on parenting

Access to childcare

- Trauma-specific treatment for adults
- Trauma-specific treatment for children or parents and children
- Safety Planning
- Peer Support
- Legal Services
- Services for all family members

Please write below goals related to adding any service elements.

Goals:

14. Continuing Care Plans

Do continuing care plans address substance use, mental illness and trauma?

Do continuing care plans include Peer Support?

Please write below any Goals suggested by the above questions.

Goals:

15. Linkages

Please place a check in front of any type of organization with which your program does not have active linkages for referral and consultation purposes.

- Domestic Violence Victim services
- Batterer Intervention Services
- Medical services
- Mental Health Treatment at different levels of care
- Substance Use Treatment at different levels of care
- Children's services

Please write below goals related to developing linkages.

Goals:

16. Exclusions

Please place a check in front of any reasons why someone might be excluded from your program

- Engages in self-harm
- Is on psychotropic medication
- Is a victim of domestic violence, fleeing an abuser

Any other exclusions?

Please write any goals related to eliminating exclusions.

Goals:

17. Please write below any other goals that have occurred to you or that are developed as a result of a review of policies, procedures and services.

Goals:

Staff Practice Survey

Questions	Check the Appropriate Box					
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I worry about my safety when I come to work						
I feel I have a lot of choice in how I do my job						
Staff here are encouraged to take care of themselves						
I believe I understand the impact of trauma on the people I work with						
I think many of our clients are so damaged that they have no chance of creating satisfying lives for themselves						
I often point out or remind clients of their accomplishments and strengths						
There are areas in the facilities in which I do not feel safe						
When I encounter a problem at work, I can count on my supervisor to help me find a solution						
Staff input is usually ignored when making decisions about the program						
Showing your dedication by putting in a lot of overtime is a good way to get appreciated in this program						
I understand the negative impact the work can have on me and what helps prevent that						
I do not think that everyone can recover from a substance use disorder						
I try to avoid arguing with my clients						
I do not have the skills to help clients calm down when they are agitated						
The way the facilities are decorated does not feel welcoming or soothing						

Questions	Check the Appropriate Box					
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
People here behave responsibly and professionally						
I don't think that my supervisors know my strengths						
We have procedures for maintaining safety when a place or client makes one of us feel unsafe						
I do not feel comfortable having conversations with clients about how trauma may be affecting them						
I can identify the strengths of each of my clients						
I don't often ask clients if they feel safe						
I believe that educating clients about trauma, substance use, mental illness and how they are connected to homelessness is an important part of my job						
I often find myself lecturing my clients						
My co-workers treat me respectfully						
There are meetings where we can discuss our work and work together to develop solutions for problematic situations						
My supervisors do not treat me with respect						
We do not have time to talk about the impact the work has on us						
I am comfortable helping clients identify the kinds of things that upset them						
My co-workers often say disrespectful things about clients						

Questions	Check the Appropriate Box					
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I believe that I know what is best for my clients more than they do						
I believe that giving out information is an important part of my job.						
I often tell clients what they should do						
I know what kinds of things "push my buttons" and I am alert to the impact that might have on my response to a client						
When I am working, there is no place I can go where I can relax and de-stress						
I pay attention to my own triggers and use my own coping strategies						
I do not feel safe expressing my opinions and concerns at work						
My privacy is valued and respected by the program						
I do not know how to help clients identify things that might help them calm down						
I rarely feel angry, impatient or disappointed in a client						
When I am upset at work, I know my supervisors will be understanding						
I help clients with the things that I think are most important						
I try to help clients evaluate the safety of different choices						
When I am upset at work, very few of my co-workers will be understanding						
I am supported in learning new things that will make me better at my job						

