Successful Supervision with Community Health Workers

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Toolkit

Successful Supervision with Community Health Workers Facilitator Manual and Toolkit were developed with support from the Delivery System Reform Incentive Payment (DSRIP) program as part of Massachusetts' section 1115 demonstration, entitled "MassHealth" (Project Number 11-W-00030/1) from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

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The Successful Supervision with CHWs Toolkit and Resources section was created through a process of collecting and collating input from a wide range of sources. It was specifically developed as a resource for participants attending the two-day *Successful Supervision with CHWs* Workshop. Its intent is to provide CHW Supervisors with practical resources that can inform their supervisory practices.

The materials which are referenced throughout the *Toolkit and Resources* section were provided by the Massachusetts Department of Public Health, Edward M. Kennedy Community Health Center, Justice Resource Institute, the Center for Health Impact, and the Boston Medical Center. Jessica Chadwick and Jaenia Fernandez served as Research Assistants on this project and compiled the *Toolkit and Resources* section contents.

We gratefully acknowledge these organizations who have contributed to the formation of this manual. Without their willingness to share their resources, this *Toolkit and Resources* section would not exist.

The examples in the *Toolkit and Resources* section are intended to highlight unique considerations in the recruitment, retention, and supervision of Community Health Workers.

In all cases, CHW Supervisors should be guided by the policies of the organization of employment, guidelines of funders, and applicable current state and federal laws and regulations.

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Resources

MDPH Community Health Worker Definition

CHWs are public health workers who apply their unique understanding of the experience, language and/or culture of the populations they serve in order to carry out one or more of the following roles:

- Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses, and community centers
- Bridging and/or culturally mediating between individuals, communities and health and human services, including actively building individual and community capacity
- Assisting people to access the services they need
- Providing direct services, such as informal counseling, social support, care coordination, and health screenings
- Advocating for individual and community needs

CHWs are distinguished from other health professionals because they:

- Are hired primarily for their understanding of the populations and communities they serve
- Spend a significant portion of time conducting outreach in the categories above
- Have experience providing services in community settings

MDPH Core Competencies for Community Health Workers

Core Competency #1: Outreach Methods and Strategies

Outreach is the process of contacting, engaging with, and helping people to learn about and use resources to improve their health and well-being. Outreach may be conducted with individuals, groups, organizations, and at the community level. In outreach, CHWs "meet people where they are," building relationships based on listening, trust, and respect. This can take place in diverse settings, including where people live, work, learn, worship, socialize, play, exercise, and conduct business. There are a variety of outreach methods, such as phone calls, in-person conversations, group presentations, distribution of print and electronic information, and social media. Effective outreach is based on learning about community needs and strengths, knowledge about available resources, and sensitivity to personal and cultural dynamics that affect behavior and relationships.

Competency includes the ability to:

- Develop and implement outreach plans in collaboration with colleagues, based on individual, family, and community needs, strengths, and resources
- Identify and share appropriate information, referrals, and other resources to help individuals, families, groups, and organizations meet their needs
- Initiate and sustain trusting relationships with individuals, families, and social networks
- Establish and maintain cooperative relationships with community-based organizations and other resources to promote client services, care, education, and advocacy
- Conduct outreach with attention to possible safety risks for self, clients, and colleagues
- Use a range of outreach methods to engage individuals and groups in diverse settings

Core Competency #2: Individual and Community Assessment

Assessment is the collection, synthesis, and use of information to help understand the needs, strengths, and resources of the individuals and communities CHWs serve. CHWs share this information with clients, professional colleagues, and community partners to help plan and carry out effective programs, services, and advocacy based on shared priorities. They engage people in honest and often difficult discussions about health status and behavior. They also gain insights about needed resources and changes and share their understanding with appropriate parties in order to help achieve desired outcomes. Assessment is an ongoing process that, when combined with regular evaluation of progress, helps assure effective, client and community-centered care.

Competency includes the ability to:

- Gather and combine information from different sources to better understand clients, their families, and their communities
- Assess barriers to accessing health care and other services

- Help people to identify their goals, barriers to change, and supports for change, including personal strengths and problem-solving abilities
- Share community assessment results with colleagues and community partners to inform planning and health improvement efforts
- Continue assessment as an on-going process, taking into account changes in client circumstances and the CHW-client relationship

Core Competency #3: Effective Communication

Effective and purposeful communication is listening carefully and communicating respectfully in ways that help build trust and rapport with clients, community members, colleagues, and other professionals. Effective communication includes a mix of listening, speaking, gathering and sharing information, and resolving conflict. CHWs are open about their roles, responsibilities, and limits. CHWs protect client privacy and confidentiality. They convey knowledge accurately, clearly, and in culturally aware and responsive ways. They are able to use language and behavior that is responsive to the diversity of cultures they encounter in their work, including with clients, community members, and other professionals.

Competency includes the ability to:

- Be respectful and culturally aware during interactions with clients
- Practice careful listening, repeating back important information as necessary to confirm mutual understanding, continually working to improve communication and revisit past topics as trust develops with client
- Pay attention to expressive (non-verbal) behavior
- Ask neutral, open-ended questions to request relevant information
- Speak clearly and honestly
- Use language that conveys caring and is non-judgmental
- Explain terms or concepts whose meanings may not be obvious to clients, community members, or professional colleagues
- Clarify mutual rights and obligations, as necessary, such as client confidentiality or CHW reporting responsibilities
- Use written and visual materials to convey information clearly and accurately
- Take care to prevent situations involving conflict. Address conflicts that may arise in a professional and safe manner

Core Competency #4: Cultural Responsiveness and Mediation

CHWs act as cultural mediators. CHWs educate and support providers in working with clients from diverse cultures and help clients and community members interact effectively with professionals working in different organizations to promote health, improve services, and reduce disparities. Culture is defined here as beliefs, values, customs, and social behavior shared by a group of people with common identity. Identity may be based on race, ethnicity, language, religion, sex, gender identity, sexual orientation, disability, health condition, education, income, place, profession, history, or other factors. Culture also includes organizational cultures, which are

reflected in how organizations deliver services. CHWs encourage and help enable clients to participate in decisions that affect their lives, families, and communities.

Competency includes the ability to:

- Explain how one's own culture and life experience influence one's work with clients, community members, and professional colleagues from diverse backgrounds
- Describe different aspects of community and culture and how these can influence peoples' health beliefs and behavior
- Describe ways the organizational culture within provider agencies and institutions can affect access, quality, and client experience with services
- Employ techniques for interacting sensitively and effectively with people from cultures or communities that differ from one's own
- Support the development of authentic, effective partnerships between clients and providers by helping each to better understand the other's perspectives
- Make accommodations to address communication needs accurately and sensitively with people whose language(s) one cannot understand
- Advocate for and promote the use of culturally and linguistically appropriate services and resources within organizations and with diverse colleagues and community partners
- Advocate for client self-determination and dignity

Core Competency #5: Education to Promote Healthy Behavior Change

Education for healthy behavior change means providing people with information, tools, and encouragement to help them improve their health and stay healthy over time. CHWs respect people's experience and their abilities to learn, take advantage of resources, and set priorities for changing their own behavior. CHWs work with clients, family and community members, and providers to address issues that may limit opportunities for healthy behavior. The CHW acts as educator and coach, using a variety of techniques to motivate and support behavior change to improve health.

Competency includes the ability to:

- Apply information from client and community assessments to health education strategies
- Develop health improvement plans in cooperation with clients and professional colleagues that recognize and build upon client goals, strengths, and current abilities to work on achieving their goals
- Apply multiple techniques for helping people understand and feel empowered to address health risks for themselves, their family members, or their communities. (Examples may include informal counseling, motivational interviewing, active listening, harm reduction, community-based participatory research, group work, policy change, and other strategies.)
- Coordinate education and behavior change activities with the care that is provided by professional colleagues and team members
- Facilitate constructive discussion in informal and group settings with clients and their families

- Provide on-going support and follow-up as necessary to support healthy behavior change
- Communicate with providers and service organizations to help them understand community and individual conditions, culture, and behavior to improve the effectiveness of services they provide

Core Competency #6: Care Coordination and System Navigation

Coordination of care and system navigation for individuals and families means that CHWs help people understand and use the services of health providers and other service organizations. They also help address practical problems that may interfere with people's abilities to follow provider instructions and advice. CHWs help bridge cultural, linguistic, knowledge, and literacy differences among individuals, families, communities, and providers. They help improve communications involving community members and agency or institutional professionals. CHWs understand and share information about available resources, and support planning and evaluation to improve health services.

