STATE INNOVATION MODEL
COMMUNITY HEALTH
WORKER INITIATIVE

Best Practices for Clinical Integration: Guide and Resource RECRUITMENT AND HIRING

CT AHEC Network
Southwestern AHEC, Inc.
SIM Program
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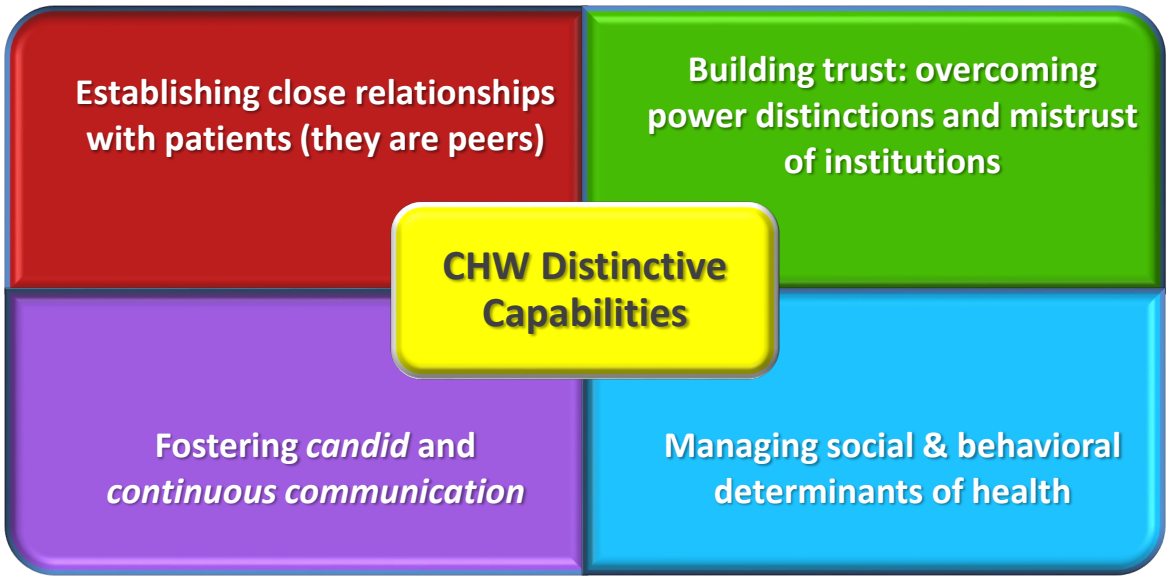
Executive Summary

The "right" CHW

There are numerous benefits to hiring the "right" Community Health Worker (CHW). Their value lies within their shared ethnicity, culture, language, socioeconomic status and life experiences with the community they serve. CHWs are able to bring firsthand knowledge of their culture into the health care setting, allowing them to serve as culturally and linguistically appropriate mediators between health providers and community members. Often times the CHW comes from the community they serve and/or has a deep-rooted connection to the shared life experiences of that community. This transformative care model offers the right combination of supporting both patients and providers in meeting their health care needs and is incorporated into the Connecticut State Innovation Model (SIM) Community and Clinical Integration Program (CCIP) standards.[1] This recruitment and hiring guide was developed to provide best practice recommendations to the CCIP Vendor and Practice Entities (PEs) on how to employ the "right" CHW. The following sections include guiding principles, job descriptions and interviewing tools to assist employers during the recruitment and hiring process.

Distinctive capabilities

One of the most important aspects of the "value added" of utilizing a CHW in a clinical practice is their distinctive capabilities, as described by Carl Rush, MRP[2], which are listed below:



Social determinants of health

Managing the social determinants of health (SDOH) may appear in many forms in an integrated team-based model of care, including:

- providing context to team members on the "whole picture" of a patient's life,
- assisting patient/family in dealing with non-medical issues affecting health status and access, &
- mobilizing the community with macro issues.

In most cases, the CHW is serving as the "SDOH expert" on the team. So why are these distinctive capabilities and qualities of a CHW so important? "If anyone can perform the functions of a CHW, why does it matter that CHWs share identity with patients? Can't a nurse or college student just call or visit high-risk patients and support them in healthy behavior change?"[3]

The Penn Center for Community Health Workers "conducted in-depth qualitative research with hundreds of high-risk patients. These patients confirmed that they felt a sense of disconnect and often mistrust with traditional healthcare personnel who did not share their background. These patients wished for non-judgmental support from someone to whom they could relate. The social psychology and health disparities literature explain that the combination of shared life experiences and innate empathy gives CHWs the potential to be a powerful force in health care."[4]

Actual examples of two CHW models that have successfully integrated CHWs into clinical care teams are mentioned below. Both utilize specific recruitment and hiring strategies.

Bronx-Lebanon Department of Family Medicine

The Bronx-Lebanon Hospital Department of Family Medicine's PCMH (BLDFM) uses a 3-step recruitment process that has led to successful hiring of their CHWs. After advertising the position, qualified applicants were added to the applicant pool and were interviewed. As Step 1, the interview "narrowed the applicant pool to those CHWs who were friendly and communicative and fluent in 1 or more languages spoken by the patients (Spanish, French and South Asian languages), natural helpers, able and willing to serve as role models and courageous advocates for their community."[5] In Step 2, they provided a pre-training to see if the potential candidates could determine if the position would be a "fit" for them. Step 3, the final one, was to invite the remaining candidates that passed the training back for a second interview. This procedure led to providing positions to successful CHWs with very little turnover.[6]

University of Pennsylvania Health System

The University of Pennsylvania Health System believes in recruiting the "right" CHW by going directly into the community. The community was asked what they wanted from their CHWs. The responses varied, but there were several common themes that stood out: "I want a CHW who I can relate to, someone I can share information with that understands where I am coming from and someone that takes time to listen and has patience." Pennsylvania Health System took this feedback from the community and used it to develop their IMPaCT CHW model.[7] In the IMPaCT™ model, community health workers provide tailored support to help high-risk patients achieve individualized health goals. Additional information on the model can be found here: http://chw.upenn.edu/impact.

Acknowledgements

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Recruitment and Hiring

About CHWs:

Understanding who and what CHWs are is critical to developing a thoughtful recruitment and hiring plan. Practices hiring CHWs will need to have a strong sense of the unique characteristics and qualities that distinguish CHWs from other service providers. Traditionally, employers might require a certain academic degree or training when searching for the right candidate and by doing so would possibly eliminate the qualified candidates they were looking for. Hiring the right CHW is truly based more on the CHW's experience and qualities[8] that can be difficult to recognize. Most importantly, CHWs are uniquely qualified for the roles they play on the care team because of their connection to the communities they serve. CHWs are either directly from the community or have a similar experience and background through which they can relate to the community served. CHWs often have a common identity and shared perspective with patients that can facilitate connections based on trust and elicit information beyond that which is shared during traditional patient encounters. This peer status between a CHW and patient is often based upon having a shared identity that is considered critical by the targeted patient population, such as socioeconomic status, culture, gender, race, ethnicity, medical diagnosis, sexual orientation, immigrant status, or preferred language.[9]