Questions	Check the Appropriate Box					
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I rarely find opportunities to help clients connect choices to outcomes						
I do not believe that encouraging change is part of my job						
I feel supported by my supervisors						
I believe too much is expected of me at work						
I know that my supervisor would support me in leaving a situation that felt unsafe to me						
I do not think my supervisors know how hard it is to do my job						
I am comfortable having conversations with clients about the pros and cons of different ways of coping with upsetting situations						
I often give clients "pop talks" so they will be motivated to change						
Procedures for handling emergencies are well-thought out, learned and practiced						
I do not feel comfortable having conversations with clients about ways they might make their current situation safer						
I try to help clients find coping strategies that work for them						
I believe I know what is expected of me at work						
I believe that many problematic behaviors were developed as strategies for coping with difficult experiences						
I almost never find opportunities to talk to clients about their triggers						
I feel supported by my co-workers						

Staff Practice Survey

Domain Codes:

- A = Staff Safety
- B = Staff Empowerment
- C = Self Care
- D = Staff Knowledge and Competence
- E = Staff Attitudes
- F = Trauma Informed Practice

Questions -- Scoring Key	Check the Appropriate Box						Domain
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	
-I worry about my safety when I come to work	0	1	2	3	4	5	A
+I feel I have a lot of choice in how I do my job	0	5	4	3	2	1	B
+Staff here are encouraged to take care of themselves	0	5	4	3	2	1	C
+I believe I understand the impact of trauma on the people I work with	0	5	4	3	2	1	D
-I think many of our clients are so damaged that they have no chance of creating satisfying lives for themselves	0	1	2	3	4	5	E
+I often point out or remind clients of their accomplishments and strengths	0	5	4	3	2	1	F
-There are areas in the facilities in which I do not feel safe	0	1	2	3	4	5	A
+When I encounter a problem at work, I can count on my supervisor to help me find a solution	0	5	4	3	2	1	A
+Staff input is usually ignored when making decisions about the program	0	1	2	3	4	5	B
-Showing your dedication by putting in a lot of overtime is a good way to get appreciated in this program	0	1	2	3	4	5	C
+I understand the negative impact the work can have on me and what helps prevent that	0	5	4	3	2	1	D
-I do not think that everyone can recover from a substance use disorder	0	1	2	3	4	5	E

Questions -- Scoring Key	Check the Appropriate Box						Domain
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	
+I try to avoid arguing with my clients	0	5	4	3	2	1	F
-I do not have the skills to help clients calm down when they are agitated	0	1	2	3	4	5	D
-The way the facilities are decorated does not feel welcoming or soothing	0	1	2	3	4	5	A
+People here behave responsibly and professionally	0	5	4	3	2	1	A
-I don't think that my supervisors know my strengths	0	1	2	3	4	5	B
+We have procedures for maintaining safety when a place or client makes one of us feel unsafe	0	5	4	3	2	1	C
-I do not feel comfortable having conversations with clients about how trauma may be affecting them	0	1	2	3	4	5	D
+I can identify the strengths of each of my clients	0	5	4	3	2	1	E
-I don't often ask clients if they feel safe	0	1	2	3	4	5	F
+I believe that educating clients about trauma, substance use, mental illness and how they are connected to homelessness is an important part of my job	0	5	4	3	2	1	E
-I often find myself lecturing my clients	0	1	2	3	4	5	F
+My co-workers treat me respectfully	0	5	4	3	2	1	A
+There are meetings where we can discuss our work and work together to develop solutions for problematic situations	0	5	4	3	2	1	B
-My supervisors do not treat me with respect	0	1	2	3	4	5	A
-We do not have time to talk about the impact the work has on us	0	1	2	3	4	5	C
+I am comfortable helping clients identify the kinds of things that upset them	0	5	4	3	2	1	D
-My co-workers often say disrespectful things about clients	0	1	2	3	4	5	E
-I believe that I know what is best for my clients more than they do	0	1	2	3	4	5	F
+I believe that giving out information is an important part of my job	0	5	4	3	2	1	C
-I often tell clients what they should do	0	1	2	3	4	5	F
+I know what kinds of things "push my buttons" and I am alert to the impact that might have on my response to a client	0	5	4	3	2	1	F