Competency includes the ability to:

- Obtain and share up-to-date eligibility requirements and other information about health insurance, public health programs, social services, and additional resources to protect and promote health
- Work collaboratively as part of a care team
- Assist in developing and implementing care plans, in cooperation with clients and professional colleagues. (Care plans should be based on needs and resource assessments. Plans should describe how each party involved will help meet the goals and priorities defined in collaboration with clients.)
- Provide care coordination, which may include but not be limited to facilitating care transitions, supporting the completion of referrals, and providing or confirming appropriate follow-up
- Provide support for clients to use provider instructions or advice, and convey client challenges to providers
- Provide support for people to understand and use agency and institutional services
- Make referrals and connections to community resources to help individuals and families meet basic social needs
- Build clients' ability to participate in making decisions about their care
- Inform care providers, to the extent authorized, about challenges that limit the ability of clients to follow care plans and navigate the health care system, including barriers outlined in the Americans with Disabilities Act

Core Competency # 7: Use of Public Health Concepts and Approaches

The knowledge base for CHW practice is strongly influenced by the field of public health. Public health is a science-based discipline that focuses on protecting and promoting population health, preventing illness and injury, eliminating health inequities, and working to improve the health of

vulnerable communities and populations. CHWs, like other public health practitioners, understand that individual health is shaped by family, community, and wider "social determinants of health." CHWs often use their knowledge of the larger contexts of clients' lives to provide support for them to overcome barriers or improve conditions that affect their health.

Competency includes the ability to:

- Use data and evidence-based practices in efforts to support clients in reaching their goals
- Gain and share information about specific health topics most relevant to the populations and communities being served
- Explain how plans for supporting individuals and families relate to wider social factors that influence health
- Explain the relationship between health and social justice
- Promote efforts to prevent injury and disease, including those that require policy changes, and support effective use of the health care system
- Promote health equity and efforts to reduce health disparities through engagement with clients, professional colleagues, and community partners
- Engage in systematic problem solving – including assessment, information gathering, goal setting, planning, implementation, evaluation, and revision of plans and methods, as necessary – to achieve shared objectives

Core Competency #8: Advocacy and Community Capacity Building

Advocacy is working with or on behalf of people to exercise their rights and gain access to resources. Capacity building is helping people develop the confidence and ability to assume increasing control over decisions and resources that affect their health and well-being. Community capacity building involves promoting individual and collective empowerment through education, skill development, networking, organizing, and strategic partnerships. Capacity building requires planning, cooperation, and commitment, and it may involve working to change public awareness, organizational rules, institutional practices, or public policy. Advocacy and capacity building go hand-in-hand and can help create conditions and build relationships that lead to better health.

Competency includes the ability to:

- Encourage clients to identify and prioritize their personal, family, and community needs
- Encourage clients to identify and use available resources to meet their needs and goals

- Provide information and support for people to advocate for themselves over time and to participate in the provision of improved services
- Advocate on behalf of clients and communities, as appropriate, to assist people to attain needed care or resources in a reasonable and timely fashion
- Apply principles and skills needed for identifying and developing community leadership
- Build and maintain networks, and collaborate with appropriate community partners in capacity building activities
- Use a variety of strategies, such as role-modeling, to support clients in meeting objectives, depending on challenges, and changing conditions

Core Competency #9: Documentation

CHWs help promote coordinated and effective services by documenting their work activities, including writing summaries of client and community assessments. They often present information to agency colleagues or community partners about their clients and issues they face. Generally, in Massachusetts, CHWs use computer technology and communicate in English, but alternative arrangements may be made in order to utilize valuable linguistic capacities, cultural experience, and community relationships that individual CHWs may bring to their work.

Competency includes the ability to:

- Organize one's thoughts and write at the level necessary for communicating effectively with clients, other community members, supervisors, and other professional colleagues
- Comply with reporting, record keeping, and documentation requirements
- Use appropriate technology, such as computers, for work-based communication, according to employer requirements
- Recognize the importance of documentation for program evaluation and sustainability and for helping clients achieve their goals

Core Competency #10: Professional Skills and Conduct

Professional skills for CHWs include how to handle ethical challenges as they address legal and social challenges facing the clients and communities they serve. Client confidentiality and privacy rights must be protected in the context of employer and legal reporting requirements. Care for clients must be balanced with care for self. CHWs understand that it is necessary to be aware of one's own emotional and behavioral responses to clients and community members and to manage personal feelings productively in order to maintain effectiveness. CHWs must be able to act decisively in complex circumstances but also to utilize supervision and professional collaboration. They must observe agency rules and the regulations governing public and private resources while exercising creativity in helping community members meet their individual and family needs.

Competency includes the ability to:

- Practice in compliance with the Massachusetts Code of Ethics for Community Health Workers
- Observe the scope and boundaries of the CHW role in the context of the agency team and agency policy
- Respect client rights under the Health Insurance Portability and Accountability Act (HIPAA) and applicable agency rules
- Understand issues related to abuse, neglect, and criminal activity that may be reportable under law and regulation according to agency policy
- Maintain appropriate boundaries that balance professional and personal relationships, recognizing dual roles as both CHW and community member
- Seek assistance from supervisors as necessary to address challenges related to work responsibilities
- Establish priorities and organize one's time, resources, and activities to achieve them

- Utilize and advocate as necessary for supervision, training, continuing education, networking, and other resources for professional development and lifelong learning for self and colleagues

Source: https://www.mass.gov/service-details/core-competencies-for-community-health-workers

Understanding Scope and Competencies:

A Contemporary Look at the United States Community Health Worker Field

Report of the Community Health Worker (CHW) Core Consensus (C3) Project:

BUILDING NATIONAL CONSENSUS ON CHW CORE ROLES, SKILLS, AND QUALITIES

This report "offers recommendations for national consideration related to CHW core roles (scope of practice), core skills, and core qualities (skills and qualities are collectively defined as competencies). The proposed roles, skills, and qualities are intended to inform the range of CHW practice. Notably, they are not intended to define the range of practice of any individual CHW or CHW organization, but rather to represent the potential range of CHW roles and skills, and an essential set of qualities. The C3 Project to date has included an analysis phase and an initial consensus-building phase. Findings are presented as "recommendations" in the report, which ends with a discussion of potential use of the findings and future directions. It is widely agreed that a greater degree of national consensus about CHW scope of practice and competencies would be an asset to the field. Currently CHW scope of practice and competencies are formally defined, or are in the process of being defined, in most states, but no national formal consensus exists. In the absence of such a consensus or guidelines, organizations providing CHW services and/or training find themselves defining roles, skills, and qualities for practicing CHWs, often in vastly different ways. In contrast, other health-related professions have achieved recognition through a process of defining their professional boundaries and occupational standards; CHWs have not yet done so in a formal way. In response to this charge, the C3 Project sought to capture how CHW roles, skills, and qualities have changed over time, particularly since the release of the National Community Health Advisor Study (NCHAS) in 199817. The Project incorporated input and facilitated consensus building among state and local CHW associations. The consensus-building process is an end, seeking greater unity and common understanding within the CHW field in the many different settings in which CHWs practice."

Source: The Community Health Worker Core Consensus Project Texas Tech University Health Sciences Center El Paso (2016).

The Massachusetts Community Health Worker's Code of Ethics

This Code of Ethics ("Code") shall serve as a guide to Community Health Workers ("CHWs") for day-to-day decision making while practicing public health work. Its purpose is to clarify the mission, values, and principles of the profession and to link these to specific standards of professional conduct. This Code shall complement, rather than replace, other employer policies.

Adherence to the Code is expected for:

1. the admission and continued membership in the Massachusetts Association of Community Health Workers ("MACHW")
2. the maintenance of certification from the MA Board of Certification of CHWs at the MA Department of Public Health.

Advocacy. I will:

1) advocate for and support all clients, so that their rights and safety are protected and maintained;
2) respect my clients' values and beliefs;
3) incorporate my client's values and beliefs into the care I provide; and
4) strive to gain and maintain the trust of my clients.

Scope of Care. I will:

1) be truthful to my clients and employer about my skills, qualifications, and certifications, including any limitations on the services I can provide;
2) refer clients to other qualified professionals for services I cannot provide.

Confidentiality. I will:

1) respect and maintain the confidentiality of all clients, including information shared verbally, as well as information in client's records; and
2) follow all local, state, federal, and employer regulations regarding confidentiality.

Professionalism. I will:

1) maintain professional boundaries at all times;
2) not participate in any illegal activity;
3) not engage in any sexual or romantic relationship with a client or client's relative;
4) not accept money, gifts***, or any compensation from a client for services performed; and
5) not accept compensation for client referrals.

***You may accept homemade gifts, as they are expressions of gratitude in many cultures.

Expanding Knowledge and Education. I will:

1) actively network with other professionals and organizations, in order to best match my client's preferences and needs to health and social services in their

region/city/town/neighborhood; and
2) strive to expand my professional knowledge base and competencies through education and participation in professional development programs.