CHWs: What to Look for

Traditional providers primarily enhance the healthcare relationship by bringing their superior medical expertise to the patient encounter, while CHWs primarily enhance the healthcare relationship by enhancing patient-centered care via their peer status. Peer status facilitates gathering additional information from patients that can be used to further tailor care and to address social or cultural barriers that impact the patient's health and disease self-management. For example, CHWs may learn details about the patient's home, neighborhood and work environments, beliefs and values about health, illness, and healthcare, familial and social relationships, and challenges (e.g., substance use or abuse, financial struggles). CHWs may learn this information in less overall time, and in more detail, than a traditional healthcare provider because patients are typically more comfortable sharing personal and potentially stigmatizing information about themselves with someone they know and trust. This additional detail can enhance overall communication, allow tailoring of patient education, strengthen the relationship between the patient and the healthcare team, and go far in creating truly patient-centered medical care.[10]

Defining Community Health Workers in Connecticut

Definition

The SIM CHW Advisory Committee recently approved the following (draft) CHW definition for Connecticut, which has been recommended for the 2017 legislative session:

A Community Health Worker (CHW) is a front line public health worker who is a trusted member of, and/or has a unique understanding of the experience, language, culture, and socioeconomic needs of the community served. A CHW serves as a liaison/intermediary between individuals, communities and health and social services to facilitate access to care, improve the quality and cultural responsiveness of service delivery, and address social determinants of health.

CHWs build individual and community capacity by increasing health knowledge and self-sufficiency through a range of culturally appropriate services such as: outreach and engagement; education, coaching, and informal counseling; social support; advocacy; care coordination; basic screenings and assessments; and research and evaluation.

Community Health Workers utilize their unique understanding of the experience, language, culture, and socioeconomic needs of the populations they serve to perform one or more of the roles identified in the recommendations of the CHW Core Consensus (C3) Project.[11]

Roles, Skills and Qualities

In addition to the CHW definition, the SIM CHW Advisory Committee recently reviewed the C3 Project's recommended roles and skills and approved modifications to it for Connecticut's CHWs to be included in a recommendation for the 2017 legislative session. Included in the recommended CHW roles and skills are sub-roles and sub-skills that may

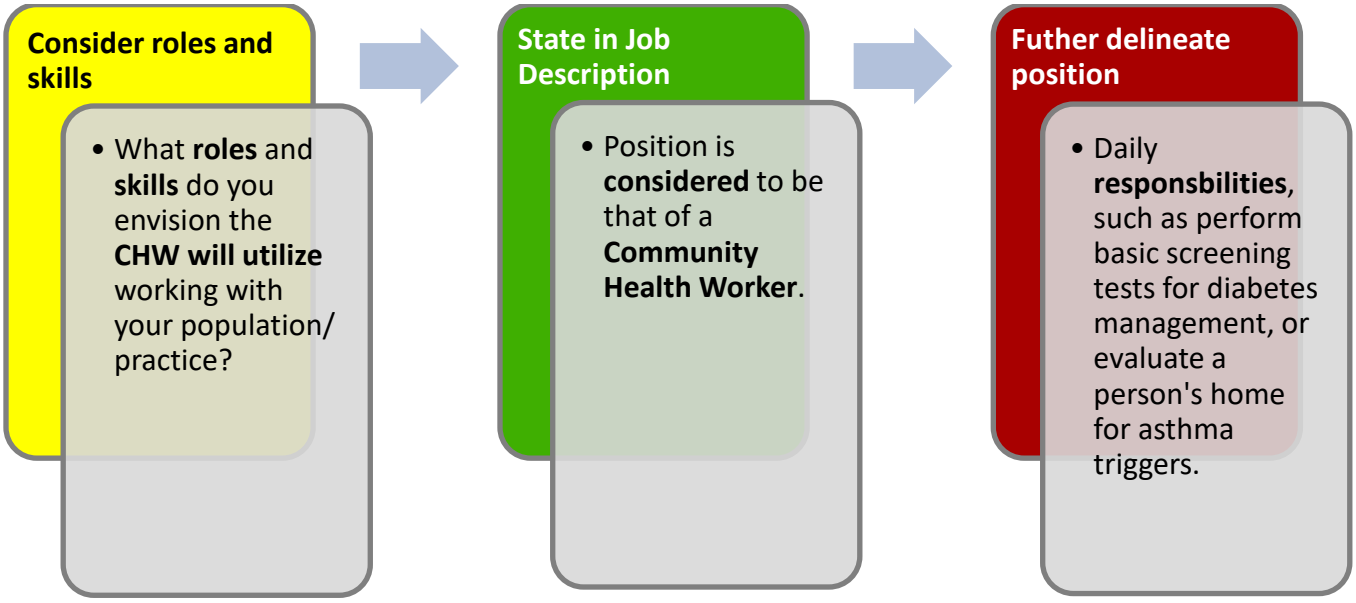
act as a footprint for projecting the daily responsibilities of the CHW within the care team. This tool can also be used to educate staff outside of the care team, as well as community partners, on how CHWs contribute to a whole-person-centered, team-based model of care. The CHW's actual job description need not include all of the recommended roles, but the employer should recognize that the CHW may need to exercise any of the roles and skills in the course of assigned duties.

The final and perhaps most important piece for understanding who and what CHWs is the qualities that make them unique and effective. CHWs have a shared life experience with their service population and express empathy and compassion for them. They are genuine and honest in their approach, open-minded, non-judgmental, and determined to make a positive impact on everyone they come into contact with. The C3 project acknowledges these and several more desired qualities of CHWs that can be enhanced, but not taught, and these should be used as a guideline to define the CHW position within the practice.[12] It is important to keep the qualities in mind when hiring a CHW, as they can make the difference between a CHW and an exceptional CHW. The full list of qualities can be found in Appendix B. See the diagram on the next page for a summary of Roles, Skills and Qualities.


ROLES
Cultural Mediation among Individuals, Communities and Health and Social Services
Culturally Appropriate Health Education and Information
Care Coordination, Case Management, System Navigation
Coachng and Social Support
Advocating for Individuals and Communities
Building Individual and Community Capacity
Providing Direct Service
Implementing Individual and Community Assessments
Conducting Outreach
Participating in Evaluation and Research
SKILLS
Communication Skills
Interpersonal and Relationship-Building Skills
Service Coordination and Navigation Skills
Capacity Building Skills
Advocacy Skills
Education and Facilitation Skills
Individual and Community Assessment Skills
Outreach Skills
Professional Skills and Conduct
Evaluation and Research Skills
Knowledge Base
QUALITIES
Connected to the Community
Mature
Friendly, Pleasant, Sociable
Patient
Open-minded/Non-judgmental
Honest
Dependable
Motivated
Empathetic
Resourceful
Persistent

Job Descriptions

When creating a job description, it is important to consider what specific roles and skills a Community Health Worker will be expected to perform. The occupation of "Community Health Worker" is an umbrella term for a number of different job titles, including community health advocates, outreach educators, peer leaders, *promotores de salud*, doulas, and patient navigators. For many decades, CHWs have made significant contributions to community-based health promotion, disease prevention, and maternal child health support.13 A 2013 Connecticut survey of Community Health Workers and employers found that CHWs are known by many different names, despite substantial overlap in the roles and responsibilities.[14] In order to dispel confusion, it is recommended that the job description (whatever the title) mention that the position is considered to be that of a Community Health Worker and further delineate the position within the description itself.