Questions -- Scoring Key	Check the Appropriate Box						Domain
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	
-When I am working, there is no place I can go where I can relax and de-stress	0	1	2	3	4	5	C
+I pay attention to my own triggers and use my own coping strategies	0	5	4	3	2	1	F
-I do not feel safe expressing my opinions and concerns at work	0	1	2	3	4	5	A
+My privacy is valued and respected by the program	0	5	4	3	2	1	A
-I do not know how to help clients identify things that might help them calm down	0	1	2	3	4	5	D
-I rarely feel angry, impatient or disappointed in a client	0	1	2	3	4	5	F
+When I am upset at work, I know my supervisors will be understanding	0	5	4	3	2	1	A
-I help clients with the things that I think are most important	0	1	2	3	4	5	E
+I try to help clients evaluate the safety of different choices	0	5	4	3	2	1	F
-When I am upset at work, very few of my co-workers will be understanding	0	1	2	3	4	5	A
+I am supported in learning new things that will make me better at my job	0	5	4	3	2	1	B
-I rarely find opportunities to help clients connect choices to outcomes	0	1	2	3	4	5	F
-I do not believe that encouraging change is part of my job	0	1	2	3	4	5	E
+I feel supported by my supervisors	0	5	4	3	2	1	A
-I believe too much is expected of me at work	0	1	2	3	4	5	A
+I know that my supervisor would support me in leaving a situation that felt unsafe to me	0	5	4	3	2	1	C
-I do not think my supervisors know how hard it is to do my job	0	1	2	3	4	5	A
+I am comfortable having conversations with clients about the pros and cons of different ways of coping with upsetting situations	0	5	4	3	2	1	D
+I offer give clients "pop talks" so they will be motivated to change	0	5	4	3	2	1	F
+Procedures for handling emergencies are well thought out, learned and practiced	0	5	4	3	2	1	A

Questions -- Scoring Key	Check the Appropriate Box						
	Does not Apply	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree	Don't Know
-I do not feel comfortable having conversations with clients about ways they might make their current situation safer	0	1	2	3	4	5	D
+I try to help clients find calming strategies that work for them	0	5	4	3	2	1	F
+I believe I know what is expected of me at work	0	5	4	3	2	1	A
+I believe that many problematic behaviors were developed as strategies for coping with difficult experiences	0	5	4	3	2	1	F
-I almost never find opportunities to talk to clients about their triggers	0	1	2	3	4	5	F
+I feel supported by my co-workers	0	5	4	3	2	1	A

Trauma Integration Self-Assessment

This self-assessment should be conducted separately for each program administered by your agency. A group of staff members with various roles should participate, and ratings should be by consensus or averaged.

Name of program: _____

Date: _____

Type of program: Check One

Prevention Services:

- Regional Centers for Healthy Communities
- Tobacco Programs
- Youth Interventions

Residential Treatment Under 30 Days:

- Adult Treatment Services (Detoxification)
- Transitional Support Services
- Transitional Medication Management

Residential Treatment Over 30 Days:

- Recovery Centers
- Transitional Group Homes
- Sober Home Programs
- Residential Residential Services for Women
- Specialized Residential Services for Youth
- Youth Residential

Ambulatory Services:

- Outpatient Grouping
- Day Treatment
- Intensive Outpatient Treatment
- Acupuncture Services
- Comprehensive Outpatient Rehabilitation Services
- Clinical Trials

Aftercare/Recovery Support:

- Supportive Case Management
- Community Support Case Management

Driving Under the Influence:

- First Offense (10-Day/12-Hour DUI Program/DUII)
- Second Offense (14-Day Residential Program for Driving Under the Influence/Second Offense DUII)
- Second Offense (for Arrested/DUII)

Homeless Services:

- Outreach, Access Shelter for Homeless
- Rapid Re-Housing Programs for PHLH

Statewide Support Services:

- Emergency Housing Referral Services

DPH Region: _____

Name of organization responsible for program: _____

Names of staff members (and their positions) participating in this self-assessment:

Name	Position
------	----------

Name, telephone number, and Email (if available) of contact person

The next five items are to be scored on the following Likert Scale:

1. Rarely 2. Occasionally 3. Sometimes 4. Often 5. Consistently

Screening

- _____ Consumers are assessed regarding their history of experiencing violence.
- _____ Consumers are assessed regarding their current safety from perpetrators.
- _____ Consumers are assessed regarding the safety of their current living situation.
- _____ Consumers are assessed regarding their history of perpetrating domestic violence.

