



# TRAINING

**IMPACT™**  
Training Manual

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## HOW TO USE THIS GUIDE

- I. Overview: This guide contains detailed outlines for a CHW training course that was developed by the Penn Center for Community Health Workers. The course was designed from qualitative interviews with high-risk patients and has been refined based on input from CHWs. This course has been evaluated by the Community College of Philadelphia and accredited for 3 college credits.
- II. Trainers: The course should be facilitated by the Manager of the IMPACT program at your institution. The Manager is the core trainer and will personally deliver many of the training sessions. However, we believe that it is important that some content be delivered by local experts (clinicians, legal aid experts, motivational interviewing trainers, etc.). This ensures that the training your CHW team receives will be locally relevant and actionable. Therefore, we recommend that the Manager arrange select sessions to be delivered by these guest speakers.

In this guide, we have included comprehensive notes for core sessions that are intended to be delivered by the IMPACT Manager or Director. We have provided only the learning objectives for sessions that are intended to be delivered by local experts, so that these individuals may have some flexibility in tailoring their content.

### II. Format:

A. All notes follow a common outline hierarchy:

#### I. Heading

A. Topic

1. Sub-topic

• Detail

\* Sub-detail

B. Sections that are bracketed are notes for the trainer and not meant to be read out loud, e.g. [Arrange chairs in a circle and ask CHWs introduce themselves]

C. Each session in this guide begins with an overview that provides key information such as: how long the session should take, who should

facilitate this session, an overview of the content and sources. Below is a sample:

Time Required	5 Hours
Recommended Facilitator	IMPACT Manager & Senior CHW
Content Overview	Who is a CHW? Core Roles and Skills Self-Awareness Stress Management Conflict Resolution Wrap Up
Sources	1. Berthold, T., Avila, A. & Miller, J., Eds. (2009). <i>Foundations for community health workers</i> . JosseyBass Public Health, San Francisco, CA.

D. Repetition is deliberate. This training covers difficult concepts, so we have attempted to introduce them repeatedly throughout the manual, in order to reinforce learning.

IV. Textbook: The textbook that we recommend for use alongside this course is: Berthold, T., Avila, A. & Miller, J., Eds. (2009). *Foundations for community health workers*. JosseyBass Public Health, San Francisco, CA. We refer to learning exercises in this textbook throughout the course notes.

V. Technical Assistance: The Penn Center for CHWs is making this training publicly available because we believe in transparency and open-access to information. However, in order to have the best quality CHW training and program, institutions will need formal training and technical assistance. We offer train-the trainer sessions for IMPACT Managers and can also deliver this full CHW training course, on-site, at your institution. Please see our website ([www.chw.upenn.edu](http://www.chw.upenn.edu)) for more details.

# PART ONE: CORE PRINCIPLES OF COMMUNITY HEALTH WORK



## SESSION 1. WELCOME AND INTRODUCTIONS

Time Required:	2.5 Hours
Recommended Facilitator :	IMPACT Director and Manager
Content:	Overview Introductions Our Purpose Goals for the Class Organization

- I. Introductions: Please say your name and share a little bit of your story. What drew you to becoming a Community Health Worker?
  
- II. Our Purpose. Every day, in hospitals and clinics, we care for patients from low-income communities. We try to help them stay healthy and control chronic diseases like diabetes or high blood pressure. However, patients may struggle because of “real-life issues:” “How can I afford the medications my doctor ordered?” “Who will watch my children while I recover from this illness?” or “Will I have access to food, transportation and housing when I leave the hospital?”

The purpose of IMPACT is to improve the health of patients from low-income communities by addressing the issues that matter most to patients themselves.

We believe that the people who can best understand what patients are going through and help them get healthier are Community Health Workers (CHWs). CHWs are people who come from the communities they serve. In IMPACT, CHWs called IMPACT CHWs will act as caring neighbors to give patients the support they need to get healthy.

IMPACT CHWs will start by getting to know patients and understanding what patients themselves think they need to do in order to get healthier. IMPACT CHWs will work with patients to set short-term goals and give them social support, advocacy and navigation to help them to achieve these goals.

### III. Goals for this class

#### A. Part One: Core Principles of Community Health Work

1. Understand what it means to be a community health worker
2. Learn about ourselves and how we can best use our own life experiences to help others
3. Understand the boundaries of being a CHW and learn how to deal with the difficulties that come with the job
  - stress management
  - conflict resolution, crisis management and de-escalation
  - ethical issues
  - privacy
  - safety concerns

#### B. Part Two: IMPaCT

1. Learn how to use the IMPaCT model
2. Practice patient-centered goal-setting
3. Learn how to provide care in a way that is sensitive to patients who have gone through traumatic experiences
4. Practice qualitative and motivational interviewing

#### C. Part Three: The Patient Journey

1. Get a big picture understanding of the health care system, the social services system and how to plug patients into these systems
2. Learn enough health vocabulary so that you feel comfortable being in the hospital and clinic
3. Understand the point of view of a patient
4. Visit a hospital and learn the basics of what it is like to be a patient in a hospital:
  - Become familiar with a discharge summary and prescriptions
  - Meet some doctors, nurses and pharmacists
5. Visit the home of a patient:
  - Learn how to conduct a safe, effective home visit
6. Visit a clinic:
  - Learn how to navigate the phone system and get appointments at health centers and clinics
  - Understand how to coach patients so that they get the most out of their clinic visits

D. Part Four: The Challenges that Patients Face:

1. Medical and health system navigation:

- Recognize a clinical emergency
- Learn how to get in touch with the physician who is taking care of a patient
- Learn the “SBAR” system of communication with a physician
- Understand your limits with clinical help

2. Trauma, mental health and substance use:

- Recognize a mental health emergency
- Understand the layout of the Behavioral Health System and how to make referrals
- Understand the basics of dealing with patients who have problems with drugs and alcohol
- Understand how to make referrals for substance abuse treatment
- Review how trauma impacts the lives of our patients

3. Family, friend and neighborhood:

- Understand how stress from friends and family members affects the lives of patients
- Understand how stress caused by the neighborhood or community affects people’s health
- Understand how a supportive neighborhood or community can improve people’s health, and how to connect patients to positive neighborhood resources

