**Cal SIM Community Health Workers**
**Workgroup Meeting**
**September 12, 2014**

Attendees: Lupe Alonzo-Diaz, OSHPD; Alma Avila, San Francisco Community College; Barbara Masters, CalSIM; Felicia Borges, OSHPD; Carol West, CHW Initiative of Sonoma County; Crispin Delgado, Blue Shield of California Foundation; Diane Factor, SEIU; Perfecto Muñoz, UC Berkeley; Wendy Soe, DHCS; Tim Berthold, San Francisco Community College; Gloria Robertson, OSHPD; Maria Lemus, Vision y Compromiso; Jennifer Byrne, DHCS; Dana Moore, CDPH; Marci Aguirre, IEHP; Shom Dasgupta, St. Johns Wellness Center; José Ruiz-Salas, Tulare County.
Scribe: Jennifer Bernstein

## 1. Training for core competencies by Alma Avila/Tim Berthold re SFCC training

Tim and Alma from City College of San Francisco spoke about the CHW training program at SFCC and what core competencies they train their students to develop.

It was acknowledged that there are many approaches to training and certifying CHWs. There also exist some differences in how people categorize competencies addressed in their curriculum. At CCSF, they focus on making sure students get a good understanding of public health, the range social determinants, and social justice. There is also a focus on core competencies for working directly with individual clients and families which includes topics such as: cultural humility, how to conduct an initial interview with client, how to provide client centered counseling, case management services, and health education. Students are also trained on how to work at the community level and how to facilitate social or support groups. An uncommon component for a CHW training curriculum that CCSF addresses concerns community organizing and advocacy skills. Importantly, students also receive training in professional skills: time management, resume development, interview skills, professionally and gracefully providing and receiving constructive feedback, working with supervisors, and resolving conflict on the job. The CCSF curriculum is very much alive and evolving through an iterative process.

The issue of personal qualities versus skills was addressed. Personal qualities might be identified as helpful for being a successful CHW, as well as for other "helping" professionals, such as mental health, and teachers. Some of those are innate qualities, but CCSF's training program also tries to help students grow and enhance those qualities through motivational interviewing techniques and promoting people's empowerment.

There is also an attempt at CCSF to be more culturally responsive. The education material needs to be more adaptable to communities they are working in.

The CHW program maintains good relationships with more than thirty employer partners who open up internships for students. Some examples of employers mentioned were: the Department of Public Health, Community Clinics, YMCA, transitional housing, agencies that work with domestic violence, CBOs and the sheriff's department.

It was asked whether certain employers have expressed specific skills, core competencies, or qualities that they are looking for in potential employees. The Department of Public Health tends to prefer people who speak other languages so they can communicate with doctors and clients. It was also stated that certain clinics do not understand what a CHW is and thus ask for skills such as phlebotomy, EKG experience, and other clinical skills that the program does not provide training for.

Another question was asked about how CHWs are trained to enter into clinical setting when there is an expectation of knowledge of medical terminology and similar clinic specific skills. Generally, if the agency wants something specific, they train the CHWs themselves on those issues. At the same time, it was noted that clinics have been slow to buy into the CHW model and are using medical assistants and others that have more of a clinical orientation. SFCC does maintain internships with a few clinics in San Francisco in which students work with patients with chronic conditions, diabetes and depression and help them implement self-management plans.

There was acknowledgement that every area has very specific requirements. A good CHW training and certification program should train students to be able to translate what they learn across different areas. They should build the skills to move from one type of CHW program to another, or into the workforce. For example, the SFCC program trains CHWs to assess what is credible and not credible information for diabetes or other conditions so that CHWs can research the specific diseases or conditions at the library for information. That is a general skill that is translatable to a variety of settings.

Three skill sets were mentioned as being of value to CHWs and those who employ them: The ability to document in records in a way that is useful to clinicians, a knowledge base of the current health system, insurance, and patient navigation within community health centers, and basic case management skills. It was also stated that a lot of these skills are learned on the job for CHWs. There is not much of an expectation that they will arrive with such specific skills.

Maria Lemus from Vision y Compromiso provided an overview of its curriculum. She indicated that the curriculum was developed seven years ago and includes nine core competencies, which include leadership, advocacy, and capacity. The training is focused on strengthening individuals' innate abilities and providing them with a foundation that enables them to move from one work setting to another. One aspect of this is for CHWs to know themselves.

The vast majority of Promotores who are trained do not work in the clinical setting and Maria noted that there can be a big jump from working in the community setting to the clinical, especially if the specific roles are not defined. She suggested that there need to be some type of bridge training to help CHWs/Ps make this transition if they are interested.

For example, the Workgroup discussed that CHWs are often underutilized in the clinical setting in terms of documentation of patients in ways that are useful to the clinical care team. Moreover, training for case management skills needs to occur and some of these may be similar

skills used by patient navigators. Although many CHWs/Ps have been informally doing patient navigator-type activities, this particular job title is new and may require specific technical skills, such as using computers, that traditional CHWs/Ps would need to develop.

Marci Aguirre from IEHP noted that specific subject matter expertise is needed in the health plan and they provided that training themselves on topics such as managed care, health insurance, Medi-Cal, choosing a doctor, etc.

It was suggested that this may be a good time to look into the apprenticeship model, which provides on-the-job training, in additional to education on core competencies. This is really valuable in a period when there is so much innovation in health care delivery models. What this approach would offer is the ability for each employer or setting to train on their specific needs, once a foundation has been built of key core competencies, such as the ability to problem solve and be flexible.