Psychoeducation

- _____ Psychoeducation is provided for consumers about domestic violence and sexual assault.
- _____ Psychoeducation is provided for consumers about the symptoms of trauma.
- _____ Psychoeducation is provided for consumers regarding skills for dealing with trauma symptoms such as grounding and self-soothing.
- _____ Consumers are provided with psychoeducation about the ways in which substance abuse and trauma/violence interact.

Services

- _____ Service plans address trauma when appropriate.
- _____ Continuing care plans address trauma when appropriate.
- _____ Consumers have access to safety planning while in treatment.

- _____ Linkages exist with domestic violence providers for referral purposes.
- _____ Trauma-specific services are provided (longer term programs only).

Policies and Procedures

- _____ Consumers are involved in their own treatment planning.
- _____ Consumer feedback is obtained and used in program development.
- _____ Plans are developed for every consumer that specify trauma triggers (events that provoke strong emotions possibly associated with past trauma) and effective coping strategies.
- _____ The plans described above are accessible to the consumer and to staff.
- _____ The plans described above are used by staff, who work with consumers to update them if they are not effective.
- _____ Procedures are in place to protect both staff and clients if a perpetrator attempts to enter.
- _____ Procedures are in place to prevent a perpetrator and a victim encountering each other in treatment.

Approach

- _____ Consumers are encouraged to examine the choices they make and their outcomes, rather than forced to do what counselors believe is best for them.
- _____ Consumers are given information about the reasons for policies and procedures, rather than directed to follow rules without explanation.

Staff Self-Assessment Evaluation Tool—University of Alabama, Birmingham, 1917 Clinic

2018 Plans

Name:

Date:

Personal/Departmental Work Accomplishments:

Work Concerns/Opportunities (personal, departmental, clinic, community):

Work Goals

Target Dates

What are you doing to serve patients/community optimally? What can you do to improve personally? What additional tools / resources would help?

How are you documenting / reporting this effort?

APPENDIX L

Sample Situation Debrief Guide¹⁵

Multnomah County HIV Clinic Staff Debrief Framework

Last updated: 3/21/17

Purpose

The purpose of this framework is to provide guidance and considerations for HSC staff when initiating, participating in, or following-up on a formal debrief. The intention of a formal debrief is to provide a safe space to process a crisis or traumatic event and create a plan for the future for support as well as to learn and develop best practices from these type of occurrences.

Framework

According to SAMHSA's concept of a trauma-informed approach¹⁶,

"A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. *Seeks* to actively resist *re-traumatization*."

In the interest of creating a trauma-informed framework, this definition will be used as the framework for this procedure.

¹⁵ E Borke, T Kempner, and J Davich. Multnomah County Health Department, Portland, Oregon. 2017.

¹⁶ SAMHSA's Trauma and Justice Strategic Initiative. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Policy, Planning and Innovation. Available at: <https://store.samhsa.gov/system/files/sma14-4884.pdf>

Realize the widespread impact of trauma and understands potential paths for recovery

- Staff training
 - » HSC will maintain commitment to ongoing training for staff (both all staff and for specific role groups as appropriate)
 - » HSC will conduct a regular staff survey to track staff perceptions about trauma, trauma-informed care, and healing as well as to identify training needs and clinic progress
- HSC Trauma Informed Care committee (TIC Talk)–The clinic’s internal trauma-informed care committee will continue meeting monthly to identify and implement trauma informed practices to improve patient care and support HSC staff.