4. Resources for daily life:

- Learn the list of insurance plans that your patients will be using
- Learn how to apply for public benefits like Medicaid or Food Stamps online
- Make a community resource database of resources that you can use for your patients

5. Motivation to be healthy:

- Learn about RTIPS: programs that have been proven to help patients with healthy behaviors
- Review Motivational Interviewing and practice using it to understand and motivate your patients

E. Part Five: Ending and Connecting

1. Learn how to facilitate a support group, which patients can use for support even after your one-on-one relationship ends

2. Learn the best way to end the relationship with a patient when your time together is over

#### IV: Organization

- A. As a community health worker, you will be very busy. No matter how organized you already are, it is a good idea to improve your organizational skills to provide the best possible care to your patients. Being organized is one of the most important things you will do as a community health worker, because it allows you to have integrity and do the things you say you are going to do.
- B. What have you done in the past to stay organized at work?
- C. The organizational tools we use in the IMPACT model are your Next Steps List and the calendar in HomeBase. These are included in your CHW manual. As we go through the course, we will practice using these tools.
- D. Here is how you should structure your day:
  1. First thing in the morning, look at:
    - The HomeBase calendar. Print this out. This will give you a snapshot of any appointments that you and your teammates have scheduled, including patient doctor appointments, home visits, etc.
    - Your Next Steps list. This will give you a snapshot of each of your patients, their goals and what exactly you need to do for them. Twice a week, your Manager will help you to create and update your Next Steps list for each patient in your caseload.
  2. Ask yourself:
    - What items on the next steps list are urgent and need to get done today?
    - Do any of your patients have appointments they will need you to attend or call them to remind them about?
    - Do you need to go on a home visit to any of your patients?
  3. Make a to-do list for your day:
    - Fold your HomeBase calendar in half. On the back, make a list of the things you need to do today (or, use a day planner if you have one). For each item, make a

little check box that you can check it off once it is done.

For example:

- Call Mr. Thomas to remind him of his appointment tomorrow
- Visit Ms. Smith at 10am with my partner CHW
- Make a 3-way call to Mr. Jones' primary care doctor so he can ask for the quit-smoking patch.
- Answer all non-urgent voicemails

- Don't forget to create an item on your list each day for answering voicemails from patients and providers as soon as you are able.
- You will be very busy, and you will need to prioritize and do the most important things first.

4. Do the work on your list. As your day progresses, update your list and your printed out HomeBase Calendar with new tasks or appointments that come up.
5. At the end of each day, transfer any new appointments that you have jotted down on your printed out HomeBase calendar onto the computer. That way, you and your team will have an updated Calendar to print out tomorrow.
6. Check your to-do-list and make sure you have completed everything that you said you would. If you were not able to get to something, make sure you apologize and reschedule. As a CHW, your word is your bond. If you "flake" on patients by not following through on the little things, you are letting them down.

E. What other tips do you have for staying organized?

F. What have been some of the challenges of staying organized at work?

## SESSION 2. COMMUNITY HEALTH WORK: CHW ROLES AND SELF AWARENESS

Time Required	5 Hours
Recommended Facilitator	IMPACT Manager & Senior CHW
Content Overview	Who is a CHW? Core Roles and Skills Self-Awareness Stress Management Conflict Resolution Wrap Up
Sources	<ol style="list-style-type: none"> <li>Berthold, T., Avila, A. &amp; Miller, J., Eds. (2009). Foundations for community health workers. JosseyBass Public Health, San Francisco, CA.</li> <li>CDC’s Division of Diabetes Translation. (2011). Community Health Workers/Promotores de Salud: Critical Connections in Communities. <a href="http://www.cdc.gov/diabetes/projects/pdfs/comm.pdf">http://www.cdc.gov/diabetes/projects/pdfs/comm.pdf</a></li> <li>Witmer A. (1995). Community health workers: integral members of the health care work force. Am J Public Health, 85, 1055-1058.</li> <li>Wiggins N, Borbon A. 1998. Core roles and competencies of community health advisors (Chapter 3). The National Community Health Advisor Study: Weaving the Future. Tucson, Arizona: University of Arizona Press (410-223-2890).</li> <li>American Heart Association. (2014). Stress Management. <a href="http://www.heart.org/HEARTORG/GettingHealthy/StressManagement/Stress-Management_UCM_001082_SubHomePage.jsp">http://www.heart.org/HEARTORG/GettingHealthy/StressManagement/Stress-Management_UCM_001082_SubHomePage.jsp</a></li> <li>Harvard Medical School. (2011). Harvard Mental Health Newsletter. Understanding the Stress response. <a href="http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2011/March/understanding-the-stress-response">http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2011/March/understanding-the-stress-response</a></li> <li>Vanderbilt University. (2011). Critical incident strain. <a href="http://healthandwellness.vanderbilt.edu/news/2011/09/critical-incident-strain/">http://healthandwellness.vanderbilt.edu/news/2011/09/critical-incident-strain/</a></li> <li>University of Wisconsin, 2010. Office of Human Resource Development. <a href="https://www.ohrd.wisc.edu/home/HideATab/LeadershipManagementDevelopment/ConflictResolution/AboutConflict/ConflictStyles/tabid/228/Default.aspx">https://www.ohrd.wisc.edu/home/HideATab/LeadershipManagementDevelopment/ConflictResolution/AboutConflict/ConflictStyles/tabid/228/Default.aspx</a></li> <li>American Heart Association (2014). Emergency Stress Stoppers. <a href="http://www.heart.org/HEARTORG/GettingHealthy/StressManagement/FourWaystoDealWithStress/Four-Ways-to-Deal-with-Stress_UCM_307996_Article.jsp#emergency">http://www.heart.org/HEARTORG/GettingHealthy/StressManagement/FourWaystoDealWithStress/Four-Ways-to-Deal-with-Stress_UCM_307996_Article.jsp#emergency</a></li> </ol>

I. Ask the group: Who is a Community Health Worker?

- A. Read aloud the testimonial of Ramona Benson from p. 4 of Berthold textbook.
- B. Define CHW: People who are “natural helpers” in the communities they serve, who do work to reduce health inequalities. There are a lot of different CHW programs in the country and across the world.
- C. CHWs in these programs work with the community in many different ways. In the CHW textbook we use in this training course, Foundations for Community Health Workers, Berthold and colleagues identify several models for CHW care:
  - 1. Health educator: CHWs that provide health education in the community or screen community members for health risks
  - 2. Outreach worker: CHWs that reach out to the community to encourage people to access medical care or testing, or to enroll them in health promotion programs
  - 3. Community organizer: CHWs that fight for change in health policy or health access, and get community members engaged in the activism
  - 4. Navigator or patient advocate: CHWs help patients navigate complicated health and social service systems to get the services they need. CHWs also help patients get more comfortable with advocating for their own medical care. This is the main job that IMPACT CHWs will have!