CHWs provide services through many avenues, including outreach, education, advocacy, and social support, and with such a wide range of roles, it is important to clearly outline the roles and skills for the position you are looking to fill.

When integrating CHWs into team-based care, it is important to begin by establishing the roles and responsibilities of each team member. Remember to be sure that the details of the CHW position (as well as all positions) are decided upon by the team after reviewing the readiness assessment. Then be sure that they are incorporated into the job description. Sample job descriptions are available in Appendices A-D. In

defining the CHW's duties, it is recommended that the employer refer to the scope of duties in the C3 Project's recommended roles and skills and resist any tendency to add duties that are more clinical in nature.

Strategies for Recruitment

Prior to recruiting CHWs, it is important for practices to truly understand the populations that the CCIP standards apply to and that they will be serving: individuals with Complex Care needs, Health Equity needs, or Behavioral Health needs. A recommended strategy for obtaining this information is to host a focus group of patients for input on what they may need assistance with. Getting this type of input from patients will assist in delivering care that is more patient-centered. The University of Chicago and the Robert Wood Johnson Foundation, as part of their *Finding Answers: Disparities Research for Change*, completed a study entitled "Integrating Community Health Workers into Health Care Teams to Improve Equity and Quality of Care," which reinforces the steps recommended for developing a successful strategy to hire the right CHW:

> Making assumptions about what peer-based attributes CHWs in your program should have and how they can be helpful to patients may lead to creating a sub-optimal CHW program and hiring CHWs who are a poor fit with patient needs. Make sure you understand your patient population and their needs by asking them directly how a CHW could be helpful and what potential CHW attributes are most important to them. For example, patient focus groups might reveal that working with a CHW experienced in successfully balancing the needs of work, caring for extended families and their own diabetes management will be more valuable than a CHW from a similar culture or ethnic background living with diabetes, but who is inexperienced in balancing work life and caring for a family.[15]

Once the practice understands the needs of the target populations, r-ecruiting CHWs can be innovative, involving community-based approaches, as well as traditional recruiting methods. Often, the best recruiters are CHWs themselves or similar individuals who work in the community or in clinical settings. Keep in mind that some high-potential candidates may not envision working in a medical practice or may not see themselves as potentially qualified to be a CHW. The CHW occupation is not necessarily widely understood in your community. Take care to use user-friendly, plain language in job announcements and word the invitation to apply in friendly and encouraging terms. Don't rely exclusively on official postings and formal advertisements – your best candidates may not see them.

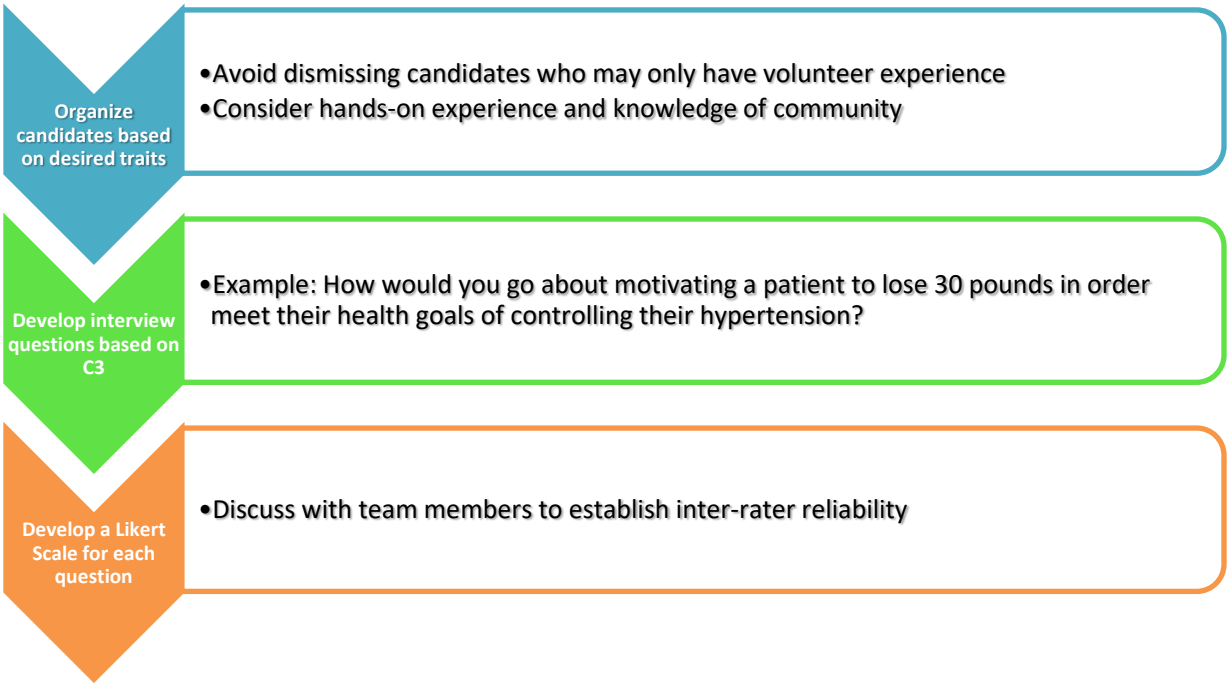
Some recruitment ideas to consider when hiring CHWs include:

- **Post internally**; staff may be interested or may know someone who fits the qualifications and is looking for work—they may even want to take copies of the job posting.
- **Recruit within the community** you serve, including networking and word of mouth.
- **Recruit from patient list** as it most likely reflects the organization's service population.
- **Share the job posting with community partners**, other community organizations, religious organizations in your community, community health centers, etc.
- **Leverage your local public health association** and CHW networks such as the Community Health Workers Association of Connecticut.
- Utilize **CHW training centers** for potential CHW candidates.[16]

Chances are that you will have many candidates applying for the position(s). The next step will be to collect the applications/resumes and begin screening them to be sure that they meet the requirements outlined in the job description.

Identifying and Interviewing Candidates

Hiring a CHW: Before the Interview



Preparing for Interviews

As the practice begins tracking applicants for the CHW position(s), it is a good idea to organize them in a way that suits your needs, such as work experience, CHW core competency training, additional specialty training, geographic location, etc. Avoid dismissing candidates who only have experience, or better yet, only volunteer experience. Here is where a recruiter may find a candidate with the best qualities and hands-on experience to deliver high quality services to your population. Also, be mindful that their résumés may not be as organized and literate as some professionals who have more education and language training, particularly if it is a bilingual candidate.

Many employers report success with conducting team interviews including representative patients and/or community leaders. It should be clear that the employer makes all final decisions, but that patient/community feedback is valued and respected.

Prior to scheduling interviews and phone screens, we recommend developing a complete set of questions to generate a comparison between candidates. It is important to base the questions on the C3 Project roles, skills, and qualities of a CHW. This way the questions asked will lead to what you want and need to know about the person as it relates to the job description. For example: *How would you go about motivating a patient to lose 30 pounds in order meet their health goals of controlling their hypertension?* This question can provide information about how they communicate with patients and whether they utilize motivational interviewing or health coaching.