Recognize

- Shared language related to trauma and healing
 - » Assist staff in becoming familiar with trauma-informed terminology
 - » Have shared terminology for identifying need/desire for a debrief
- Identifying possible signs of a traumatic response

-
- | | |
|---|--|
| <ul style="list-style-type: none"> ● Eating disturbances (more or less than usual) ● Sleep disturbances (more or less than usual) ● Low energy ● Depression, spontaneous crying, despair and hopelessness ● Anxiety ● Fearfulness ● Irritability, anger and resentment ● Emotional numbness | <ul style="list-style-type: none"> ● Guilt feelings ● Grief reactions ● Memory lapses, especially about the trauma ● Difficulty making decisions ● Decreased ability to concentrate ● Feeling distracted ● Intrusive thoughts ● Withdrawal from normal routine and relationships |
|---|--|
-

Respond

- Immediate planning
 - » When a supervisor recognizes or is notified by staff about a possible traumatic response or event, they will assist in determining best short-term plan to ensure staff and client(s) impacted by crisis have adequate and necessary support and resources. Each plan developed by supervisor and staff will be specific to the unique situation and staff/client(s) impacted. Plans could include but are not limited to:
 - ✓ Taking a “breather” break in a quiet/calm space or going on a short walk around the building
 - ✓ Connecting with another support person
 - ✓ Arranging for transportation
 - ✓ Having another staff work with the involved patient
 - ✓ Taking time off
 - ✓ Informal check-in or case consultation to discuss incident and follow-up plan

- » Supervisor and staff will determine if formal debrief needs to occur.
- » Supervisor will determine who else needs to know about crisis and plan and communicate with minimal staff necessary.
- Initiating a formal debrief
 - » What is a formal debrief?
 - ✓ A specific time/space set aside to discuss what happened, how staff/clients were impacted, what worked/didn't work during event, what follow-up is needed
 - ✓ A formal debrief typically includes the supervisor and staff who have been impacted by crisis or traumatic event
 - » Any staff person can initiate a formal debrief by informing supervisor that debrief is needed
 - » Goal is to have the debrief as soon after the event as is possible. This will depend on situation and how many staff are impacted. Supervisors will work with staff to identify appropriate time and assist with coverage plan to support staff to attend.
 - » Supervisor will find space to hold debrief that maintains confidentiality and avoids including staff not aware/impacted by event
- Holding a formal debrief meeting
 - » Identify someone to gently facilitate debrief (ideally not someone impacted by traumatic event)
 - » Identify someone to take notes of any action/follow-up items
 - » Potential questions to consider/discuss during debrief. This will depend on who/how many people participating in debrief.
 - ✓ What happened? Brief facts
 - ✓ What were your first thoughts?
 - ✓ What is the worst thing about this event for you?
 - ✓ What symptoms are you experiencing?
 - ✓ What can we do to help you feel whole?
 - ✓ What went well?
 - ✓ What could have been improved or done differently?
- Documentation
 - » Use debrief notes template
 - » Debrief notetaker will be sure to record the following:
 - ✓ Brief description of event (date, staff involved, MRN of any clients involved)
 - ✓ What worked and what could have been done differently during event
 - ✓ Follow-up plan and who will be responsible for ensuring these action item(s) happen and when
 - » Supervisor will determine if Incident Report form needs to be completed

- » As appropriate depending on situation, supervisor will notify All Staff via email to acknowledge that an event occurred (without details) and that debrief did/will occur and that follow-up communication will happen with anything all staff needs to know as well as any lessons learned
- » Following formal debrief, supervisor will send email to those involved in debrief that includes follow-up plan