Care of Everyone. I will:
1) respect the rights, dignity, and worth of all people; and
2) never deny services to someone due to that person's race, religion, nationality, culture, gender, physical characteristics, age, sexual orientation, or gender identity

Committing to Community Health Work. I will:
1) be loyal to and advocate for CHWs and the work they do at the local, state, national, and international levels.

Medical Interpretation. I will:
1) be honest with my employer and clients about my skills to provide medical interpretation and only interpret two-way conversations between a client and a provider if I am trained as a medical interpreter

Wellness and Safety. I will:
1) be honest with myself and my employer when a client requires care that is too emotionally difficult for me; and,
2) strive to maintain a safe environment for myself, my colleagues and those I serve.

Employer's Policies. I will:
1) support my employer and all of my employer's policies and regulations. If a conflict arises between my employer and this Code of Ethics, I will appropriately raise my concerns with my employer.

Signed by **Community Health Worker** _____ Date: _____

272 CMR 8.00: Professional and Ethical Standards of Conduct for Certified Community Health Workers

8.1: Purpose

272 CMR 8.00 defines the standards of conduct for all Certified Community Health Workers certified by the Board of Certification of Community Health Workers.

8.2: Standards of Conduct for Certified Community Health Workers

The Standards of Conduct for Certified Community Health Workers include:

(1) Use of Title. A Certified Community Health Worker shall only identify himself or herself as a Certified Community Health Worker while in the possession of a current certification.

(2) Misrepresentation of Credentials. A Certified Community Health Worker shall not misrepresent his or her credentials related to the practice of community health work including, but not limited to, those indicating education, type of community health worker certification, professional experience, or any other credential related to his or her work as a community health worker.

(3) Practice Under a False or Different Name. A Certified Community Health Worker shall engage in the practice of community health work only under the name in which such certification has been issued.

(4) Acts within Scope of Practice. A Certified Community Health Worker shall only perform acts within the scope of community health worker practice as defined in M.G.L. c. 112, § 259 and 272 CMR 6.01.

(5) Competency. A Certified Community Health Worker shall only assume those duties and responsibilities within his or her scope of practice and for which he or she has acquired and maintained necessary knowledge, skills, and abilities.

(6) Responsibility and Accountability. A Certified Community Health Worker shall be responsible and accountable for his or her judgments, actions, and competency in the course of performing his or her duties as a Certified Community Health Worker.

(7) Documentation. A Certified Community Health Worker shall make complete, accurate, and legible entries in all records required by federal, state and local laws and regulations.

(8) Falsification of Information. A Certified Community Health Worker shall not knowingly falsify, or attempt to falsify, any documentation or information related to any aspect of certification as a community health worker, the practice of community health work, or the delivery of community health worker services.

(9) Alteration or Destruction of Records. A Certified Community Health Worker shall not inappropriately destroy or alter any record related to his or her work as a Certified Community Health Worker.

(10) Discrimination. A Certified Community Health Worker shall not withhold or deny care or services based on age, ancestry, marital status, sex, sexual orientation, gender identity, race, color, religious creed, national origin, diagnosis, or mental or physical disability.

(11) Client Abuse, Neglect, Mistreatment, or Other Harm. A Certified Community Health Worker shall not abuse, neglect, mistreat, or otherwise harm a client.
(12) Infection Control. A Certified Community Health Worker shall not place a client, himself or herself, or others at undue risk for the transmission of infectious diseases.
(13) Client Dignity and Privacy. A Certified Community Health Worker shall safeguard a client's dignity and right to privacy.
(14) Client Confidential Information. A Certified Community Health Worker shall safeguard client information from any person or entity, or both, not entitled to such information. A Certified Community Health Worker shall share appropriate information only as required by law or authorized by the client for the well-being or protection of the client.
(15) Sexual Contact. A Certified Community Health Worker shall not have sexual contact with any client with whom he or she has a current community health worker/client relationship or with any former client who may be vulnerable by virtue of disability, age, illness, or cognitive ability.
(16) Professional Boundaries. A Certified Community Health Worker shall establish and observe professional boundaries with respect to any client with whom he or she has a current community health worker/client relationship. A Certified Community Health Worker shall continue to observe professional boundaries with his or her former clients who may be vulnerable by virtue of disability, age, illness, or cognitive ability.
(17) Exercise of Undue Influence. A Certified Community Health Worker shall not exercise undue influence on a client, including the promotion or sale of services, goods, appliances, or drugs, in such a manner as to exploit the client for financial gain of the Certified Community Health Worker or third party.
(18) Borrowing from Clients. A Certified Community Health Worker shall not borrow money, materials, or other property from any client.
(19) Undue Benefit or Gain. A Certified Community Health Worker shall interact with clients without undue benefit or gain to the Certified Community Health Worker or third party.
(20) Relationship Affecting Professional Judgment. A Certified Community Health Worker shall not initiate or maintain a community health worker/client relationship that is likely to adversely affect the community health worker's professional judgment.
(21) Advertising. A Certified Community Health Worker shall not engage in false, deceptive, or misleading advertising related to community health work.
(22) Fraudulent Practices. A Certified Community Health Worker shall not engage in any fraudulent practice including, but not limited to, billing for services not rendered or submitting false claims for reimbursement.
(23) Impersonation. A Certified Community Health Worker shall not impersonate another community health worker or other health care provider, or knowingly allow or enable another person to impersonate him or her.
(24) Aiding Unlawful Activity. A Certified Community Health Worker shall not aid any person in performing any act prohibited by law or regulation.

(25) Circumvention of Law. A Certified Community Health Worker shall not receive from, or offer, give, or promise anything of value or benefit to, any official to circumvent any federal, state and local laws and regulations.
(26) Practice While Impaired. A Certified Community Health Worker shall not act as a community health worker while impaired.
(27) Unlawful Acquisition and Possession of Controlled Substances. A Certified Community Health Worker shall not unlawfully obtain or possess controlled substances.
(28) Duty to Report to the Board. A Certified Community Health Worker who directly observes another community health worker or health care professional engaged in any of the following shall report that individual to the Board: (a) abuse of a client; (b) practice of community health work while impaired by substance use; (c) diversion of controlled substances.
(29) Violence. A Certified Community Health Worker shall not endanger the safety of the public, clients, or coworkers by making actual or implied threats of violence or carrying out an act of violence.
(30) Compliance with Agreements and Orders. A Certified Community Health Worker shall comply with all provisions contained: (a) in any agreement he or she has entered into with the Board; or (b) in any order issued to him or her by the Board.

____ I certify, to the best of my knowledge, that the information I have provided for this application for certification and all supporting documents is truthful and accurate. I understand that any failure to provide truthful and accurate information in this application for certification may be grounds for the Board of Certification for Community Health Workers to deny issuing certification to me; to suspend or revoke a certification issued to me; or to deny renewal of a certification issued to me, all in accordance with Massachusetts law.

APPLICANT SIGNATURE: _____ DATE _____
PRINT NAME _____
NOTARY NAME**:** _____
COMMISSION EXPIRES: _____

[Seal]

Sample CHW Interview Questions

General

- What interests you about this position?
- Tell me what you already know about our agency.
- What might you find challenging about this position?
- How would you describe your work style?
- How have your experiences prepared you for this position?
- What do you think it takes for a CHW to be successful in this position?
- What personal characteristics do you think are necessary for this job?
- How would you describe your ability to work as a member of a team?
- What do you expect to be doing in five years?
- Have you ever had difficulty with a supervisor? How did you resolve the conflict?
- Tell me about a problem you recently handled. Were you successful in resolving it?
- What has caused you the greatest difficulty at work?
- Tell me about the salary range you are seeking.
- Describe an instance when you had to think on your feet to get out of a difficult situation.
- Tell me about a time when you had to go above and beyond the call of duty to get a job done.
- Tell me about a time when you were not very satisfied or pleased with your performance
- What kind of supervisor do you work best for? Provide examples.
- Describe a situation that required a number of things to be done at the same time. How did you handle it? What was the result?
- How do you determine priorities in scheduling your time? Give examples.
- Give an example of when you had to work with someone who was difficult to get along with. Why was this person "difficult"? How did you handle that person?
- What was the most significant contribution you have made at your last job?
- If you had to work with someone you did not like, or did not like you, how would you handle it?
- What is your understanding of harm reduction? How would you apply the harm reduction approach to… (provide situation)?

Behavioral

Decision Making and Problem Solving

- Give me an example of a time when you had to keep from speaking or making a decision because you did not have enough information.
- Give me an example of a time when you had to be quick in coming to a decision.
- Give me a specific example of a time you used good judgment and logic in solving a problem.

- Give me an example of a time when you used your fact-finding skills to solve a problem.