II. Core Roles and Skills

- A. No matter what specific job a CHW has, there are certain core functions that he/she performs. What do you think these core functions should be? Everyone please name one core function you think a CHW should do.
- B. Below are the CHW functions defined by the experts<sup>1</sup> that are most relevant to our work at IMPACT:
  - 1. Provide social support to patients
  - 2. Provide direct services and community referrals
  - 3. Help patients use cultural and community strengths to address the barriers they face
  - 4. Advocate for the needs of patients and their communities

5. Educate providers about health needs, cultural concerns and barriers faced by patients in the community
6. Provide culturally relevant health education
7. Build patients' capacity for self-advocacy and behavior change

C. Now I'd like to spend some time explaining how these core CHW roles fit into the job of an IMPACT CHW:

1. Provide social support to patients: This may be the most important role of an IMPACT CHW. Our patients often feel isolated and lonely, with inadequate social support to face the difficulties in their lives. CHWs visit patients in the home and hospital and call them on the phone regularly, using deep listening skills to make patients feel truly heard.
2. Provide direct services and community referrals: IMPACT CHWs provide direct services to patients including assistance filling medications at the pharmacy, assistance scheduling appointments and providing transportation and accompaniment to appointments. IMPACT CHWs are experts on resources available within the community, and refer patients to a diverse range of services, including senior centers, recreation centers, the Department of Public Welfare and community development corporations.

There are two important things that distinguish an IMPACT CHW's way of making referrals:

- IMPACT CHWs think outside the box. They don't just make the same referral to a public agency over and over again. They make creative referrals that fit patient's needs. For example, if Mr. Smith tells an IMPACT CHW that he is depressed and used to enjoy playing a musical instrument, the IMPACT CHW may refer him to a local music school.
  - Whenever possible, IMPACT CHWs don't just hand patients a referral—they make sure that the connection happens. This means using a 3-way call or actually going with a patient to a food pantry.
3. Help patients use cultural and community strengths to address the barriers they face: IMPACT CHWs help patients overcome



barriers by strengthening ties within the community. They also help patients use cultural and community strengths, to address the challenges they face.<sup>4</sup> For example, an IMPACT CHW might help a patient reconnect with their community of faith for moral support by helping a patient call her faith leader from the hospital. An IMPACT CHW might also accompany a patient to a neighborhood advisory council meeting to help him regain a sense of life purpose and social support.

4. Advocate for the needs of patients and their communities: IMPACT CHWs advocate for patients on an individual level, by making sure that they get access to the resources they need within health and social service systems. IMPACT CHWs also advocate for patients collectively, by bringing barriers faced by multiple patients to the attention of supervisors and other advocates, so that these issues can be addressed on a systems level.

For example, a CHW may call the utility company with a patient to advocate for her to get a payment arrangement instead of having her gas shut off. Also, if an IMPACT CHW and Manager realize that a large group of patients are frequently facing problems with a publicly funded service provider, we might call a community legal aid group to help us address the problem.

5. Educate providers about health needs, cultural concerns and barriers faced by patients in the community: IMPACT CHWs meet patients in the clinic or hospital to make them feel comfortable in what might be an unfamiliar or alienating environment. They get to know patients and serve as a bridge between patients and the healthcare team. IMPACT CHWs meet with (or “round with”) the healthcare team regularly in order to educate them about their patients perspectives, concerns and goals.
6. Providing culturally relevant health education: Be careful with this one. CHWs need to know their limits for giving medical advice. For example, if I am a CHW with asthma, I might be tempted to give my patients medical advice about how

to treat asthma from my own personal experience. But my medical needs might be different from my patients' medical needs, so I might be giving them advice that is wrong, or even dangerous!

7. Building patients' capacity for self-advocacy and behavior change: IMPACT CHWs support patients and help them change their health behaviors (like how they eat, exercise, etc.) Two techniques that you will learn are motivational interviewing and patient-centered goal setting.

These roles all have a common goal: to help people. That seems easy, but it is not.

- D. Can you all reflect on a time when you had to ask for help? How did that feel? (Prompt for reactions of fear, anger, resistance etc.) How did these emotions make it hard for you to accept help and listen? Was the person who helped you skillful? Why? What did they do?
- E. We talked about the core roles, which all have the common goal of helping people. In order to fill those roles, CHWs need to certain personality traits and skills. What kind of traits and skills do you think CHWs should have?
- F. The following are core CHW skills that are discussed in the Berthold textbook:
  1. Interpersonal communication:
    - Good listener
    - Warm personality
    - Trustworthy
    - Open-minded and objective
    - Sensitive and empathetic
    - Takes good care of his or her own mental health
    - Self-awareness
  2. Organizational and time management:
    - Always does what they say they will do
    - Reliable
    - Follows-through and doesn't let people down
  3. Empowerment:
    - Be patient
    - Show, don't tell

4. Strong & deep knowledge of the community:
  - Understands both people's struggles and the resources available in the community
  - Knows what's out there
5. Basic knowledge of health issues
6. Knowledge of how to navigate the system
  - Understands the health and social service systems
  - Knows how to connect patient to resources
  - Knows how to make good referrals to resources that will help patients
  - Fosters personal contacts
7. Advocacy Skills
  - Understands how to be pushy and get things done, while still
  - Being polite
  - Knows how to talk to and get along with different types of
  - People (doctors, nurses, welfare workers, community members, patients)

These are traits and skills that you already possess, and that we will work on strengthening during this training and beyond.

Of all of these skills listed, the most important two for being an IMPACT CHW are: Being a good listener and always doing what you say you will do.