Resist Re-Traumatization

- Formal debrief follow-up
 - » Debrief follow-up plan—Each debrief will have a follow-up plan of any action items identified that includes who will be responsible for ensuring these things happen and by when (ex: supervisor will check-in with staff member tomorrow to ensure they contacted EAP)
 - » Documentation—All debrief notes will be collected and retained by clinic manager for later review and to note any patterns and/or lessons learned
 - » Clinic manager (and clinic management team as appropriate) will review debrief notes to identify if any systemic issues and/or policies contributed to situation and determine next steps to address these issues.
- Resources
 - » Benefits offered by Multnomah County
 - ✓ Massage—Most County health plans offer massage benefits and weekly onsite massage is available in the McCoy building.
 - ✓ Fitness—The Multnomah County Wellness Program operates two large employee Wellness Fitness Centers and offer a range of high to low impact worksite fitness classes.
 - ✓ Mindfulness—Soon to be offered onsite at McCoy are regular mindfulness practice sessions by Hun Taing, the Health Department’s Trauma and Healing Coordinator
 - ✓ Trainings—The County offers several workshops that staff can register for using the Online Training Calendar. This includes Practicing Mindfulness in the Workplace, Compassionate Communication, and an annual Trauma-Informed Learning Series.
- Other Resources
 - ✓ Trauma Informed Oregon—a statewide collaborative aimed, in part, at promoting and sustaining trauma informed practices to support wellness and resilience. Includes resources for individuals here: <http://traumainformedoregon.org/resources/resources-individuals-families/>
 - ✓ JBS International Trauma-Informed Resources—over 20 self-care resources and mobile apps that provide self-help, education, and support for those who have experienced trauma and for those who work with traumatized individuals at <http://trauma.jbsinternational.com/traumatool/Module3Resources.html#Self-Care>
- TIC Talk will continue development of a resource binder for staff that can be used during debrief or any needed time

Debrief Meeting Notes

Debrief meeting date: _____

Debrief note taker: _____

Debrief attendees: _____

Event Details

Date of event

Brief description of event

MRNs of any clients involved during event

Staff impacted by event

Supervisor(s) involved during event

What worked well during event?

What could have been done better during event?

Follow-up Plan & Action Items

Who is Responsible?

When will this happen?

Incident Report Completed? Yes No

Supervisor initials: _____

APPENDIX M

Examples of Quality Improvement

Quality Improvement Lead by CHWs at Multnomah County HIV Clinic

Example 1: CHWs were involved in all aspects of Quality Improvement (QI) at the MCHD HIV Clinic on an ongoing basis. CHWs were trained along with other staff on QI methods. CHWs designed and lead several innovative improvement projects. These projects addressed concerns raised by both coworkers and clients. For example, one CHW helped to address the issue of HIV and meth in the gay community after hearing from clients about their struggles with meth and sex. The CHW and clients came up with the idea of using a book group format to pull together a support group around meth and healthy living with HIV. The Thriving Men Book Club was created and piloted.

With the help of clients and the clinic's Client Advisory Board (CAB) members, the CHW created a book list and polled clients to access level of interest, days and time and most convenient locations. The findings were presented to the clinic management team (CMT). The idea was well received by CMT with one caveat—that the CHW partner with licensed counseling staff to deal with difficult emotions that might surface during the group discussion. Management was also helpful with providing space, copies of books and refreshments. The first book was *Men, Meth and Lust* by David Fawcett. The CHW used discussion guides and exercises from the author to help the group find meaning and applications of the book's principles. Attendance fluctuated over the eight-week pilot, but a core group quickly surfaced and there was a regular attendance of 8 to 10 clients each session. Clients developed new insights into meth as well as new ways to relate and connect with their peers. Each session, clients provided feedback for improving the book group. The CHW was responsible to make these improvements. The buy in and cooperation of clients, management and CAB made this QI project a great success. The group went on to read other self-help books.

Example 2: The clinic's Community Advisory Board (CAB) had piloted a clinic orientation and information sharing service called *Here for You!* Volunteer CAB members would set up coffee, tea and snacks in a designated area in the waiting area. They welcomed clients were and answered common questions about the clinic and HIV resources in the community. Sometimes clients would reveal serious issues that needed a quick intervention by a staff member. The CHW team through trial and error, decided to coordinate their schedules so that at least one of them was in clinic during *Here for You!* to support the CAB volunteers. This enriched the CAB's volunteer efforts and improved client's real-time access to CHWs. It also helped CHWs connect with homeless clients who tended to drop in for coffee and treats during *Here for You!*

Management, Leadership, Quality Processes and Consumer Involvement Lead to Improved Project Outcomes

Multnomah County Health Department's HIV Clinic's efforts have addressed the following aspects of quality improvement:

- Linking the HIV quality management program with the organization's overall quality management program;
- Staff education efforts;
- Unique or comprehensive methods of communicating with staff about quality improvement activities across the local HIV continuum of care; and
- Engaging clients in quality improvement.