Difficult Situations

- Tell me about a recent situation in which you had to deal with an upset customer or co-worker.
- Tell me about a difficult decision you've made in the last year.
- Please tell me about a time you had to fire a friend.
- Describe an instance when you had to think on your feet to extricate yourself from a difficult situation.
- Describe a time when you set your sights too high (or too low).
- Tell me about a time when you missed an obvious solution to a problem.
- Give me an example of a time when you tried to accomplish something and failed.

Leadership

- Give me an example of a time when you motivated others.
- Tell me about a time when you delegated a project effectively.
- What is the toughest group that you have had to get cooperation from?
- Have you ever had difficulty getting others to accept your ideas? What was your approach? Did it work?
- Give me an example of when you showed initiative and took the lead.

Decision Making

- Give me an example of a time when you had to make a split-second decision.
- Tell me about a time when you were forced to make an unpopular decision.
- Describe a time when you anticipated potential problems and developed preventive measures.

Motivation

- Describe a situation when you were able to have a positive influence on the action of others.
- Tell me about a time when you had to go above and beyond the call of duty to get a job done.

Communication

- Tell me about a situation when you had to speak up (be assertive) in order to get a point across that was important to you.
- Have you ever had to "sell" an idea to your co-workers or group? How did you do it? Did they "buy" it?
- Describe a situation in which you were able to use persuasion to successfully convince someone to see things your way.
- Tell me about a time you were able to successfully deal with another person even when that individual may not have personally liked you (or vice versa).

Conflict Resolution Skills

- What is your typical way of dealing with conflict? Give me an example.
- Tell me about a time you were able to successfully deal with another person even when that individual may not have personally liked you (or vice versa)
- Give me a specific example of a time when you had to conform to a policy with which you did not agree.

Interpersonal Skills

- What have you done in the past to contribute toward a teamwork environment?
- Describe a recent unpopular decision you made and what the result was.

Planning and Organization

- How do you decide what gets top priority when scheduling your time?
- What do you do when your schedule is suddenly interrupted? Give me an example.
- Give me an example of a time when you set a goal and were able to meet or achieve it.
- Tell me about a time when you had too many things to do and you were required to prioritize your tasks.

Other Behavioral Questions

- Give me an example of an important goal which you had set in the past and tell me about successes in reaching it.
- Describe when you were faced with a stressful situation that demonstrated your coping skills.
- Please discuss an important written document you were required to complete.

Situational

- Describe a situation where there was conflict in the workplace? How did you respond? Why?
- Describe a challenging client you had to work with. How did they challenge you? How did you respond and why?
- You are supervising a good performing employee who is chronically late to work. How would you intervene and why?
- You just spent 15 minutes doing risk reduction planning with someone at their home. When you are done, they ask you out for coffee. What would you do and why?
- A funder is coming to review files. You are new to the job and discover that your predecessor did not keep good files. What would you do and why?

Adapted from: MA DPH HIV/AIDS Bureau, 2008.

Boston Medical Center's Community Wellness Advocate Interview Guide (Adapted)

Competency	Sample Interview Questions
Cultural Competence ***Understands how one's beliefs, values, customs, and social behavior influences their interactions with individuals, institutions, and systems around them***	1) How will your knowledge of culture and tradition influence (help or hinder) your ability to serve BMC's patient population? 2) Describe a time where you functioned and communicated effectively and respectfully within the context of varying beliefs, behaviors, and backgrounds. 3) Tell me about a time you suspected a client/patient was experiencing challenges (not following treatment plan, missing appointments, etc.) due to cultural preferences. What steps did you take to understand their preferences?
Communication Skills ***The ability to choose a communication behavior that is both appropriate and effective for a given situation***	1) Tell me about a time you had to deliver a difficult message to a client/patient or provider. How did you convey it? What was the end result? 2) Give me an example of how you determine what kind of communication style(s) you use when interacting with someone. What factors do you consider? 3) Describe a time you were misunderstood. What happened? What steps did you take to rectify the situation? What would you have done differently?
Teamwork ***Promotes cooperation and commitment within a team to achieve goals and deliverables***	1) Please share a time when you had to work closely with others as part of a team in order to complete a task or assignment. Please describe the situation, your actions, and the outcome. 2) Can you tell me a time when you had conflict on your team? What was your role? How did you resolve it? 3) Give an example of how you've balanced cooperation with others and independent thinking.
Advocacy and Community Capacity Building ***Works with or on behalf of people to exercise their rights and gain access to resources. Promotes individual and collective empowerment through education, skill development, networking, organizing, and strategic partnerships.***	1) Please describe your experience in navigating communities. What are some potential barriers you've encountered? How did you address these barriers? 2) Describe how you have worked to create hospital- and/or community- based environments that are welcoming and inclusive?
Interpersonal Skills ***Treats others with courtesy, sensitivity, and respect; considers and responds***	1) Give an example of methods you've used to be able to establish a successful relationship with clients/patients and colleagues.

appropriately to the needs and feelings of different people in different situations	2) Tell me about a time you had to work with an individual or a group of people with whom you did not feel comfortable working. How did you navigate the work environment? 3) Tell me about a time you let your prejudices affect a situation with a patient or client.
Health Behavior Change ***Acts as an educator and coach and works with clients, family, and community members, and providers to address issues that may limit opportunities for healthy behavior***	1) Are you familiar with Harm Reduction? Give me an example of how you have applied this concept to your work in previous roles. How would you apply it to work with our patient population? 2) Why do you feel it is hard from some people to change their behavior even when it is harmful to them? 3) Can you tell us about a situation in which you were working with someone who was engaged in a harmful behavior? What was your intervention? Was your involvement helpful? What did you learn from this case?
Care Coordination and System Navigation ***Helps people understand and use the services of health providers and other service organizations***	1) Share an effective method you have used to develop and/or maintain cooperative working relationships with agencies and organizations within and outside of healthcare settings. 2) Share an experience in which collaborating with health specialists or a community-based organization helped you to effectively respond to an individual's needs and establish goals to successfully meet their needs.

Source: Jessica Aguilera-Steinert, MS, LICSW at Boston Medical Center

Pre-Interview Phone Screen

*Adapted from PACT Project JRI Health

The purpose of this screening tool is to assist an employer to select candidates to conduct a face-to-face interview by having a brief conversation that can help identify concerns or select candidates to interview in a face-to-face meeting.

- Give introduction to program and position.
- Tell us how your past experiences relate to this position. *(The goal is to get a sense of the candidate's personal connection to the population served or challenges associated with the condition or health/socio-economic status and to learn about their professional experiences.)*
- What skills would you bring to this position?
- Why do you want to work with this community? (*The goal is to get a sense of the candidate's commitment to, connection to or passion for the community, condition, or environment of the participants engaging in these services)*
- Do you have [x] language skills?
- Do you have a car you can use every day for work? *(If necessary, for the position- fill in any relevant requirements that are non-negotiable.)*
- Other questions?
    - Bring back for an interview? ☐ Yes ☐ No

Source: Community Health Worker Program Development Resource Guide, *Section 1: Recruitment & Hiring.*

CHW First Interview Tool

*Adapted from PACT Project JRI Health

Give an introduction to program and position and elicit initial questions *(Include major roles and responsibilities, goals of the program and how the CHW relates to the team).*

Interests and Experience

- Tell us how your past experiences relate to this position.
- Why do you want to work with this community?
- Tell us about your experience working with people with [*x condition*] What is your experience working with people who are encountering [x condition]?
- Tell us about your experience working with people with chronic diseases: (e.g., Hypertension or Pre-Diabetes (insert your program specifics).
- Tell us about your experience working with people with substance use challenges.
- Tell us about your experience working with people with mental illness.
- Tell us about your experience working with people in domestic violence situations.
- Tell us about your experience providing case management services.
- Are you familiar with the harm reduction approach? If so, tell us how you might apply it to work with our client population (if not, give brief definition and elicit philosophy of care).
- Can you give us an example of when you helped someone make change?
- What do you think motivates people to make changes in their behaviors?
- Tell me about a time you have had to set limits with someone who was asking too much of you.
- What concerns, if any, do you have about working in people's homes? What do you think is important to keep in mind when doing so?
- Are there any groups of people with whom you don't feel comfortable or would feel uncomfortable working with? Why?
- Tell me about an achievement in your work of which you are most proud.
- Tell me about an event at work that was a "learning moment" for you.

- Given what you know about this job, what do you anticipate are your growth areas?
- How does this position fit in with your other goals and plans?
- Do you own a reliable car? What are your thoughts on spending a lot of time driving/driving to new places (explain policy on car liability)?