Utilizing a scoring system such as a Likert Scale for each question will help to identify those candidates who interviewed well and assist in the call-back decision for a second interview. However, interrater reliability is difficult to control, so team discussions following the interviews are highly recommended.

To determine who should be interviewed, we recommend conducting phone screenings to get a first look at their communication skills, to explain the program and position in more detail, and to ensure their interest and yours in moving forward. This will save time in the immediate future and provide additional interactions with candidates to make an informed decision.

Initial interview

It is during the initial interview when you will be able to get a sense of the personal qualities of each candidate by the types of questions asked, and how they are asked. As discussed earlier, the qualities should be used to define the CHW within the practice. A key recommendation is to create questions and related activities that will help reveal the qualities you are seeking.[17] In Appendix G, you will find examples of how to phrase questions related to assessing the many qualities of a CHW, such as patience: *"You and your client have been waiting in the Social Security*

Administration office for over an hour and you notice your client starting to get impatient. How would you approach this situation to ensure the client stays for their appointment?"

The interviewer may gather an abundance of information about the candidate from this one question, not just about their level of patience with clients, which can be used to create a professional profile of the CHW to determine consistency throughout the interview. It can also provide information about how they interact with the Social Security office administration, as well as the client in this situation.

Another important piece to assess during the interviewing process is their connection to the community served. There are many aspects of the community that can be explored to gain a sense of how much they know:

- Physical environment
- Infrastructure
- Demographics
- History
- Culture, both formal and informal
- Resources
- Economics
- Politics[18]

When asking key questions, the interviewer should get a sense that the CHW is the expert in this setting. The practice has a sense of the community that they serve – and this is a perfect time to get a sense of how well the candidate knows the community – its characteristics, assets, and barriers that community members may encounter.

Assessing Data Entry Skills

You may require a CHW to perform data entry into an electronic data management system. A simple **data entry exercise** can provide insight about computer skills.

**Since data entry and analysis is a skill that can be taught, this exercise should only be used as a tool to determine the level of skill the candidate possesses.*

Depending on the job description, most CHWs will be required to enter data into an electronic data management system. Incorporating a simple exercise to measure this skill will provide additional insight and reinforce the decision-making process when the time comes. Often times individuals report that they are computer literate and familiar with the Microsoft Office applications; an exercise, such as a writing sample about an experience that helped motivate them to work as a CHW, or a data entry exercise that requires basic data procedures and analysis, may clear any doubt about their ability to perform those duties.

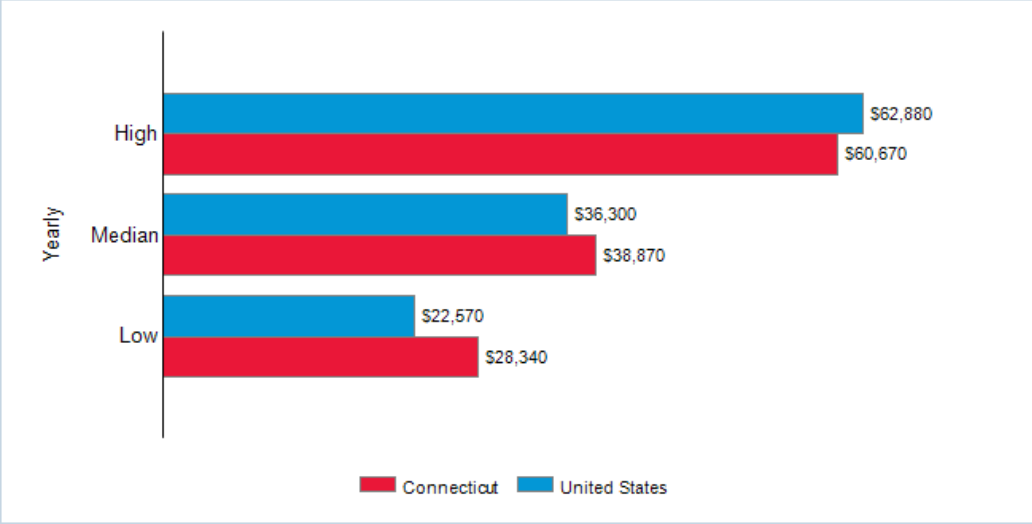
Interviewing Tools

You may find that traditional interviewing tools are not always helpful in hiring CHWs. This guide provides several interviewing tools in the Appendix to be referenced during your development stage of the interviewing process. There are 4 sample job descriptions, 1 phone screen template, 1 interview guide, several additional samples of interviewing questions based on the skills and qualities of a CHW, and a data entry and analysis exercise. Finally, we've included a first interview and follow-up second interview guideline that includes role plays and case scenario discussions for a thorough approach to finding the right CHW for your care team. The second interview tool provides an opportunity for asking more detailed information about experience with specific disease entities or types of clients. Please use all instruments as you see fit and tailor them to your organization's culture.

Salary Information

Current earnings data as depicted below (**Figure 1**) in the Bureau of Labor Statistics 2015 has a median wage for CHWs as $17.45 hourly, $36,300 annual in the U.S.[19] Connecticut offers slightly higher wages compared to the rest of the country. Wages are typically commensurate with experience and CHWs are no exception. Budgets and policies will vary from practice to practice, and therefore consideration for developing a career ladder for CHWs within the organization may help create fair wages and opportunities for the workforce, not to mention staff retention.

Figure 1. Yearly Wages for Community Health Workers in CONNECTICUT 2015



https://www.onetonline.org/link/summary/21-1094.00#WagesEmployment

Career Ladder for CHWs

Career advancement for Community Health Workers is important to consider when expanding an organization's workforce to include CHWs. As the CHW workforce grows and becomes more accepted within Connecticut's State Innovation Model Community and Clinical Integration Program (CCIP) within the Advanced Networks and the Patient Centered Medical Home Plus program, job security and advancement must be incorporated into the organization's plans.

As an employer begins to incorporate CHWs into their practice, it is important to look ahead at how the CHW can move up in the organization as they master their position and look to expand the horizon of their work. As the CHW gets acclimated to their position and becomes a valued member of the team, it is important to recognize their contributions to the organization. This can be accomplished by providing opportunities for CHWs to grow through continuing education, specialization, and expansion of duties, which may include supervisory roles and providing training for other CHWs. The agency/organization may plan for the CHW to grow further within the agency though possible career ladders.

In the Center for Disease Control and Prevention's (CDC) CHW E-Learning Series, they describe three specific needs for improving career development for the CHW workforce:

- CHWs need a career ladder with advancement options.
- They need pathways to related careers and special supports in pursuing them.
- CHW employment should be viewed as a possible entry to the workforce for welfare recipients, and for people who were formerly incarcerated.[20]

It is recommended that CHW employers keep these needs "front and center" as they build their CCIP team.

The CDC describes how employers can create career ladders for CHWs. "As with many entry-level jobs, employers may offer salary increases and upgraded job titles for increasing levels of independent responsibility, including graduated levels of supervisory responsibility."[21] As CHWs gain experience and participate in continuing educational opportunities, they often serve as mentors to new CHW staff, and eventually may serve as trainers. This is often a part of the inherent qualities of the CHW, that is, not only to provide and serve their clients, but also to enhance the capabilities of their peers.