- G. Exercise: Listening and Timing. I will need a volunteer for this exercise: I will play the patient and you will play a CHW. [Allow the CHW to introduce himself and ask you a question. Hesitate for 2-3 seconds before you start talking. See if the CHW interrupts you.]
1. Here is something that we all do, but don't often realize. We are not comfortable with silence. So we often start talking while the other person is still thinking and makes it seem like we are rushing them. The first rule of IMPACT is the 7-second rule. Whenever there is a pause in the conversation, count to 7 before you start talking again. That will give the patient enough space to take their time speaking and they will feel like you are really listening.
- H. Exercise: The Senior CHW and I will do a role play of an interview

with the patient.

[The CHW introduces him or herself and conducts an intake interview rapidly, firing close-ended questions and not allowing the patient time to finish a thought. The CHW's body language is very stiff and formal; she holds a clipboard in front of her face.

The role-play then starts over fresh, repeating the prior scenario of an initial meeting with a patient. This time, the CHW uses open and inviting eye contact and body language, slows down the interview, asks open ended questions and pauses to see if the patient has more to say. This time it feels like a conversation and not as if the CHW is rushed or reading off a script. The CHW uses empathetic body language and statements. The patient shares a lot more about him or herself than previously.]

1. What did you notice the first time we did the interview?
2. What changed in the second go-around?
3. What did the CHW do differently?
4. How did the patient respond differently?

### III. Self-awareness

- A. Community health workers have an ethical responsibility to be self-aware, because that is the first step to overcoming biases, becoming objective and open-minded so they can help their patients. As we say in IMPACT: You are your own instrument. Just like surgeons use a scalpel to operate on patients, you use your own personal traits and skills to help patients become healthier. So, it is important that you get to know yourself.
- B. No matter how much you already know about yourself and others, you can always learn more. Let's do an exercise from our textbook together. [Refer to the section entitled, "Self Evaluation" pg. 173 in the Berthold textbook. Arrange chairs in a circle, and ask the group to discuss their personal reactions to each discussion question.]

### IV. Stress Management for CHWs

- A. Stress is a very real part of the job of being a CHW. You are dealing with people when they are sick and going through difficult

times. Let's go through a case study from our text book and have a discussion about stress: [Read aloud case study: Mamphela pg. 338 of the Berthold textbook. Ask the group to answer discussion questions for this case study.]

B. Stressor: Can anyone define this word? What is a stressor?

1. An event or situation that causes a stress response in the body and the mind.
2. The source of stress can be positive or negative.<sup>1</sup>
3. Can anyone give me some examples of stressors?

C. Physical stress response: What happens in your body when you are under stress? How does your body feel? Here are some common physical responses to stress:<sup>1,6</sup>

1. Stress hormones released: cortisol, adrenaline. These make you feel like you are being chased by a tiger.
2. Increased blood pressure
3. Increased heart rate
4. Faster breathing
5. Digestion slows down
6. What is the purpose of the fight or flight response? When would this physical response to stress be useful?

D. Mental and Emotional responses to stress: Think about a time when you were under a lot of stress. How did you feel mentally and emotionally? Common mental and emotional responses include:<sup>1</sup>

1. Frustration
2. Feeling overwhelmed
3. Irritable
4. Hopeless
5. What else?

E. Stressors we face in our everyday lives: What are some sources of stress that people face in their day-to-day lives?

1. Can you give me some examples of stressors we face at work?
  - Deadlines
  - Negative feedback from supervisors
2. Stressors we face at home?
  - Bills
  - Messy house

- Loud neighbors keep you up all night
- 3. Stress from our children or our CHWs?
  - Baby throwing a temper tantrum
  - Getting in an argument with your spouse
- 4. What about experiencing racism, sexism, homophobia, transphobia?
  - Wondering if you didn't get a job because of your race or gender
  - Getting accused of shoplifting when you weren't
- 5. Traumatic experiences. For example: every time the Vietnam veteran heard a loud noise, he felt like it was gunfire or a bomb going off

F. What are some stressors that you might experience at work, as Community Health Workers serving low-income communities? [Read examples from Berthold textbook] What else can you think of?

1. Feeling like you have to be in two places at once in order to serve your patients
2. Lots of patients on your caseload and not enough time to meet all their needs
3. Watching a patient go through an illness or die
4. Facing the same problems with your patients over and over again (e.g. lack of stable housing) and knowing there are just not enough resources out there.
5. Having a patient disappear or let you down
6. Having a patient who is in a domestic violence situation
7. Having a patient who is suicidal

G. Positive stressors at work could be:

1. Taking on new responsibilities at work
2. Learning a new skill (such as how to facilitate support group or how to do peer counseling) and trying it for the first time with your patients

H. Dealing with stress: We are all unique and our response to stress is unique as well. Two people exposed to the same event may be affected in very different ways. This is because:

1. Stress is cumulative<sup>7</sup>—a person with many stressors or sources of trauma might have a harder time coping
2. Our response to stress is shaped by the resources we have to help us cope with stress. These resources make some of us

more resilient to stress than others.

- I. Resources for Managing Stress. Resources for managing stress could be the things you do as an individual to manage stress, to stay healthy and to relax. They could also be resources in your environment, family and community that give you support.
- J. Can anyone think of some examples of resources for managing stress? These could be:<sup>5,1</sup>
1. Talk to your friends or family every day for at least a few minutes
  2. Eat healthy, including lots of vegetables and fruits
  3. Get exercise every day, even if it is just a little bit
  4. Volunteer or join a faith group
  5. Meditate or pray every day
  6. The American Heart Association suggests that you do at least one thing you enjoy every day, even if it's just for 15 minutes
    - Do a craft or art project
    - Listen to music
    - Hang out with your friends
    - Go for a nature walk
    - Play a sport
    - What is an example of a fun activity you could do for 15 minutes every day?

The great thing is that we can always build more resources for dealing with stress. These are the same resources that we encourage our patients to identify and build upon. If you can learn to recognize and improve your own resources for managing stress, not only will you be happier and better able to do your job, you will also be able to teach your patients to manage their own stress.

- K. What do you do when you are at work and feeling really stressed out? Here are some suggestions for what you can do in a stress emergency:<sup>9</sup> [Screen short video OR read list of emergency stress stoppers, available online from the American Heart Association]
- L. Do any of these seem like things you would like to try? What do you do for self-care or to manage your stress? What else could you do for self-care? What do you wish that you did to take care of yourself?
- M. Mindfulness is a technique for relaxing by focusing completely on

the present moment. It is helpful for stress reduction, trauma and healing. We will do a few mindfulness exercises from the UCLA Mindful Awareness Research Center throughout the training so that you can get comfortable with them. These mindfulness recordings are available for free online, so you can use them any time you want.