Post - Interview Summary:

Address:

- Insight (about self and other people)
- Confidence
- Autonomy
- Administrative skills
- Organization
- Cultural competence
- Fit/match with current team (including what this person could add to the existing team)
- Overall ability to connect to new people (warmth, humor, comfort, respect, thoughtfulness, listening skills)

Skills/assets:

Areas for growth:

Bring back for another interview? ☐ Yes ☐ No

Who will follow up with applicant: _____

Probable timeline: _____

CHW Orientation Toolkit – EMK

Community Health Workers (CHW) Orientation Toolkit
Edward M. Kennedy Community Health Center
Worcester, Framingham, Milford MA

Mass League of Community Health Centers
Community Health Institute 5_5_2016

Marcia Nascimento, Community Health Worker Supervisor, Framingham
Sue Schlotterbeck, Director, Health Equity

CHW Orientation Toolkit and related trainings, documents and resources were developed with financial support from the **Commonwealth Corporation Health Care Workforce Transformation Fund**. The Center for Health Impact (CHI) is the lead on this grant and Kennedy CHC is the employment partner.

EDWARD M. KENNEDY
Community Health Center

Source: https://massleague.org/Calendar/LeagueEvents/CHI/2016/NascimentoSchlotterbeck.pdf

CHW Assessment Toolkit – C3

The Community Health Worker Core Consensus Project
TTUHSC EL PASO

COMMUNITY HEALTH WORKER ASSESSMENT TOOLKIT

A FRAMEWORK FOR ASSESSING SKILLS PROFICIENCY AND FOSTERING PROFESSIONAL DEVELOPMENT

Caitlin G. Allen
J. Nell Brownstein
Maria Cole
Gail Hirsch

Community Health Worker Core Consensus Project
Texas Tech University Health Sciences Center El Paso

Source: https://0d6c00fe-eae1-492b-8e7d-80acecb5a3c8.filesusr.com/ugd/7ec423_c3c4b559904d417e851c5dfb5ab25bc8.pdf

Reference Check Tips

The principles that apply to interview questions also apply to reference questions: ask only work-related questions; ask the same or similar questions for all candidates; ask open-ended questions, not those that can be answered yes/no.

Before asking questions, briefly describe the position for which the person applied. Be respectful of the person's time and limit questions to those you think are most important.

Sample Questions (select based on the job you are filling):

- What were the beginning and ending employment dates for ___? What position(s) did they hold? Salary history?
- How long have you worked with or supervised this individual?
- What were their most recent job duties?
- How would you describe their overall performance?
- How was their attendance? Were they punctual?
- How well did they prioritize their responsibilities?
- What areas of performance did they excel in?
- What areas of performance did they have to work on?
- How would you compare their work to the work of others who performed the same job?
- How would you describe their ability to work independently? Can you give me an example?
- How would you describe their ability to work under pressure? Can you give me an example?
- Are they a self-starter? Can you give me an example?
- How would you describe their ability to meet deadlines?
- How would you describe their verbal and written skills?
- How would you evaluate their organizational skills?
- How would you evaluate their ability to take constructive criticism? Can you give me an example?

- How would you assess their interpersonal skills?
- How do they handle conflict situations? Can you give me an example?
- How do they get along with co-workers? With managers?
- How do they respond to supervision? What kind of supervision do they work best under?
- How would you describe their ability to share information needed to get the job done?
- Why did they leave their job with you?
- Do you have any advice that would help them be successful in this position?
- Based on your experiences with them, do you think they would be successful in this type of position?
- Would you rehire this person? Why?
- Were there any issues that we need to be aware of before making a hiring decision?
- Is there anything else job-related that you can tell me about them that would be helpful?

CHW Job Description Examples

Below are sample job descriptions for CHW roles in health care settings for people with chronic diseases. They can be adapted to any program with role specific adjustments.

Job Description #1

General Job Statement:

The Community Health Worker (CHW) plays a key role by providing social, behavioral and resource support to patients as they navigate the health care system. The CHW is a member of the health center's primary care team, and partners closely with different providers, patients, and outside organizations. He/she is responsible for increasing patients' access to health care and community resources/social services, facilitating communication between patient and care teams; and providing culturally appropriate health education and self-management support.

Key Responsibilities:

- Coach patients in effective management of their chronic health conditions and self-care
- Provide education in individual or group sessions, screening, brief interventions and facilitate referrals to other community-based resources
- Assist patients in identifying the barriers to health that they identify and prioritize
- Assist patients in understanding care plans and instructions; help patients develop health management plans and goals
- Document activities, care plans, and outcomes in an effective manner consistent with organization's policies and procedures
- Provide ongoing follow-up, basic motivational interviewing and goal setting with patients
- Help clients in identifying and utilizing community resources, including scheduling, and accompanying them to appointments, and assisting with completion of applications for programs for which they may be eligible
- Facilitate communication and coordinate services between providers; Work collaboratively and effectively within multidisciplinary team
- Build and maintain positive working relationships with clients, providers, supervisors, and staff
- Continuously expand knowledge and understanding of community resources, services and programs provided

- Identify and apply appropriate role definition and skilled boundaries

Requirements/Qualifications:

- Any combination of 3-years health/social services experience preferably in health care setting or community-based organization
- Minimum of high school degree or equivalency
- Creativity, flexibility, sound judgment, and ability to take initiative
- Strong communication and writing skills
- Excellent time management and organizational skills
- Demonstrated ability to work as an effective team member in a complex and fast-paced environment.
- Excellent interpersonal skills and demonstrated ability to interact professionally with culturally and educationally diverse staff and clients
- Verifiable good driving record and reliable transportation
- Bilingual/bicultural (Spanish) encouraged to apply
- Demonstrated technical experience with Microsoft Word, Excel (or similar databases), and Internet Explorer
- Positive attitude and open to changing environment

Job Description #2

General Job Statement:

The Community Health Worker (CHW) is responsible for helping patients and their families to navigate and access health and community services and adopt healthy behaviors. The CHW works as a member of the Primary Care team through an integrated approach to care management and community outreach. As a priority, activity will promote, maintain, and improve the health of patients and their family. Provide social support and informal counseling, advocate for individual and community health needs, assess self-management needs and health literacy level, and provide health education.

Key Responsibilities:

- Responsible for establishing trusting relationships with patients and their families while providing general support and encouragement
- Utilize motivational interviewing skills to identify the patient's individualized goals and priorities for their health

- Work closely with medical providers to help ensure that patients have comprehensive and coordinated care
- Conduct intake interviews with patients identifying barriers to optimal health
- Follow-up with patients via phone calls, home visits and visits to other settings where patients can be found
- Help patients set personal health goals and support adherence to those goals through identification of barriers and facilitators
- Work collaboratively with multidisciplinary team members
- Be knowledgeable about community resources appropriate to needs of patients/families
- Be responsible for providing consistent communication to the Care Management Coordinator to evaluate patient/family status, ensuring that provided information, and reports clearly describe progress

Requirements/Qualifications:

- High school diploma or its equivalent
- Written and oral fluency in Spanish and English required. Experience working in a multi-cultural setting
- Experience working in a community-based setting for at least 2 years preferred
- Basic computer skills (Outlook, Excel, and PowerPoint helpful)
- Ability to initiate and maintain positive working relationships with team members and other organizations
- Excellent written and verbal communication skills

Sourced: Community Health Worker Program Development Resource Guide, *Section 1: Recruitment & Hiring*

Sample Orientation Template

Massachusetts Department of Public Health
Division of Prevention and Wellness
Office of Community Health Workers

SAMPLE Checklist for CHW Onboarding/Orientation Needs:

- ❑ Review of employee handbook
- ❑ Review of departmental policies
- ❑ Review of administrative procedures, computer systems, log ins, ID badges, supplies, equipment, etc.
- ❑ Review of other team members' roles (schedule brief one-on-one Interviews with them)
- ❑ Shadowing opportunities: Who/When/Where?
- ❑ Include CHW in the following relevant team meetings:

  _____

Supervision Plan:

- ❑ Individual supervision – weekly/bi-weekly
- ❑ Group supervision -- bi-weekly/ monthly
- ❑ Case Reviews/conferences
- ❑ CHW Supervisor Training Needs: _____

CHW Trainings Needs:

- ❑ CHW Core Competency
- ❑ Review of referral workflow
- ❑ Review of documentation protocols
- ❑ Review of procedure manuals
- ❑ Review of patient records tools
- ❑ Review of home visiting policy
- ❑ Review of Assessment Tools
- ❑ Review of electronic health records, or any other data bases, if applicable
- ❑ Health specific topics: _____

- ❑ Motivational Interviewing skills
- ❑ The Stages of Change model of care

Goals and Expectations for:

1st Month:

2nd Month:

3rd Month:

Sourced: Community Health Worker Program Development Resource Guide.