"Experienced CHWs can make excellent trainers, and this responsibility can offer job enrichment as well as opportunities for higher pay. Another option is to create specialist CHW positions, such as breast-feeding counselor within a WIC program, or becoming a trained medical

interpreter. Certification for specialized duties can carry an enhanced job title and supplemental pay. Finally, larger employer organizations may wish to create senior CHW positions as troubleshooters or consultants, who assist other CHWs or teams with problem solving or setting up special projects."[22]

Examples of possible levels for a CHW Career Ladder with suggested roles of increasing responsibility include:

Title	**Roles**
CHW 1:	Health education basic health assessment, visual screening for red flags. A specialty topic could dictate a ladder, such as: women's health, diabetes, asthma, breastfeeding, children's health, behavioral health, dental, HIV, etc.
CHW 2:	Eligibility screening, Health Insurance Enrollment, Prevention Screening, Lifestyle change counseling, e.g., exercise classes, etc.
CHW 3:	Patient Engagement with PCP for Preventive/Routine Care, Medical Interpreting, provides Training and Job Shadowing for new CHWs
CHW Lead:	Supervision of CHWs, Leads Team meetings, participates in Grand Rounds

Certification can be required of all CHW levels of the career ladder or may begin with CHW 2 or 3. The CHW Lead should be certified.

It is important to recognize that a CHW may choose to have community health work as a lifelong career, or they may utilize CHW positions as "steppingstones to other health-related occupations.[23] Also called "Up and Out" (of CHW work), employers may enable CHWs to be exposed to and provide access "to established health career tracks in areas such as patient care, clinical technician, or medical administration." [24]

APPENDICES

Appendix A: Care Management CHW Job Description

Camden Coalition of Healthcare Providers

Title: Care Management Community Health Worker (CHW)

JOB DESCRIPTION

The Community Health Worker will be an integral member of the Care Management multidisciplinary outreach team. Together with nurses, social workers, and AmeriCorps volunteers, the CHW will assist with care plan implementation, help develop care management strategies, and work with team members to provide linkages for the various health and social needs of patients. The team works in the field in a variety of Camden settings, including patient homes, medical day centers, homeless shelters, and the ED/inpatient floors of each city hospital.

DUTIES AND RESPONSIBILITIES

Work under the direction of the RN Care Manager; determine plan for care management; coordinate care plan; and complete tasks as necessary to complete medical care plan goals

– Tasks may include, but are not limited to:

- Language/medical translation
- Scheduling medical appointments and transportation
- Reminder/confirmation phone calls
- Collecting vitals
- Disease management, including symptom tracking and reporting, health education/prevention, and maintenance of patient's supplies and durable medical goods
- Maintain outreach team/medical supplies inventory
- Accompany patients to appointments as needed
- Referrals to any additional services (e.g., DSME, nutritional support)
- Act as peer support for enrolled patients, which includes advocacy as patients navigate the medical system and relationship building with individuals and their families
- Enter and maintain electronic records, compile reports, and complete other program documentation in a timely manner (e.g., progress notes, incident reports, client track, letters, etc.); other administrative responsibilities as needed
- Participate in interdisciplinary case conferences/team meetings
- Coordinate with RN to report on patient progress and confer if intervention needs to be modified or discontinued
- Play a consistent and active role in identifying project inefficiencies and finding collaborative solutions to the problems
- Other duties and responsibilities as directed

QUALIFICATIONS and REQUIREMENTS

- Current High School Diploma or GED required; Bilingual English/Spanish preferred
- Certified Medical Assistant (CMA) preferred; 1-2 years' experience providing clinical services; experience in community/
- outpatient setting preferred
- Ability to effectively provide clinical care to socially and medically complex patients in a variety of nontraditional settings;
- experience in serving in poor, urban environments; familiarity with Camden is preferred
- Exceptional organizational and interpersonal skills, with attention to detail required; strong oral/written communication
- skills are a must
- Ability to work collaboratively in a team and manage multiple priorities, utilize effective time-management skills, and
- exercise sound administrative and clinical judgment
- Demonstrated ability to work well with people of various ages, backgrounds, ethnicities, and life experiences
- Requires the ability to travel to multiple office locations; valid driver's license and automobile that is insured
- No on-call responsibilities; no weekend hours required.

Brooks, B.A., Davis, S., Frank-Lightfoot, L., Kulbok, P.A., Poree, S., & Sgarlata, L. (2014). Building a Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs. Published by Community Health Works. Chicago: Authors. pg.39.

Appendix B: CHW Integration Sample Job Description

Making the Connection: The Role of Community Health Workers in Health Homes

The Community Health Worker (CHW) will be an integral member of an interdisciplinary health home care management team. The CHW will work closely with health home patients, care managers, other care management team members, health care providers, social services providers, and community partners to effectively manage the care of designated health home patients.

Requirements:

- Conduct patient outreach and engagement activities to designated health home patients, including face-to-face, mail, electronic, and telephone contact.
- Conduct outreach and engagement activities that support patient continuity of care, including re-engaging patients in care if they miss appointments and/or do not follow up on treatment.
- Assist patients in completing patient consent forms.
- Conduct initial and periodic needs assessments, including assessing barriers and assets (e.g., transportation, community barriers, social supports); patient and family or caregiver preferences; and language, literacy, and cultural preferences.
- Support the development and execution of patients' care plans, including assisting patients in understanding care plans and instructions and tailoring communications to appropriate health literacy levels.
- Promote patient treatment adherence through assessing patient readiness to make changes; assisting patient in making changes to daily routines; identifying barriers; and assisting patients with developing strategies to address barriers.
- Provide informal counseling, behavioral change support, and assistance with goal setting and action planning.
- Assist patients with navigating health care and social service systems, including arranging for transportation and scheduling and accompanying patients to appointments.
- Assist care managers in monitoring and evaluating patients' needs, including for prevention, wellness, medical, specialist, and behavioral health treatment; care transitions; social and community service needs.
- Identify available community-based resources and actively manage appropriate referrals, access, engagement, follow-up, and coordination of services.
- Coordinate patients' access to individual and family supports and resources, including resources related to housing; prevention of mental illness and substance use disorders; smoking cessation; diabetes; asthma; hypertension; self-help/recovery resources; and other services based on individual needs and preferences.
- Provide support for chronic disease self-management to patients and their families.
- Coordinate access to the basic determinants of health (e.g., food, clothing, shelter, income, utilities).
- Use health information technology to link to services and resources and communicate among team members, providers, and patients and their families/caregivers.
- Collect and report on data for program evaluation.
- Provide information on patients to care managers, other care team members, and providers.
- Manually and/or electronically document activities and patient information and interventions in patient-tracking systems, care management software programs, and other program systems.
- Other duties as assigned.

Appendix C: CHW Sample Job Description - Complex Health Needs/Depression

COMMUNITY HEALTH WORKER / 40 HOURS / DAY

Specific to complex health needs and/or depression

GENERAL SUMMARY/OVERVIEW STATEMENT

This is a full-time, temporary position for someone interested in helping patients with complex medical and social problems improve their access and utilization of health care services.