Clinic staff, including CHWs, are engaged in reviewing quality data and implementing quality improvement processes. All staff members are assigned to one of four Building Better Care (BBC) provider teams. These teams meet twice a month to review team-level data, identify areas for improvement, and develop/implement improvement plans.

For the HIV Clinic, implementation of robust quality improvement has involved:

- Providing staff with training on teamwork, communication, and conflict resolution
- Creating time in the provider schedules for team meetings
- Integrating behavioral health and front office staff into the medical teams
- Running new monthly data reports that highlight key performance measures
- Orienting staff to *The Model for Improvement* (rapid improvement cycle processes) to test solutions to team-identified problems
- Adopting an active coaching style of supervision as well as changing the behaviors of leaders to model process improvement tenets

Leadership

It is critical to the success of quality improvement initiatives to have visible leadership support to champion the intervention and promote buy-in and support from other staff and funders.

Clinical and Operational Quality Improvement

The clinic's quality management program builds on *The Model for Improvement* which is promoted by the Institute for Healthcare Improvement. Our quality program is called Building Better Care (BBC). The guiding principles include:

- Team members are co-located
- Frequent communication among all team members
- The team is proactive in meeting the needs of their patients

- Behavioral health is incorporated into primary care visits
- Every team member is engaged, doing what they are uniquely qualified to do
- “Not my job” is not part of the vocabulary.

The BBC model requires that teams take responsibility to review their team outcomes monthly and develop a plan for measures not meeting their target or that show less robust results than previous months. In the course of doing their work, teams identify processes that are inefficient, redundant, create rework, or simply do not accomplish the purpose for which they are intended. The care teams utilize the Plan-Do-Study-Act (PDSA) cycle to test and implement changes in real work settings. The PDSA cycle guides the test of a change to determine if the change is an improvement.

The Clinic Management Team is responsible for ensuring there is a quality improvement system and a process for monitoring, evaluating and improving the access, quality, appropriateness of services, and that care is delivered in concordance with the PHS Guidelines. The current management team includes the medical director, the clinic manager, the nursing supervisor, clinical pharmacist, lead case manager, grants manager, a medical provider, and the operations supervisor.

The Clinic Quality Management Team meets monthly to guide and review the quality improvement efforts of the clinic. The team membership includes a diverse representation of both role groups and provider teams. Membership rotates every twelve months so that all clinic staff has an opportunity to participate over time. The Quality Management Team: 1) identifies opportunities to improve clinic operations, clinical outcomes, and track team-based/clinic improvements; 2) regularly reviews data (clinical measures, patient satisfaction etc.) and identifies priorities for improvement; 3) plans, implements, and monitors spread for site-based and program-wide improvement initiatives; 4) monitors individual team progress; 5) problem-solves issues/challenges. Clinic Management Team members (one or two persons) participate in the Quality Team meetings.

Role of Consumers in the Quality Management Program

Clients are involved in quality improvement through the Client Advisory Board (CAB), focus groups, and satisfaction surveys. The Client Advisory Board (CAB) is made up of 9 consumers who work to: promote community outreach, engage clients in advocating for their own needs, give clients a voice in clinic decisions and policies, and provide education to clients and the community. The clinic management team seeks input from the CAB whenever any major changes are being contemplated, and when forces outside the HIV Clinic’s control are causing client difficulties. Examples of CAB activities include:

- Improvements made to the waiting area and patient restrooms to make them more welcoming to clients.
- A bulletin board to post educational material and provide a forum for the clinic staff to post educational materials for patients.
- A plan to have a peer support program, (Here for You!) provided by CAB members to connect and welcome patients and connect them to community resources.

- Input to a project to re-engage out-of-care patients.
- Creation of a subcommittee to develop client arts and crafts venues. This effort was successful in involving clients who had not been previously engaged in clinic or support activities.
- Provision of input and approved clinic design for the new building where the clinic will be moving.

The CAB gives input to all quality initiatives. For example, the CAB provided input to the “open access” initiatives, implementation of MyChart, the women’s wellness project and the revised intake process. Clients also help pinpoint areas needing improvement and suggest interventions to be piloted.

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