Sample Home Visiting Protocol

*Adapted from JRI Health/PACT project

MDPH CHW Program Development Guide

Safety Protocol and Keys to Successful Home Visiting

Respect People's Homes

- Respect people's private spaces and the privilege you have in entering them. Practice non-judgment and respect cultural differences.
- Be there when you say you will be; schedule appointments and be consistent!
- Be aware and observant. Speak at a low volume unless client assures you there are no confidentiality concerns.
- When in doubt, ask! (the patient directly, or supervisor)

Talk with Clients

- Confidentiality- Ask clients at the start of visits: what should I call myself when I visit if someone asks?
- Visitors- How should we handle things if someone comes in? Who is safe and who isn't? Do we need codes?
- Guidelines discuss in advance with active substance users
    1. Don't use for two hours beforehand so the meeting will be productive
    2. If you need to use, call to reschedule
    3. Don't have paraphernalia or substance out and visible
    4. If a client seems impaired or has visible paraphernalia, tell them you'll need to reschedule and leave the home.

What to Wear

- Ideal – Professional and comfortable
- Choose clothing that's appropriate for both patient's homes and clinics/hospitals or community-based organizations
- Avoid clothing that might send any confusing messages to patients (sexy, too casual, overly formal)

Getting Support

- Doing home visits can feel isolating, as you're "out there on your own"
- Rely on open communication with your supervisor. When possible, your supervisor may join your visit to assess the situation and support you.

- Always have your (charged) cell phone with you.
- Use your teammates (for check-in, troubleshooting, support)
- In the community, you're an ambassador for the program!

Safety Guidelines

1. If you ever feel unsafe or uncomfortable in someone's home or meeting place, leave the premises immediately and contact your supervisor by cell.

2. Set up ground rules if you think there might be a safety concern in the future. Meet patients for the first time outside the home and outline our safety expectations: that they will not have drugs or paraphernalia visible; that they will notify us if there are weapons in the home; that they will notify us if there is a potentially dangerous person in the home or nearby; and that overall, they will treat us with respect, let us know if the safety circumstances have changed so we can evaluate for ongoing visits, and never make threats.

3. If weapons are in the home, and revealed to you, leave right away.

4. If a physical altercation occurs between your patient and any other person, DO NOT try to resolve the problem or intervene in any way. Leave immediately and debrief with your clinical supervisor or manager that day.

   If you need to visit a client and are worried about safety, implement a Safety Call.

   1. Call supervisor to confirm that you are going to visit the client.

   2. Call supervisor again at the end of the visit to confirm your safety.

   3. If you do not call back, supervisor will try to reach you. If the supervisor cannot reach you, they will call the police.

Mental Health and Medical Emergencies

If your client has a mental health or medical emergency, page the client's PCP (Primary Care Physician) or another primary provider and call 911, then call your manager. Refer to agency suicide and homicide prevention policies for more detail.

Source: Community Health Worker Program Development Resource Guide, *Section 5: Integration*.

Sample CHW Communication Guidelines

*Adapted from JRI Health/PACT project

MDPH CHW Program Development Guide

CHW Communication Expectations

- Check email daily
- Listen to voicemail messages daily, delete old messages to ensure room for new ones
- Respond to supervisor call/text within 2 hours (unless there's an emergency)
- **Providers**: respond within 48 hours and at least monthly contact for each patient
- **Clients**: respond within 24 hours, ideally same day
- When away, change voicemail message and email "out of office" reply
- If home sick for a day, change voicemail only
- Reschedule/cancel your appointments yourself with clients and staff if you will be out
- Call/text ahead if you will miss or be late to any meeting, case conference, team meeting
- Plan your time off ahead, request early and work with supervisor to ensure coverage of client needs and provider communication
- All administrative issues go through manager (time off, schedule changes, calling in sick, changes in level of service for clients such as graduations or changing from 4 visits a month to 2 visits a month)

Source: Community Health Worker Program Development Resource Guide, *Section 5: Integration*

Sample Cellphone Guidelines

*Adapted from JRI Health/PACT project

MDPH CHW Program Development Guide

1. Work cell phones are to be used **EXCLUSIVELY** for work purposes: calling/texting clients and colleagues, checking work email, maps/navigation for work-related driving, etc.
2. Do not use your work cell phone for any personal use (personal phone calls, texts, personal email, Facebook, games, purchases, etc.).
3. Do not purchase or download any applications without the approval of your supervisor.
4. During work hours, you are expected to keep your work cell phone charged and available to you.
5. Set a security password or PIN on your screen so that you can protect confidentiality if someone else picks up your phone.
6. Do not let others use your work cell phone, unless you are with a client using it for a call and you are able to ensure that the call is brief and that they do not access other features of the phone.
7. Set your phone to silent or turn it off outside of working hours (for this program, between x pm-x am and on weekends). Do not answer or respond to client calls/texts you receive outside of working hours—wait until the next workday.
8. Please do not use your phone while driving, other than the navigation function! Texting/talking while driving is dangerous and texting while driving is illegal
9. Please take the utmost care with this phone—do your best not to damage, break, or lose it! New phones are an avoidable expense and a strain on the program. We will replace them as they become less functional over time.

Handout - Stages of Boundary Setting

Adapted by Edward M. Kennedy Community Health Center from *Initiation and Engagement of Alcohol and Other Drug Treatment: Module 2: Strategies for Approaching, Engaging and Motivating Clients,* a MassHealth/UMass Medical School Curriculum for Community Health Workers developed by the Center for Health Impact, Inc.

Boundaries are imaginary lines that we draw to protect mind, body and soul and allow us to be with others in a way that honors us both.

- When setting boundaries always, always, be calm – with no emotional charge. Don't even try setting boundaries when you are angry or charged. Calm down first.
- Keep your language simple, clear, and focused on the behavior and how you feel about it.
- Remember your goal is not to make the other person feel bad but rather to change the behavior, so you want their full co-operation.
- This is not about making the other person wrong or scoring points. It is about creating an environment of mutual respect in which your relationship can grow.

1. Inform. Let the other person know your standard, or what is bothering you. If there is a problem, clearly and simply let the other person know - don't make a guessing game out of it. Example: Do you know I am not allowed to communicate with you outside my working hours?

2. Request. If the other person doesn't stop or change the behavior after #1 (most will) simply and clearly ask them to stop or change the behavior. Example: Will you please stop calling my cell phone every night?

3. Educate. Give alternatives, and/or model the new behavior yourself. Example: You can call me between the hours of 9 – 5. Let's make a plan about who you can call at other times if you need something.

4. Warn. First give this some careful thought. If you give a warning, you must be able to carry it through. If the behavior keeps repeating, it may be necessary to give fair warning that there will be consequences if the behavior continues. Example: If you keep calling me every night, my boss may assign someone else to work with you.

CLAS Self-Assessment Tool

CLAS Self-Assessment Tool

The following questions are designed to help programs **identify their own challenges and goals** and develop a work plan with **concrete tasks** to achieve or address them using basic elements of Culturally and Linguistically Appropriate Services (CLAS) standards. DPH considers CLAS work to be an ongoing improvement project. Your contract manager will help support your efforts to implement CLAS as part of your contractual expectations and will monitor continuous improvement based on your program's self-assessment and proposed work plan.

Organization

Organization Name:

Address:

City: **State: Zip:**

Contact Person for CLAS Implementation

First Name: **Last Name:**

Title:

Telephone: **E-Mail**:

Culturally Competent Leadership and Workforce

1. Does your program **recruit, retain, and promote** staff that reflects the cultural diversity of the community? (*CLAS Standard 3*) **Check one.**

   ☐ Our staff **fully** reflects the cultural diversity of our community.
   ☐ Our staff **partially** reflects the cultural diversity of our community.
   ☐ Our program staff **does not** currently reflect the cultural diversity of our community.

2. Does your program have **written policies and procedures** that support recruitment, retention, training, and promotion practices? (*CLAS Standard 2*) **Check one.**

   ☐ **All** our staff are aware of / universally trained on them.
   ☐ **Not all** our staff are aware of / universally trained on them.
   ☐ Our program does not currently have written policies and procedures that support these diversity practices.

3. Do program staff members at all levels and disciplines receive **training** in culturally- and linguistically appropriate service delivery? (*CLAS Standard 4*) **Check ALL that apply.**

   ☐ Training is provided to staff as standard part of orientation **for new hires** at all levels and disciplines.
   ☐ Training is provided **at least once a year** to staff at all levels and disciplines.
   ☐ Training is provided, but not in a standardized / routine manner.
   ☐ Our program does not currently provide this training.

Language Access / Communication

4. Does your program provide **timely professional interpreter** services, at no cost, to all Limited English Proficiency (LEP) clients, including those clients who use American Sign Language? (*CLAS Standard 5, Federal mandate*) **Check one.**

   ☐ Always
   ☐ Most of the time
   ☐ Sometimes
   ☐ Our program does not currently provide timely professional interpreter services.

5. Do all LEP or Deaf / Hard of Hearing clients receive **verbal and written notices** about their right to language assistance services? (*CLAS Standard 6, Federal mandate*) **Check ALL that apply.**

   ☐ Verbal notices are provided.
   ☐ Written notices are provided.
   ☐ Our program does not currently provide either verbal or written notice about this right.