A Community Health Worker (CHW) is a trusted member of the community who helps patients' better access and coordinates their health care. We believe that CHWs have the skills and experience to understand what patients are going through and help them get through difficult times. CHWs are people who come from the communities they serve. CHWs act as caring neighbors to help patients address the social and medical problems that lead to poor health. The goal of a high risk community health worker is to assist the most high risk patients with the tasks of getting medical care, working on health goals (such as arranging care, filling medication prescriptions, planning healthy meals, or finding time to exercise), and to help them deal with the "real-life" issues that keep them from staying healthy. Although a CHW is not in a clinical role, having the capacity to learn basic clinical concepts in order to identify when a referral to a licensed clinician is appropriate is an important skill.

The CHW will work with high risk Neighborhood Health Plan and other Medicaid patients receiving care at the Hospital affiliated primary care practice. This particular high risk patient population presents a unique set of challenges, including higher rates of mental illness and substance abuse. These patients are also often harder to contact and engage. And with weaker ties to their primary care practice, many of these patients visit their local emergency department instead of their primary care doctor and receive fragmented care. Our project aims to integrate CHWs into the primary care team, serving as a bridge between the primary care team and patients in the community that are at high risk but are disconnected with primary care. By doing so we hope to re-engage patients with their primary care team and improve their patient experience and health outcomes. As a CHW on this project, you will develop trusting working relationships with the patients you work with and be supported by a primary care team that includes primary care physicians, care coordinators, and social workers.

PRINCIPAL DUTIES AND RESPONSIBILITIES

- Provide community health work services for patients identified as high risk due to medical or psychosocial challenges

- Attend initial and continuing education training programs including self-directed reading and in-person and online learning
- Work with patient and provider to set goals for patient's care
- Meet patients in their homes and perform structured assessments that include goal setting
- Meet patients in the emergency department, primary care clinic or hospital to reinforce and advance patient goals
- Make weekly follow-up calls and regular home visits to patients.
- Motivate patients to meet their health goals
- Provide culturally sensitive services to patients from different cultures
- Coordinate with the Resource Specialists to access resources for identified problems including homelessness, substance abuse and food insecurity after assessment by a licensed social worker clinician
- Assist patients with organizing their records, making follow-up appointments, and filling their prescriptions
- Help patients fill out applications for Medical Assistance and SNAP (Supplemental Nutrition Assistance Program)
- Provide advocacy, patient education and support in accessing community-based and hospital-based programs
- Refer to internal or external care management services when other issues are identified (i.e. food insecurity, domestic violence, etc.)
- Develop and maintain strong working relationships with the nurse care coordinator, behavioral resource specialist, primary care physician and health center behavioral health team
- Document each patient encounter in detail
- Prepare reports and documents as needed or requested
- Attend a weekly group meeting with program supervisors
- Other duties as reasonably assigned

QUALIFICATIONS

- Bachelor's degree preferred.

SKILLS/ABILITIES/COMPETENCIES REQUIRED

- Local community resident with good knowledge of the resources of the community.
- Prior experience as a community health worker, health coach or outreach worker desired; health care experience a plus but not required.
- Demonstrated commitment to impacting the care of high risk patients.
- Solid knowledge of the Core Competencies for CHWs (as identified by Massachusetts, Department of Public Health):
    - Outreach Methods and Strategies
    - Client and Community Assessment
    - Effective Communication
    - Culturally Based Communication and Care
    - Health Education for Behavioral Change
    - Support, Advocate and Coordinate Care for Clients
    - Apply Public Health Concepts and Approaches
    - Community Capacity Building
    - Writing and Technical Communication Skills
    - Special Topics in Community Health
- Prior experience using motivational interviewing a plus but not required.
- Excellent oral and written communication skills.
- Ability to carry out written and oral instructions.
- Ability to exercise judgment in the application of professional services.
- Self-motivated.
- Ability to work both independently and as a team member in multicultural settings.
- Ability to speak Spanish is a plus.
- Detail-oriented with the ability to multi-task.
- Ability to plan and structure workday.
- Comfortable with home visits and outreach
- Strong time management, organizational and planning skills
- Must have two references
- Must successfully pass a background check and pre-employment physical exam
- Must be willing to commit to the full time period of employment
- Proficient in all Microsoft Applications, including MS Word and Excel

- Able to perform computer data entry

WORKING CONDITIONS

The work will be based in an outpatient primary care practice at the Hospital. The CHW is expected to perform as a member of the patient's outpatient primary care team, assisting in the advancement of the patient's care plan by outreaching to patients in the community, making visits to patients' homes and accompanying patients to scheduled clinic appointments. Hours will be primarily 9am-5pm Monday-Friday, but occasional evenings/weekends may be required. Please note this position is temporary at this time and limited in duration to 40 weeks due to grant funding and will be subject to review prior to renewal. Please apply only if you are able to work full time through October 2017. Please include a letter of interest stating your reasons for applying and describing what skills you can bring to this role. Only complete applications will be reviewed.

EEO Statement

The Hospital is an Equal Opportunity Employer. All qualified applicants will receive consideration for employment without regard to race, color, religion, creed, sex, sexual orientation, gender identity, national origin, ancestry, age, veteran status, disability unrelated to job requirements, genetic information, military service, or other protected status.

Appendix D: CHW Program Coordinator sample Job Description - Asthma

Position Title: Program Coordinator **Reports to:** Asthma Center Directors

Department Name: Asthma Center: Children's Center for Community Research

Market Anchor: $17.50/hr. x 20 hrs./week

Position Summary:

The Program Coordinator for the Asthma Center's Collaborative for Asthma Equity (CASE) (aka "The Collaborative") is part of a team that is responsible for organizing, coordinating and conducting the community-based activities that are part of an asthma needs assessment and a subsequent multi-faceted asthma intervention.

Key Responsibilities:

1. Coordinates the community-based activities of the Collaborative
2. As a member of CASE
    a. Assists with survey development and design
    b. Identifies and engages key community partners
    c. Develops training manuals and program implementation guides.
    d. Coordinates focus groups, interviews
    e. Assists in developing tools for assessing program effectiveness and conducts study of program effectiveness
    f. Participates in the day to day management of the grant
3. Conducts focus groups, interviews and surveys with community members. Related activities can include:
    a. Training medical students and other students in the conduct of surveys
    b. Transcribing Spanish focus groups
    c. Support for other project aspects including field work activities

4. Acts as a liaison and back up to the Childhood Wellness Alliance.
5. Assists with data organization
    a. Assures completeness of surveys and interviews
    b. May participate in data entry and analysis
6. May order supplies and monitor study funds
7. Interfaces with funding agencies
    a. Organizes site visits and conference calls
    b. Assures data integrity and completeness
    c. Works with site visitors
8. Maintains professional expertise through involvement in professional organizations and continuing education programs. Encourages team members to adhere to professional standards and to expand competencies.
9. May represent program on local or national level including poster and platform presentations of project findings.