[Dim the lights, asks everyone to get comfortable. Explain that we are going to listen to a five minute guided meditation from the UCLA Mindful Awareness Research Center. Play Track 1, Breathing Meditation 2009. (Free audio download at the link below): <https://itunes.apple.com/itunes-u/mindful-meditations/id434136047?mt=10>. Provide web address above so that CHWs can download free mindfulness meditations for further use.]

- N. Motivation for self-care: Do you ever have trouble feeling motivated to take part in self-care activities like the ones we just listed? What makes it hard for you to do these things?
1. CHWs are great at taking care of other people but often bad at taking care of themselves
  2. We can't help others if we are not practicing self-care!
- O. Let's each try making a commitment to do something to take care of ourselves this month during training. For homework, develop your own self-care action plan (p. 357 of the textbook)

## V. Conflict Resolution

- A. Introduction: Being a CHW often means having to deal with conflict. CHWs often work with people who have experienced illness, racism, poverty, exposure to violence, and lack of access to safe housing or healthy food. When communities are under stress, more conflict is likely to occur.
- B. Conflict: "disagreement through which the parties involved perceive a threat to their needs, interests or concerns"<sup>8</sup>
- C. We all have our own way of handling conflict. Experts on conflict resolution recognize at least five different ways of engaging in conflict: competing, accommodating, avoiding, compromising and collaborating.<sup>8</sup> I want you to listen to this description of the five styles of conflict and think about which of these is most like yours. Why



would I ask you to do this? It can be helpful to be aware of your own conflict style in order to better resolve conflicts you have with others.

1. Competing: in this style of conflict, you are pitting your needs against the needs of others. You are aggressive and seek to control the discussion and set the rules. A person with a competing style of conflict might be afraid that if they cannot control the conversation, their needs will not be met.
2. Accommodating: this style of conflict is the opposite of competing. If you have an accommodating style of conflict, you prioritize the needs of others over your own needs. You are more concerned with maintaining a good relationship than with getting your needs met. When your needs don't get met, you might eventually feel resentful.
3. Avoiding: if you are conflict avoidant, you are afraid of conflict. You don't bring up your concerns or needs, because you want to avoid a conflict at all costs. Being conflict avoidant can also make you feel resentful, and your pent-up frustration can eventually explode, which might even ruin the relationship.
4. Compromising: This approach to dealing with conflict is where you negotiate a trade-off with the other party. You get some of your needs met, but perhaps not all of them. You might be left a little unsatisfied, and might not totally trust the other party to give you what you need. This lack of trust can hinder full collaboration.
5. Collaborating: In this approach to conflict, all parties work as a team, trusting each other to come to a solution that meets the needs of everyone. We come to few meeting everyone's needs as a common goal, and work to find a creative way to get there.

Which of these approaches to conflict do you use most often? Which ones would you like to use more, and why?

- D. Role Playing Exercise: I want you to form pairs and work on some role plays together. You and your partner should recreate the scene of a conflict that went badly.
- E. As you guys just demonstrated in that role play, conflict is stressful and makes people react emotionally. But here is an important fact: resolving conflict is a skill that you can learn. In other words, it isn't

that some people are “just good at dealing” with conflict and others are not. It is a skill that you can practice, just like riding a bike. Here are some communication strategies that will help you deal with conflict:

1. Listen. People get agitated when they feel like they are not being heard. Use the 7-second rule, stay calm and just let people talk until they come to a natural pause.
2. LISTEN.
3. Listen :)
4. Say that you are committed to resolving the conflict and will do your best.
5. Find something positive to say about the other party. You can try mentioning another time when you both worked well together.
6. Talk about the values that you share: “I know that you and I both want to help this patient get better.”
7. Rather than acting like you already know everything, be curious about the other’s point of view: Instead of “I know what happened!” say, “What happened? What was that like for you?”
8. Assume that the other person has good intentions. Just because Ms. Jones is offended, that does not mean that Dr. Smith meant to offend her.
9. Take responsibility for anything that you regret doing or saying
10. After you have talked things out, leave the past behind. Focus on what you can do in the present to improve the situation for the future.
11. If things get heated:
  - Draw some boundaries: “I am really glad that we can talk about this, but I want to remind you that we expect our patients to treat us with respect.”
  - Be aware of your own anger. Stay “inbounds” with your behavior. Know when to disengage: If you feel yourself getting angry and unable to communicate professionally, it is time to disengage.
  - Safety is the most important thing.

F. Role Playing Exercise: I want you to get back into your pairs and replay that previous conflict scene, but this time apply the techniques you just learned.

## VI. Wrap-up

G. Please don't forget to do your homework and develop your own self-care action plan (p. 357 of the textbook)

H. In our next session, we will talk about ethical guidelines for CHWs. You will have many questions about your boundaries as a CHW and what is ethical in your role. Questions like the ones found on p. 160 of our text book [read aloud].

## SESSION 3. PATIENT PRIVACY, BOUNDARIES AND SAFETY

Time Required	2.5 Hours
Recommended Facilitator	IMPACT Manager & Senior CHW
Content Overview	Homework review Ethics, Boundaries and Confidentiality Safety Homework
Sources	1. Berthold, T., Avila, A. & Miller, J., Eds. (2009). Foundations for community health workers. JosseyBass Public Health, San Francisco, CA.

- I. Homework Review: Let's do a quick go around and talk about the self-care action plans you created for homework. [Make note of anyone who did not complete homework and talk to them about this after class].
  
- II. Ethics, Boundaries and Confidentiality
  - A. Great. Now I want to switch gears and talk about the ethical code of CHWs. [Read aloud from pg.160 and also read the CHW Code of Ethics]
  
  - B. Let's recap those ethical questions that we read about at the end of last session.
    1. Let's go through and discuss each of these questions one by one. I want to hear what you all think is the right thing to do.
    2. For many of these, there is no exact right or wrong answer. However, our organization has developed the following answers based on our policies. [Please have on-hand your agency's Mandated Reporting Policy or the Mandated Reporting Guidelines for your state.]
      - Q: Is it every okay to break my patient's confidentiality?
  