6. Are Deaf / Hard of Hearing clients and clients with disabilities provided a copy of your program's **Disability Access notice**? (*CLAS Standard 6, Federal mandate*) **Check one.**

   ☐ Always
   ☐ Most of the time
   ☐ Sometimes
   ☐ Our program does not currently provide Disability Access notice to clients.

7. Does your program offer **written materials** in languages that target the diverse cultural groups in your service area/population? (*CLAS Standard 8, Federal mandate*) **Check one.**

   ☐ Written materials are offered in the languages of **all cultural** groups in our service area/population.
   ☐ Written materials are offered in the languages of **some** cultural groups in our service area/population.
   ☐ Our program does not currently offer written materials in the languages of the cultural groups in our service area/population.

8. Does your program clearly **display images / post signage visibly** that shows inclusivity for the diverse cultural groups including LGBTQ and people with disabilities in your service area/population? (*CLAS Standard 8, Federal mandate*) **Check one.**

   ☐ Images / signage visibly posted in the languages of **all** cultural groups in our service area.
   ☐ Images / signage visibly posted in the languages of **most** cultural groups in our service area.
   ☐ Images / signage visibly posted in the languages of **some** cultural groups in our service area.
   ☐ Our program does not currently post images / signage visibly in the languages of the cultural groups in our service area.

Organizational Support and Accountability

9. Does your program **have a plan** to identify and address CLAS needs for underserved populations? (*CLAS Standard 9) Check* **one.**

   ☐ A plan is fully developed and being implemented.
   ☐ A plan is currently in draft form **or** only partially implemented.
   ☐ Our program does not currently have a written plan

10. Does your program **review** your written CLAS plan at least once a year to assess CLAS progress and needs? (*CLAS Standard 10*) **Check one.**

    ☐ Written CLAS plan is reviewed by program about once a year.
    ☐ Our program does not currently review our written CLAS plan once a year.
    ☐ Not applicable: our program does not currently have a written CLAS plan.

11. Does your program collect **client satisfaction data** to inform culturally- and linguistically appropriate service (CLAS) delivery? (*CLAS Standard 14*) **Check one.**

    ☐ Always
    ☐ Sometimes
    ☐ Our program does not currently collect client satisfaction data to inform CLAS delivery.

12. Does your program use Race, Ethnicity Language (REL) **community/service area** data to help design and deliver program services? (*CLAS Standard 11*) **Check one.**

- ☐ REL community data used in **all** applicable situations to design/deliver program services.
- ☐ REL community data used **most of the time** to design/deliver program services.
- ☐ REL community data **sometimes** used to design/deliver program services.
- ☐ REL community data **never** used to design/deliver program services.

13. Does your program use REL **client** data to help design, deliver and evaluate program services? (*CLAS Standard 11*) **Check one.**

- ☐ REL client data **always** used to design/deliver program services
- ☐ REL community data used **most of the time** to design/deliver program services
- ☐ REL client data **sometimes** used to design/deliver program services
- ☐ REL client data **never** used to design/deliver program services

14. Does your program **participate in partnerships** with other agencies that target the diverse cultural groups in your service area/population? (*CLAS Standard 13*) **Check one.**

- ☐ Our program participates in partnerships with other agencies that target **all** the diverse cultural groups in our service area/population.
- ☐ Our program participates in partnerships with other agencies that target **some** of the diverse cultural groups in our service area/population.
- ☐ Our program does not currently participate in partnerships with other agencies that target the diverse cultural groups in our service area/population.

15. Have you used the "*Making CLAS Happen"* manual? (An electronic version of the manual is posted on the DPH Office of Health Equity's website:
- ☐ Yes
- ☐ No, not yet

Work Plan
Think of the area most meaningful or relevant to your program's goals and challenges. Select one or more of the questions above and briefly describe what you will do to improve your CLAS efforts this year. Activities/work plans should be realistic and attainable, appropriate to your program/staff capacity. Your DPH contract manager will review, monitor and support your efforts. The DPH CLAS manager is available to provide technical assistance—call 617-994-9806.

Identify a current challenge or goal of your program:

Which question number(s) from above relate(s) to that challenge or goal:

What will you do to address or achieve your challenge or goal through CLAS?

How will you measure progress in addressing or achieving your identified challenge or goal?

What impact on health outcomes do you expect as a result of these activities?

Models for CHW Integration

While there are multiple ways to include CHWs in healthcare teams, we have chosen to share three common models:

MODEL 1: Contracting
CHW services are contracted by the primary care entity from a separate community-based organization. Supervision is provided by the contracting entity, usually at the organization where the CHW is based. Services can be provided at the health care entity, in the community, or in both settings.

Model 1 Example:

- A private urban hospital that contracts CHWs through a community-based organization. CHWs provide home visits for asthma education and assessment and coaching and referrals to community resources. Nurse case managers supervise CHWs and help coordinate care with the patient's primary care team, specialty care teams, and community services. The program was initially funded by government grants, the hospital's Office for Community Health, and private donations.

MODEL 2: Staff in community setting
CHWs are staff at the healthcare facility, where they are supervised. They conduct some activities in the healthcare setting but spend much of their time with patients in community settings including the patient's home.

Model 2 Example:

- CHWs support the primary care physician's by working in individuals' homes and community. In this model, the health system is dedicated to addressing the community's specific needs and challenges. CHWs deliver community level interventions including smoking cessation, asthma management, obesity and diabetes prevention, and teen pregnancy counseling. The key element of this model is CHW's working directly in the community to address specific issues that both the patient and the community face. Sinai Urban Health supports CHWs work, with training, while allowing the CHW to maintain their close connection to the community.

MODEL 3: Staff in healthcare setting
CHWs are staff at the healthcare facility, where they are supervised, and their services are provided primarily at that facility.

Model 3 Example:

- CHWs working at the Bronx-Lebanon Hospital serve as a bridge between healthcare providers and the community. CHWs are trained to provide outreach, education, referrals, and follow-up care for patients. In this model, CHWs regularly assist in patient navigation throughout the Bronx-Lebanon hospital system.

Source: Community Health Worker Program Development Resource Guide, *Section 5: Integration*.

Barriers and Recommendations for Successful Integration

1. **Barrier: Role confusion and developing professional identity**
   The term *CHW* can include a wide range of roles and responsibilities that can vary based on individual CHWs, organizations, and funding streams. Because of the wide breadth of services a CHW can provide, organizations and providers have a hard time understanding the function and duties of the CHW. Organizations can also struggle with identifying the infrastructure changes that need to occur within their system to support the integration of CHWs. For example, CHWs require a unique supervision structure as discussed in the Supervision section of this CHW Program Development Guide.

   Recommendations:
   1. Clearly define and document the role and tasks of the CHW including who they serve, how patients are referred to them, and the breadth and limits of their role.
   2. Clearly define supervision responsibilities. The CHWs and care teams should know who to go to for questions and guidance.
   3. Prepare the clinical and administrative staff prior to hiring the CHW and include them in design of the position and the workflow of the CHW
   4. Identify and engage any additional specific internal stakeholders and educate them on the benefits and proper integration of CHWs
   5. Treat CHWs as full members of the clinical team and include them in all regularly scheduled multidisciplinary team meetings and case reviews
   6. Provide CHWs with access to the EHR. CHWs should be able to enter encounter level data and to access relevant patient data.
   7. Include CHWs in the care plan tool that is used by the clinical team and provide a space for their contributions.
   8. Provide CHWs and all other staff responsible for home-based or community-based work with laptops that have internet access. This allows travelling staff to be able to enter patient data into the common data base or EHR, access resources and education tools, and communicate with the provider team.[1]

2. **Barrier: Conflicting professional concerns about CHWs on the healthcare team**
   Due to the wide range of job functions that may fall under a CHWs scope of work, other members of the healthcare team may feel threatened or be concerned about the impact hiring a CHW will have on their position. Additionally, the fact that the CHW training model is quite different from the multi-year training that other types of providers receive can be a cause of concern to some organizations and providers.

   Recommendations:
   1. Encourage clinicians to appreciate that having CHWs on the team can allow them to be able to focus more on their specific job tasks while CHWs cover other aspects of patient

[1] Allen CG, Escoffery C, Satsangi A, Brownstein JN. Strategies to Improve the Integration of Community Health Workers Into Health Care Teams: "A Little Fish in a Big Pond". Prev Chronic Dis 2015; 12:150199. DOI: .

care. Emphasize that CHWs can make the provider's job easier by taking over patient coordination duties. CHWs can conduct patient outreach, patient education, patient navigation, and referrals.

2. Highlight the fact that CHWs can help reach patients who have unclear barriers to behavior change and can spend significant time supporting them as well as reach patients who have been out of the health care system for a period of time.