A challenges is created when CHW training happens in isolation of the workplace. CHWs need to understand the context of where they are working and the agency they are working in.

This was touched on in the last meeting: the role of the employer and setting, and the need to identify what employers are willing and committed to do. It is more than hiring somebody. There has to be a real commitment to training on specific issues and skills that working in that setting would require.

Students should be prepared to be able to conduct research, understand causes and symptoms for a variety of common conditions, and apply it to their job. CHWs do not get certified unless faculty members give them passing grades. There must be confidence that the student as a CHW will demonstrate mastery of core competencies, but it is up to an employer to add on unique pieces of information specific to their program.

**2. Review core competencies matrix: Do the three categories of core competencies make sense?**

The matrix below was proposed as a way to identify core competencies needed for the Cal SIM. With regard to the matrix, it was suggested that the CalSIM Initiative specific skills be set aside and thought of as more a responsibility of the employer to help train. The core skills need to be something that can be applied in any setting.

It was noted that the way competencies are broken down in the matrix is different than typically seen. It might be more useful to review other approaches and categories to align what other states are doing and with the national literature.

There was a question about the purpose of attempting to define the core competencies in this context, since what it means to be a CHW does not need to change. For the Workgroup's purposes, it is to develop a common understanding of what the core competencies are, particularly as the apply to Cal-SIM and what prospective providers, plans or other employers

may need to consider. Moreover, at some point, issues related to core competencies may affect policy and reimbursement strategies.

It was pointed out that the CDC has a webinar series that addresses who and what CHWs do, which might include information about core competencies.
http://www.cdc.gov/dhdsp/pubs/chw_elearning.htm

The Workgroup observed that there is a whole new generation of CHWs coming into the field, and with the increased attention on potential CHW roles within the clinical setting, a pipeline that connects this workforce to jobs could be very helpful. Local Work Investment Boards could play that role with some input from employers. Vision y Compromiso is doing a survey of employers to assess what they need, as well as what Promotores need, in order to inform what the pathways are for CHWs/Ps to bridge from the community to the various settings, including clinical settings.

Workgroup members also suggested that materials be developed to explain what CHWs do, particularly as they relate to Cal-SIM. Perhaps a presentation package for communities who have not worked with CHWs before could be put together. The package could provide examples of what CHWs do in clinical settings.

| DRAFT MATRIX: CHW/P Core Competencies | | |
|---|---|---|
| **Core CHW/P Qualities & Skills** | **Cal-SIM Initiative-specific skills** | **Work-setting related skills** |
| ***Personal Qualities***<br>Example:<br>▪ Cultural connection/ relationship to the community<br>▪ Empathy, compassion<br>▪ Interpersonal relationships<br>▪ Motivational<br><br>***Skills***<br>Example:<br>▪ Listening skills<br>▪ Communication skills<br>▪ Teaching<br>▪ Health promotion/ education<br>▪ Intake skills<br>▪ Advocacy skills | 1. Maternity Initiative—Ex:<br>▪ Knowledge of prenatal care<br><br>2. Health Homes for Patients with Complex Needs—Ex:<br>▪ Knowledge of particular disease or condition<br>▪ Relevant care support & coordination skills<br><br>3. Palliative Care—Ex:<br>▪ Knowledge of end-of-life issues<br>▪ Comfortable working with end-of-life issues<br>▪ Knowledge of community's cultural perspectives on end-of-life<br><br>4. Accountable Communities for Health—Ex:<br>▪ Knowledge of community resources | Example:<br>▪ Computer skills<br>▪ Data entry skills for electronic health record |

# CHW SCOPE OF PRACTICE: ROLES AND RELATED TASKS

## ROLE I
### OUTREACH AND COMMUNITY MOBILIZATION
- Preparation and dissemination of materials
- Case-finding and recruitment
- Community strengths/needs assessment
- Home visiting
- Promoting health literacy
- Advocacy

## ROLE II
### COMMUNITY/CULTURAL LIAISON
- Community organizing
- Advocacy
- Translation and interpretation
- Community strengths/needs assessment

## ROLE III
### CASE MANAGEMENT AND CARE COORDINATION
- Family engagement
- Individual strengths/needs assessment
- Addressing basic needs – food, shelter, etc.
- Promoting health literacy
- Coaching on problem solving
- Goal setting and action planning
- Supportive counseling
- Coordination, referrals, and follow-ups
- Feedback to medical providers
- Treatment adherence promotion
- Documentation

## ROLE IV
### HOME-BASED SUPPORT
- Family engagement
- Home visiting
- Environmental assessment
- Promoting health literacy
- Supportive counseling
- Coaching on problem solving
- Action plan implementation
- Treatment adherence promotion
- Documentation

## ROLE V
### HEALTH PROMOTION AND HEALTH COACHING
- Translation and interpretation
- Preparation and dissemination of materials
- Teaching health promotion and prevention
- Coaching on problem solving
- Modeling behavior change
- Promoting health literacy
- Adult learning application
- Harm reduction
- Treatment adherence promotion
- Leading support groups
- Documentation

## ROLE VI
### SYSTEM NAVIGATION
- Translation and interpretation
- Preparation and dissemination of materials
- Promoting health literacy
- Patient navigation
- Addressing basic needs – food, shelter, etc.
- Coaching on problem solving
- Coordination, referrals, and follow-ups
- Documentation

## ROLE VII
### PARTICIPATORY RESEARCH
- Preparation and dissemination of materials
- Advocacy
- Engaging participatory research partners
- Facilitating translational research
- Interviewing
- Computerized data entry and web searches
- Documentation