  - A: There are two scenarios where CHWs should break confidentiality. CHWs should explain these scenarios to patients up front so that they are not surprised later on.

1. CHWs always report everything to their manager. They should never keep secrets from their Manager, even if the patient requests this. This allows them to be supported and prevents CHWs from getting into an unsafe or ill-advised position.
2. Discuss Mandated Reporting Policy: In most states, CHWs MUST break confidentiality and report the following to an authority: immediate threat of harm to self or others, witnessed child abuse or neglect.
  - Q: My patient asked me to advocate for her with the local housing authority—is that something I can do?
  - A: Short answer is yes. Talk about defining the scope of responsibility of community health workers.
  - Q: What do I do if I am in a patient’s home and I see a child being abused?
  - A: Again, talk about Mandated Reporting Policy and provide specific instructions about the chain of reporting: e.g. CHW–Manager–Director/Social Services.
  - Q: A homeless patient with two children needs money to pay for a child’s medication. Can you give her money for the medication?
  - A: Short answer: No. Talk about professional boundaries.
  - Q: A patient with HIV informs you that she hasn’t disclosed her HIV status to her CHWs and she is continuing to have unprotected sex. One of these CHWs is also another patient of yours. What should you do?
  - A: Short answer: you can encourage your patient to disclose but you cannot tell her partner. You should discuss this with your Manager.
  - Q: A former patient asks you out on a date: You are single, available and interested. What should you do?
  - A: Say NO.
  - Q: A patient offers to loan you \$3 so you can take the bus home. You forgot your wallet and could definitely use the loan. What should you do?
  - A: Definitely do no ever take money from patients. You should always have a cell phone and can call your Manager if you are stranded.

- Q: A patient with three young children reports that her boyfriend has been beating her. She doesn't want anyone else to know. What should you do?
- A: This is not a mandated reporting scenario unless there is threat of harm to her children. Regardless, tell your manager and conduct a 3-way call to the national domestic violence hotline (1800-799-SAFE).

### III. Safety

A. Next, we are going to talk about safety. I'm going to present you with a sample case to illustrate some safety principles:

You are a Community Health Worker in an outpatient OB/GYN clinic. Your patient Leslie is a 21 year old mother who was recently discharged from the hospital after giving birth to her newborn daughter. Leslie has a developmental delay and needs support as she learns how to take care of her new baby. You have been working with Leslie as her CHW since the 3rd trimester of pregnancy.

Leslie is married and has told you that her husband Mike has "mental health issues." Based on your conversations with Leslie and your observation of her husband on a previous home visit, you suspect Mike is not getting mental health treatment, and is possibly using drugs. Mike also participates in the care of infant. Leslie and Mike recently took the baby to a pediatric clinic where concerns about Mike's behavior were expressed.

You and your coworker, a Senior Community Health Worker, recently made a home visit to provide support to Leslie and her husband (if interested) in the care of and bonding with infant. The visit took place in the patient's living room and the infant was sleeping upstairs. You and Leslie were talking when Mike came down stairs spoke but appeared somewhat agitated. After listening briefly to what was being said, Mike indicated he felt infant should be woken up during the night to change and feed. Leslie replied that the infant may not need to be awakened. Mike told her to "be quiet" and became more agitated, his voice became louder and he continued to move closer to you until he was almost standing over you. You explained to Mike and Leslie that they seemed to be doing a good job with their infant but if they had further questions you could help them get in touch with the pediatrician's office. Mike's cell phone rang—it was upstairs

and he went to answer it.

1. What would you do?
2. Who would you contact?

Allow the group to discuss their answers to the above questions. Then clarify that the CHW should leave any situation immediately if they feel unsafe. Once in a safe place, the CHW should call his supervisor and make a plan. This may include calling the national domestic violence hotline (1800-799-SAFE). Actually call this number on speaker phone during this training session so that CHWs feel comfortable with using this resource: the counselors are excellent and will usually answer your questions. In this scenario, if the CHW feels that there is risk of harm to the child, he must follow Mandated Reporting Guidelines for your state and agency.

- B. Now that we have gotten through that case, let's review the Safety guidelines in your IMPACT CHW manuals. Please open your manuals to the Safety section and I'll ask for volunteers to take turns reading it aloud. [Read Safety Section]

IV. Homework: For the next session, please read the introduction sections in your IMPACT CHW manuals.

## PART TWO: IMPaCT



## SESSION 4. INTRODUCTION TO IMPACT AND FRAMEWORKS FOR CARE

Time Required	5 Hours
Recommended Facilitator	IMPACT Director & Local Trauma-informed Care Expert
Content Overview	Homework Review Introduction to IMPACT Trauma Informed Care
Sources	<ol style="list-style-type: none"><li>1. Center for Disease Control and Prevention. (2013). The Adverse Childhood Experiences Study. <a href="http://www.cdc.gov/ace/index.htm">http://www.cdc.gov/ace/index.htm</a></li><li>2. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. <i>Am J Prev Med</i> 1998;14:245-258.</li><li>3. Jones, J. M. (2007). Exposure to chronic community violence: Resilience in African American children. <i>Journal of Black Psychology</i>, 33(2), 125-149.</li><li>4. Lipschitz, D. S., Rasmussen, A. M., Walter, A., Cromwell, P. &amp; Southwick, S. M. (2000). Clinical and functional correlates of post-traumatic stress disorder in urban adolescent girls at a primary care clinic. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 39(9).</li><li>5. Yehuda, R., Halligan, S. L. &amp; Grossman, R. (2001). Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion. <i>Development and Psychopathology</i>, 13 (2001), 733-753.</li><li>6. SAMHSA- National Center for Trauma-Informed Care. (2014). <a href="http://www.samhsa.gov/nctic/">http://www.samhsa.gov/nctic/</a></li></ol>

- I. Homework Review: Did everyone read the introduction section of their IMPACT CHW manuals? [Make note of anyone who did not complete homework and talk to them about this after class.]

II. Introduction to IMPaCT: Our IMPaCT Director is going to give you an overview of the IMPaCT system. Please open your CHW manuals and follow along. [Read through the 'Overview' section of the IMPaCT CHW manuals. Watch Dr. Kangovi 's video explanation of the IMPaCT model on the Penn Center for Community Health Workers website.]