3. Barrier: Concern about potential liability issues that a CHW could encounter in practice.

Recommendations:

1. Develop policies and procedures to support the role and tasks of the CHW that are shared with or developed by the team. For example, a home visiting policy, a referral policy, communication protocols and clear boundaries regarding their scope of practice and protocols addressing emergencies in the field.

4. Barrier: Sustainable funding for CHWs

Recommendations:

1. CHWs are largely grant funded and most payers do not cover reimbursement of CHWs yet in Massachusetts. There is a group that is working on addressing this crucial barrier and developing strategies to recommend to Mass Health and to promote, as Accountable Care Organizations are developing in the state. This group is a coalition of providers, advocates, CHWs, CHW supervisors, and others motivated to find sustainable funding and is called the Linkages Community of Practice.

5. Barrier: Demonstrating cost-effectiveness of including CHWs in Care Teams

Many organizations lack the capability to track the cost-benefit of the CHW. For an organization to value the integration of the CHW, they must understand the contributions and savings the CHW brings to the care team compared to the cost of hiring and supporting a CHW. The use of CHWs on a care team can lead to better patient outcomes and decreased overall healthcare spending.

Recommendations:

1. Use existing data and reports to assist the development of measures to track.

Example: Evidence demonstrates that CHW interventions targeting patients with high resource utilization result in savings to the medical system. In 2013, the Institute for Clinical and Economic Review (ICER) prepared a report for the New England Comparative Effectiveness Advisory Council (CEPAC) summarizing results of the best quality studies, primarily randomized controlled trials, of interventions that include CHWs.7 The majority of the fourteen cost studies reviewed showed a net cost savings (i.e., "cost offsets from reduced healthcare utilization were greater than the marginal costs of the intervention") over six months to two years follow-up. Most economic analyses took the perspective of a Patient Centered Medical Home (PCMH) provider who would be responsible for expenditures for services and for financial risks incurred.

- Cost reductions were generally due to a reduction in urgent care use, including hospitalization.

- Leaders at most of the 32 Massachusetts community health centers employing CHWs that responded to a 2014 survey indicated that CHWs' greatest value is in supporting high-risk, high-cost patients.

- Include cost-oriented measures such as health care utilization (ED use and inpatient hospitalizations) in your evaluation measures for your CHW program.

- Include all relevant costs of including CHWs into an organization's programming.
  - Health insurance and other benefits
  - Mileage for CHWs conducting home visits
  - Training costs including initial and ongoing training
  - Supplies such as laptop and cellphone for CHWs conducting home visits to be able to document appointments and connect to resources including their supervisor when in the field
  - Supervision costs

Source: Community Health Worker Program Development Resource Guide, *Section 5: Integration*.

The Community Health Worker Assessment Toolkit:

A Framework for the Assessment of Skill Proficiency to Promote Ongoing Professional Development

"When and How to Use This Report: Many programs struggle with how to assess skill proficiency among CHWs in their organization. The report offers key tenets for assessing CHW skills, along with case studies and examples, and various templates that may help in developing a program's assessment. Just as the initial C3 report did, it offers field-driven insight and practice recommendations about these issues, which should be adapted and modified as appropriate to a specific program or organization's needs. Therefore, this report will be most valuable for CHW employers (supervisors and program managers) and CHWs who are interested in assessing their skills both during the hiring process, as well as on the job. This report does not include specific techniques for assessing CHW skills in a training context. While it is important to assess skills in the training context, it is outside the scope of this project. The following figure depicts a typical process for CHW recruitment, training, and hiring. After recruitment, CHWs are assessed based on their qualities (e.g., ability to communicate and build trust). CHWs are usually hired based on these attributes and receive formal training thereafter. CHW skills are often then assessed in the training context (e.g., pre- and post-tests at the end of training, observation of role-playing, other techniques) and CHWs often continue to receive training after hire. Targeted training and ongoing performance assessment continue for CHWs on the job… his outline offers a broad overview of key steps in the recruitment, hiring, and training process."

Source: Allen, C., J.N. Brownstein, M. Cole, G. Hirsch. The Community Health Worker Assessment Toolkit: A Framework for the Assessment of Skill Proficiency to Promote Ongoing Professional Development. A product of the Community Health Worker Core Consensus (C3) Project. Texas Tech University Health Sciences Center El Paso, 2018.

CHW Integration / Supervision Resource List

- Institute of Medicine of the National Academies (2015), *Bringing Community Health Workers into the Mainstream of US Health Care. National Academy of Sciences.* Evidence of how CHWs can enhance team-based care to help achieve the triple aim: better care, better health, and lower costs. Road map on how to integrate community health workers into team based primary care.

- The Institute for Clinical and Economic Review (2013), *Community Health Workers: A Review of Program Evolution, Evidence on Effectiveness and Value, and Status of Workforce Development in New England Report.* This report aims to help understand the latest evidence on the effectiveness and value of community health workers and provide guidance to stakeholders on potential "best practice" options for implementation of CHW programs in New England. The report talks about the evolution of CHWs in the U.S, effectiveness of CHW programs, the economic impact that they could have and perspectives from policy experts regarding CHWs programs. It also gives recommendations about best practices to improve their integration to health delivery models.

- California Health Worker Alliance (2013), *Taking Innovation to Scale: Community Health Workers, Promotores, and the Triple Aim – A Statewide Assessment of the Roles and Contributions of California's Community Health Workers.* This report from the California Health Worker Alliance illustrates how to advance the development of a CHW workforce. It provides a present profile of the current engagement, roles, skills, and performance of community health workers among California's health care safety net providers, and the extent to which organizations have experienced barriers to and identified actions that will promote broader engagement. Additionally, this report talks about CHWs contribution towards achieving the triple aim objectives and practical strategies to take their engagement to scale.

- Sinai Urban Health Institute (2014), *Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings.* The primary aim of this paper is to develop guidelines for the Implementation of CHW models and tools to aid programs wanting to more critically examine processes, outcomes, cost, and cost-benefits associated with CHW interventions.

- The Urban Institute (2013), *Integrating Community Health Workers into a Reformed Health Care System*. This report discusses the challenges with financing structures, workforce training, and service organization and how those can hinder the expansion of the CHW workforce. Additionally, it covers the roles played by CHWs, evidence of their achievements, opportunities for them under health care reform, and recommends productive next steps for growing the CHW workforce.

- The Massachusetts Department of Public Health (2015), *Achieving the Triple Aim: Success with Community Health Workers*. This white paper demonstrates the value a CHW can add to the care team by reducing costs, improving health, improving quality of care, and

reducing health disparities.

- The Community Health Worker Core Consensus Project Texas Tech University Health Sciences Center El Paso (2019) *The Community Health Worker Assessment Toolkit: A Framework for the Assessment of Skill Proficiency to Promote Ongoing Professional Development.* This report offers key tenets for assessing CHW skills, along with case studies and examples, and various templates that may help in developing a program's assessment. Just as the initial C3 report did, it offers field-driven insight and practice recommendations about these issues, which should be adapted and modified as appropriate to a specific program or organization's needs. Therefore, this report will be most valuable for CHW employers (supervisors and program managers) and CHWs who are interested in assessing their skills both during the hiring process, as well as on the job. https://docs.wixstatic.com/ugd/7ec423_c3c4b559904d417e851c5dfb5ab25bc8.pdf

- The Community Health Worker Core Consensus Project Texas Tech University Health Sciences Center El Paso (2018). *Together Leaning Toward the Sky (including: C3 Project CHW Roles and Competencies Review Checklist).* This report offers a review of findings from the Community Health Worker Core Consensus (C3) Project for work carried out from 2014-2018 in two phases. To see other C3 Project resources, visit C3project.org. The C3 Project's reports and graphics are intended to support Community Health Workers (CHWs) and other stakeholders working to foster the growth and development of CHW practice and related policies, increasing the capacity of CHWs to promote health equity and access to systems of care. A primary product of C3. https://docs.wixstatic.com/ugd/7ec423_cb744c7b87284c75af7318614061c8ec.pdf

Acronyms

C3	Community Health Worker Core Consensus Project
CBO	Community-Based Organization
CHI	Center for Health Impact
CCHW	Certified Community Health Worker
CHW	Community Health Worker
CLAS	Culturally and Linguistically Appropriate Services
EAP	Employee Assistance Program
EHR	Electronic Health Record
EMK	Edward M. Kennedy Community Health Center
FBO	Faith-Based Organization
HIPPA	Health Insurance Portability and Accountability Act
HR	Human Resources
MACHW	Massachusetts Association of Community Health Workers
NACHW	National Association of Community Health Workers
OCHW	Massachusetts Department of Public Health's Office of CHWs
QA	Quality Assurance
ROI	Return on Investment
SDOH	Social Determinants of Health
SES	Socioeconomic Status
VT	Vicarious Trauma