Requirements:

1. Able to demonstrate all of the Core Organizational Competencies or has potential to do so.
2. Community Health Worker or related field with 1-2 years' experience
3. Excellent oral and organization skills.
4. Computer skills
5. Travel to homes in urban communities
6. Some weekend and evening work required.
7. Must be Bilingual (English and Spanish).

Attributes:

1. Self-starter who is flexible and has the ability to bring projects to completion.
2. Independent worker
3. Ability to communicate with and bring together diverse groups.

4. Team player who shows creativity.

Physical Requirements:

1. Lifting requirements - 15 lbs.
2. Sitting - 50%
3. Walking - 25%
4. Standing - 15%
5. Bending - 10%
6. Keyboarding - 75%
7. Telephone - 25%
8. Travel - Limited in-state

Date Created : Jan. 31, 2017 Approved by: _____

Appendix E: Pre-Interview Phone Screen

Adapted from PACT Project JRI Health[25]

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

1. Give introduction to program and position.
2. 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.)
3. What skills would you bring to this position?
4. Why do you want to work with this community? (The goal is to get a sense of 'lived experience' of the candidate. Specifically to assess their commitment to, connection to or passion for the community, condition, or environment of the participants engaging in these services)
5. Do you have x language skills?
6. 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.)
7. Other issues?

- Bring back for an interview? ☐ Yes ☐ No

Appendix F: CHW Interview Guide – Sample Template for Employers

Position: COMMUNITY HEALTH WORKER

Candidate's Name_____

Date/Time of First Interview_____ Interviewer_____

I. Interview Questions

1. Tell us a little about yourself, your interests, and what you know about this position.

2. If a friend or coworker were asked about some of your attributes, what would they say about you?

3. Describe a project you've done in the past – preferably in a work situation – that you were especially excited about and proud of.

   - What was your role? Be specific
   - Who else did you work with to accomplish your objective?
   - Did you encounter any obstacles? How did you respond?

4. What aspects of your current or most recent job do you like the least? What are/were the biggest pressures?

5. What type of computer experience do you have? Please describe in detail.

6. How would you describe your community and what has been your experience working with individuals within your community? Specifically what challenges you've faced and what successes you've had.

Behavior-Based Questions (listening for previous work experience examples from the candidate to help explain how they would handle the situations presented):

7. One role of a CHW is to conduct outreach. If you're working with an immunization action plan program and have to locate children in the community who require immunization updates, what community outreach methods would you use to locate them?

- What methods would you use when regular outreach strategies, such as phone calls and letters have failed?

9. It is Friday at 1 PM. You have just learned from your supervisor that you must finish calling 30 clients to find out why they missed their dentist appointment and how can you motivate them to reschedule. You also have to enter the follow-up encounter data in the electronic health record for all of these actions and correct last week's data that was entered incorrectly by a co-worker trying to help out. In addition, you have to get materials ready for a health fair on Monday morning. How would you approach the rest of your day to accomplish these tasks?

10. Why should we hire you?

11. Any questions for us?

II Writing Sample/Computer Skills

Take 10 minutes to type up a description of an experience you've had that helped motivate you to work as a CHW. This can be either a job- related experience or something in your personal life. What was the experience and how did it affect you? Your answer should be about a half page, typed.

III Computation Skills

A portion of the Community Health Worker position involves entering information into spreadsheets to track progress on the projects we are involved in.

a) Please find the excel spreadsheets and add the responses from the "No-Show Tracking Form" into each row and total the numbers at the bottom for each column. Be sure to enter a 0 for any column with no responses.

   Note: For the column titled "People," simply enter the total number of listed children at bottom. No total is needed for "Parent's Name" or "Phone #" columns.

Note: This template was created by Southwestern AHEC, Inc. and is used internally and modified as needed during recruitment and hiring of various professionals.

Appendix G: Additional Sample Questions – CHW Skills & Qualities

CHW Skills (Note: advanced skills questions)

1) **Individual and community assessment skills:**
   a) How would you identify the social determinants of health that are affecting a client's living and/or health conditions?
   b) How would you gather community resources that will be of assistance to your client?

2) **Outreach skills:**
   a) Explain a time when you were able to reach a target population in the community. Describe the population and what steps you took to reach them and be successful.

3) **Interpersonal Relationship/Capacity building:**
   a) How do you engage a client upon first visit?
   b) How do you motivate them to communicate with you on the first visit?
   c) How do you establish a long-term, trusting relationship?
   d) Your client lives on a very busy street where cars often speed. There are a number of children that play in their yards and the mothers are concerned with the children's safety. What can you do to build capacity with the mothers of the neighborhood to initiate change in this community?

4) **Communication skills:**
   a) How would you go about motivating a patient to lose 30 pounds in order meet their health goals of controlling their hypertension?
   b) What is a good approach to successfully navigate a conversation from a doctor to a patient who's bi-lingual and diagnosed with diabetes for the first time?

5) **Service coordination/navigation skills:**
   a) How would you help a client who is missing appointments because they have 8 separate doctors to follow-up with on many different issues?
   b) Once the first appointment is complete for a client who is suffering from HTN, what are some follow-up steps taken to coordinate their care ongoing and to ensure that client experiences improved health outcomes?

6) **Advocacy skills:**
   a) Explain a time when you had to advocate for a client's needs.
   b) How would you teach a client to advocate for themselves?

7) **Education and facilitation skills:**
   a) Describe a time when you had to educate a group of people on a particular topic. What was the subject and how did you get participation?

8) **Professional skills and conduct:**
   a) What may be your concerns working in a client's home that demonstrates signs of hoarding?
   b) How would you conduct yourself if your client accused you of stealing money from their house?

9) **Evaluation and research skills:**
   a) Describe the importance of data collection and documentation in relationship to client progress.

10) **Knowledge base:**
   a) Why is difficult for people to make changes in their health even though they understand the risks?
   b) How would you assess a client's knowledge about their asthma?

CHW Qualities (Note: advanced qualities questions)

1) **Open-mindedness:**
   a) Tell me about a time when a client or co-worker didn't understand your ideas. How did you approach this?
   b) You knock on your client's door during a home visit and your male client is dressed in female clothes for the first time. How do you proceed with the interaction?

2) **Patience:**
   a) You and your client have been waiting in the social security administration office for over an hour and you notice your client starting to get impatient. How would you approach this situation to ensure the client stays for their appointment?

3) **Empathic/Caring/Compassionate:**
   a) Tell me how do you know when you have connected with the person you're trying to help?
   b) What is your response to a client when they say you don't understand what I am going through?
   c) Say you encounter a client who was uncharacteristically upset and/or difficult to calm down during a follow-up home visit. What would be your approach to achieve a positive outcome?

4) **Connection to the Community:**
   a) How would you describe your community and give examples of how you have contributed and supported it over time?

5) **Motivated/Dependable/Responsible:**
   a) You encounter a situation in which a person has refused to take their medicine and they are diabetic.
      i) How did you motivate the person?
      ii) What was the outcome?

6) **Maturity/Honesty:**
   a) How would you handle making a mistake when explaining a confidentiality form to a client after they have signed off?
   b) Tell me about a time when you had to handle a situation that challenged fairness or ethical issues regarding a client or family member.