III. Trauma informed care

A. Can anyone describe patients that they know that fit the Profile A patient and the Profile B patient? We are going to spend the next chunk of time talking about trauma-informed care, which is especially important for Profile A patients.

B. What are traumatic experiences? Can anyone define them?

C. "Trauma-informed care" is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives."<sup>6</sup> A lot of what we know about the effect of trauma on people's lives comes from a large scientific study called the Adverse Childhood Experiences (ACE) Study.<sup>1</sup> The first ACE Study was conducted by Kaiser Permanente on 17,000 people enrolled in their health plan, expanded by CDC and replicated in numerous places around the world.

The ACE study asked people about potentially traumatic experiences in childhood, such as living with someone who uses street drugs, being in foster care, being physically or sexually abused, or having a household member in prison. They also asked about health problems the person was experiencing. The questionnaire given in this study can be seen online here: <http://www.cdc.gov/ace/questionnaires.htm> [Pull up or distribute a copy of the survey]

Here is what the ACE Study found:

1. Roughly two-thirds of participants reported an ACE score of one, meaning that they had experience at least one potentially traumatic childhood event
2. One in five participants reported ACE score of three or more
3. As the ACE score increases, the risk for the following health problems increases in a strong and graded fashion:
  - Alcoholism and alcohol abuse

- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Illicit drug use
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Multiple sexual partners
- Sexually transmitted diseases (STDs)
- Smoking
- Suicide attempts
- Unintended pregnancies
- Early initiation of smoking
- Early initiation of sexual activity
- Adolescent pregnancy

Why do you think people who have lived through traumatic childhood events are more likely to have these health problems? Why would experiencing more than one traumatic event make you even more likely to have health problems?

- D. "PTSD: Post-Traumatic Stress Disorder": A mental health condition caused after one experiences a traumatic event that can last for months or years. What are some of the symptoms of PTSD?
1. Quick to anger/ highly irritable
  2. Difficulty sleeping
  3. Flashbacks or nightmares
  4. Hypervigilance
  5. Emotional numbness/detachment
  6. Intense feelings of guilt or worry
  7. Inability to imagine the future
- E. How could these symptoms affect a person's ability to manage their health? How do you think people in the healthcare field (e.g. Doctors, nurses, CHWs) view people who have these symptoms? [Prompt for "difficult patient", "non-compliant" and "train-wreck."]
- F. Studies show that daily life stressors, such as financial stress, neighborhood stress, racism, and sexism can make people less resilient to trauma and more likely to get PTSD. This is how low-income communities can often become areas of high PTSD. How

does that make you feel? Do you recognize this in your community?

- G. "Complex Trauma:" When a person is exposed to more than one traumatic event, or lives under ongoing conditions that are dangerous.<sup>3</sup> Experiencing multiple traumatic events can make you less resilient and more likely to get PTSD. Who might be more likely to have complex trauma and never really get to feel safe? [Prompt for examples, e.g. sex-worker, a refugee, a person in a neighborhood with lots of gun violence, an undocumented immigrant.]
- H. "Intergenerational Trauma": Some studies have found that children whose parents have PTSD are more likely to get PTSD themselves.<sup>5</sup> Why might this be? Trauma is contagious. It ripples through a families and communities, affecting everyone. This is why we believe that trauma is a community health issue.
- I. The good news is that people like CHWs can help to break the cycle of trauma by practicing trauma-informed care. Here are some practical trauma-informed care tips:
1. Help the patient like they're in control from the beginning of the encounter
    - Ask permission to enter the room/ speak with the patient
    - At the beginning of your meeting, summarize major goals for your encounter, mention how long you expect it will take
  2. Use deep listening skills
    - Make eye contact
    - Use open and receptive body language
    - Use reflections to indicate that you are listening and make sure you really understand what the patient is saying
  3. Ask permission for all physical contact.
  4. Don't be afraid to ask patients about trauma history, particularly if you see possible signs of PTSD or a lot of psych diagnoses in the medical record.
    - Ask in a way that normalizes their experience: "many of my patients have had a traumatic experience in when they were young."
    - Ask permission to ask about trauma history: "A lot of my patients who are struggling with the types of issues

you have, had traumatic experiences when they were younger. If it is OK with me asking, how is that for you?"

5. Normalize and validate the patient's feelings
  - Trauma can be isolating and the symptoms of PTSD can make patients feel like they are crazy. Say things like:
    - \* "I'm so sorry that happened to you. You didn't deserve that."
    - \* "You are obviously a very strong and resourceful person to get through that."
    - \* "After what you have been through, it is so impressive that you are coming in here to take care of your health."
6. Be aware of what trauma symptoms might look like as you work with patients. Realize that patients often have good reasons for doing the things they do, though those reasons are not always immediately apparent. For example:
  - Angry outbursts and irritability (Ask yourself if these might be PTSD symptoms)
  - A patient could refuse to take her meds (Survivors of sexual abuse are sometimes unable to swallow large pills)
  - Drugs and alcohol abuse are often used to numb PTSD symptoms
7. Help the patient feel in control of their choices and the plan they are working on with you
  - Always ask permission to share information with the patient.
  - Then lay out all the available options and allow your patient to choose.
  - Make it clear that the decision is ultimately up to the patient.
8. Establish good boundaries throughout all encounters with the patient. Patients who have experienced trauma can have a hard time establishing boundaries. You can help by being a model for good boundaries in your professional relationship.
  - If their behavior is inappropriate, let them know.

## SESSION 5. IMPACT OUTPATIENT CARE

Time Required	5 Hours
Recommended Facilitator	IMPACT Manager Senior CHW
Content Overview	Introduction to IMPACT Outpatient Care IMPACT Outpatient Care Step-by-Step Homework

### I. Introduction to IMPACT Outpatient Care

A. All of you will be trained using both the IMPACT Outpatient Care and IMPACT Transitions CHW manuals. Today we are going to go through the nitty-gritty steps of your work with patients as an IMPACT Outpatient Care CHW. Please turn to the step-by-step overview section of your IMPACT Outpatient Care Manual. Here you will find an overview of what you do as a Outpatient CHW throughout your day. On the next page, you will see a more detailed overview of each of these steps. We are going to read through the step by step guide and practice the interviews you will do with patients along the way.