7) **Persistent/Creative/Resourceful/Adaptable:**
   a) You are accompanying a client to their doctor's appointment. You are five minutes away from the doctor's office and the client gets a call saying that the appointment is cancelled due to an emergency. What are your next steps?

8) **Discretion/Endurance/Respect/Honor/Loyalty and Self-Control:**
   a) It is 3:30pm and you have spent an hour convincing the client to keep their 4.00pm doctor's appointment. You are ready to leave the house and a family member comes in with tickets to a concert that starts in an hour. The client tells you that they are going to the concert. How do you handle this?

Appendix H: Data Entering Exercise – 3pgs

Community Health Worker Position

Candidate's Name _____ Date: _____

Data Exercise Instructions: Please enter the following data into the No-Show Spreadsheet on the Laptop. Please add the responses on the attached "No-Show Tracking Form" and enter the totals for each column on the total line at the bottom. Be sure to enter a 0 for any column with no responses. *Note: For column titled "People," simply enter the total number of listed children for total at the bottom. No total is needed for "Parent's Name" column or "Phone #" column.*

Patients	Appointment	Call Outcome	Reason
D.G	Wed. 9 AM	No answer	?
M.F.	Friday 4 PM	Mother	No car
F.R.	Monday 11 AM	Grandmother	Spoke Russian
M.L	Monday 10:30 AM	Busy	
G.D.	Thursday 3:45	Wrong Number	
T.C.	Friday 9 AM		Not interested
F.W.	Friday 2:45		No insurance
T.C.	Tuesday 10 AM	Not in service	
E.O.	Tuesday 1:45		Sick
Y.R.	Wed. 11:30		No Child Care
P.C	Monday 10:30		Forgot
W.F.	Monday 9:30		Forgot
P.C.	Monday 10:30		Forgot
R.F.	Wednesday 3:30		Rude
Y.D.	Tuesday 2:45		No child care
P.W.	Wed. 1:00		No Insurance
R.S.	Monday 1:45	No Answer	
T.D.	Tuesday 11:30		Can't Afford

Worksheet: No-Show Tracking Form for Children 0-18 Years of Age

People	Day of Original Appt.												Call outcome					Reason for missed appt.							Total
	M am	M pm	T am	T pm	W am	W pm	Th am	Th pm	F am	F pm	S am	S pm	No Ans	Busy	Left Mess	Wrong # or NIS	Call Back	Forgot	Sick	No Trans	Can't Afford	No Child Care	Not Inter-ested	Other*	

* e.g. Already rescheduled (2), no insurance (2) insurance problem (2), front desk were very rude, did not receive a reminder call (2), not aware of appt, parent had to work late. This data may not reflect on an entire week of missed appointments.

Answers to No-Show Tracking Form for Children 0-18 Years of Age

Dates	Day of Original Appt.												Call outcome					Reason for missed appt.							Total
	M am	M pm	T am	T pm	W am	W pm	Th am	Th pm	F am	F pm	S am	S pm	No Ans	Busy	Left Mess	Wrong # or NIS	Call Back	Forgot	Sick	No Trans	Can't Afford	No Child Care	Not Inter-ested	Other*	
D. G.					1								1											1	
M. F.										1					1					1					
F. R.	1														1									1	
M. L.	1													1											
G. D.								1								1									
T. C.									1														1		
F. W.										1														1	
T. C.			1													1									
E. O.				1															1						
Y. R.					1																	1			
P.C.	1																	1							
W. F.	1																	1							
R. F.						1																		1	
Y. D.				1																		1			
P.W.						1																		1	

R. S.		1										1												
T. D.			1																	1				

* e.g. Already rescheduled (2), no insurance (2) insurance problem (2), front desk were very rude, did not receive a reminder call (2), not aware of appt, parent had to work late. This data may not reflect on an entire week of missed appointments.

Appendix I: Data analysis - Question and Answer format (optional)

Instructions: Answer the following questions using the data compiled in the spreadsheet:

1. What percentage of the total were Wednesday A.M. appointments? _____%

2. What is the total # of children for whom we were able to identify a "Reason for missed appointment"? _____

3. What percentage of the total in C (above) was due to "No Transportation?" _____%

4. How many children did not show for the appointment?

5. How many children could not come because the parent had no Child Care?

6. How many forgot?

7. How many could not afford the appointment?

8. How many could not afford and had no insurance?

9. What percentage of children did not get dental care because they could not afford or had no insurance?

10. What is the percentage of families that couldn't be reached because they did not answer the phone?

11. How many families could not be reached because of the wrong number or not in service?

12. What is the percentage of families that could not be reached for any reason?

13. What is the total number of families for which you got a reason for missing the appointment?

Appendix J: CHW Recruitment – First Interview Tool

Adapted from PACT Project JRI Health[26]

Recruiter: Give 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* (or experience in your personal life if it's relevant). What is your experience working with people who are encountering:
- Chronic Diseases: Hypertension or Pre-Diabetes (insert your program specifics)
- Substance use?
- Mental illness?
- Domestic Violence?
  - Or proving case management services?
- Are you familiar with Harm Reduction? 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?
- Can you tell me about a time that you have had to set limits with someone who was asking too much of you?
- Do you have any concerns about working in people's homes? What do you think is important to keep in mind when doing so?
- What types of groups of people have you experience working with or supporting in your life outside or work?
- Are there any groups of people with whom you don't feel comfortable or would feel uncomfortable working with? Why?
- Can you tell me about an achievement in your work of which you are most proud?
- Can you 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?
- Language skills?
- 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)?
- Other issues?

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: _____

Appendix K: CHW Recruitment - Second Interview Tool

Role Plays and Case Discussions

Adapted from PACT Project JRI Health[27]

1) **Hypertension and Kidney Disease**

Jennifer is a 78 year old woman who has poorly managed hypertension and kidney disease for over 30 years. She reports often not taking her medications as prescribed and is at risk for becoming very sick soon. She has been hospitalized repeatedly and is at risk of needing to begin dialysis. She reports she feels "ok" and takes her hypertensive medications when she feels sick.

- ❑ How would you approach her understanding about her health conditions and poor medication adherence?

2) **Provider Relationships and Patient Empowerment/Advocacy**

Mary is a 42 year old African American woman who has a 20+ year history of homelessness and poor medication adherence who has recently stabilized. At medical visits Mary's provider, who is a white man, often keeps his back to her reading the computer and asking her questions and rarely looks at her directly. This behavior angers Mary and she and her CHW have discussed how disrespected she feels by him. She says she wants to continue with him nonetheless because he is so smart and a famous doctor.

- ❑ How do you, the CHW, help her discuss this issue and what do you do in the appointment to help her bring it up?

3) **Depression and Home Visits**

George has been depressed off and on in his life and was hospitalized for suicidal thoughts three years ago. Today when you arrive, he takes a long time to answer the door and when he finally lets you in, you see that he is still in his pajamas, hasn't bathed, the shades are all drawn, and that he won't look at you. You ask how he is feeling and he says "not great." He explains that he hasn't slept well and that he doesn't feel like eating. He reports that he hasn't felt like seeing anyone and he isn't answering the messages people have left on his voice mail.

- ❑ What do you do?

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