### II. IMPACT Outpatient Care Step-by-Step

A. Ask for a volunteer to read the overview section of the IMPACT Outpatient Manual. Next, have the group read and discuss the detailed steps as a group. After reading the step 6: Conduct the Meet the Patient Interview, the two facilitators (Manager and Senior CHW) should complete a pre-prepared role-play of the Meet the Patient interview. One facilitator should play the part of a CHW, and the other a patient. Ask the trainees to take notes on a blank copy of the Meeting the Patient Interview.

1. Once the Meet the Patient Interview is completed, the facilitator should ask the group to spend a moment reviewing

the Roadmaps created by the patient with the help of their CHW:

- Are the Roadmaps good ones that help the patient reach their long term health goal?
  - Are the Roadmaps concrete and measurable? How would you change the Roadmaps to make them more concrete and measurable?
  - Does the Plan section of the Roadmap include: Who What Where and When? How would you change the Plan to include this?
2. Ask the trainees to pair off into teams of two, to role-play a CHW and a patient. The CHW should interview their patient and help them create Roadmaps, and take notes on a blank Meet the Patient Interview.

B. Now that we have completed the Meet the Patient Interview, let's go back to the Step-by-Step guide in your manual to see what to do next. Can I have volunteers read steps 7, 8, 9?

1. After reading Step 9: Following Up with Your Patient," the two facilitators (Manager and Senior CHW) should complete a pre-prepared role-play of the Follow-up Interview using the prior CHW and patient characters. Ask trainees to take notes on a blank follow-up script.
2. Allow time to answer any questions.
3. Ask the trainees to pair off into the same teams of two as earlier, to role-play the Follow-up Interview and take notes.

C. Now that we have completed the Follow-up Interview, let's go back to the Step-by-Step guide in your manual to see what you do next. Can I have volunteers to read out step 10? [Note that this step covers clinical issues and psychiatric emergencies—answer any questions but assure trainees that these topics will be covered again in the training in much greater detail.]

1. After reading Step 11: Pre-Doctor Coaching, the two facilitators (Manager and Senior CHW) should complete a pre-prepared role-play of the Pre-Doctor Coaching Interview using the prior CHW and patient characters. Ask trainees to take notes on a blank Pre-Doctor Coaching script.
2. Allow time to answer any questions.
3. Ask the trainees to pair off into the same teams of two as earlier, to role-play the Pre-Doctor Coaching Interview and

take notes.

D. Can I have a volunteer to read Step 12: Attend the Doctor's Appointment?

1. After reading, the two facilitators (Manager and Senior CHW) should ask for a volunteer to play the role of the doctor and role-play the Doctor's Appointment Interview using the prior CHW and patient characters.
2. Ask trainees to take notes on a blank doctor's appointment interview script.
3. Allow time to answer any questions.

III. Homework: For the next session, please conduct the Meet the Patient Interview with one of the other CHWs in the training program and enter your notes into HomeBase. [Spend 1-2 hours teaching CHWs how to use HomeBase. This will occur throughout the training.]



## SESSION 6. IMPACT TRANSITIONS

Time Required	5 Hours
Recommended Facilitator	IMPACT Manager & Senior CHW
Content Overview	Homework Review Introduction to IMPACT Outpatient Care IMPACT Transitions Step-by-Step Homework
Source	1. Project Boost Patient Pass. (2014). <a href="http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=27659">http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&amp;TEMPLATE=/CM/HTMLDisplay.cfm&amp;CONTENTID=27659</a>

- I. Homework Review: I've reviewed each of the interviews you entered into HomeBase and provided you with some feedback. Don't worry if it was difficult to use the computer, we will practice this throughout the month.
  
- II. Introduction to IMPACT Outpatient Care: We have adapted the IMPACT Model so that CHWs can work with patients in two main settings, the outpatient care clinic and the hospital. We previously learned about how IMPACT Outpatient Care CHWs meet their patients in the clinic and work with them to manage a chronic condition, such as diabetes, high blood pressure or COPD. Today we are going to talk about IMPACT Transitions. This is the system that the IMPACT CHWs based in the hospital use to guide their work with patients. IMPACT Transitions is very similar to IMPACT Outpatient Care. You will still be using similar interview guides to do patient-centered goal setting with your patients. However, in IMPACT Transitions, you will be meeting your patient in the hospital instead of the clinic. Instead of coming up with a goal to manage a chronic condition, like losing weight or lowering blood pressure, IMPACT Transitions will help uninsured/Medicaid patients to stay healthy after they are discharged from the hospital.

Transitions IMPACT CHWs will begin by getting to know patients and understanding what patients themselves think they need to do to stay

healthy after discharge. IMPACT CHWs will work with patients to set goals for these issues and help them achieve their goals. In addition to helping patients meet their own goals for recovery, IMPACT CHWs will help patients with some important things that all patients require after hospitalization: arranging follow-up care and help filling medication prescriptions.

Instead of working with patients for six months, Transitions IMPACT CHWs work with patients from the time of their stay in the hospital until the first primary care appointment. If your patient has a smooth transition from the hospital to home, you will be working with a patient for as little as two weeks.

### III. IMPACT Transitions, Step-by-Step:

- A. Now we are going to go through the nitty-gritty steps of your work with patients as an IMPACT Transitions CHW. Please turn to the Overview section of your IMPACT Transitions Manual. Here you will find a step by step guide of what you do as a Transitions IMPACT CHW throughout your day. On the next page, you will see a more detailed overview of each of these steps. We are going to read through the step by step guide and practice the interviews you will do with patients along the way.
1. Ask a volunteer to read the Overview of the IMPACT Transitions CHW Manual. Have the group read and discuss the detailed steps as a group.
  2. After reading the Meet the Patient Interview, the two facilitators (Manager and Senior CHW) should complete a pre-prepared role-play of the Meet the Patient Interview. One facilitator should play the part of a CHW, and the other, a patient. Ask the trainees to take notes on a blank copy of the Meet the Patient Interview.
  3. Once the Meet the Patient Interview is completed, the facilitator should ask the group to spend a moment reviewing the Roadmaps created by the patient with the help of their CHW:
    - Are the Roadmaps selected good ones to help the patient reach his or her long term health goal?
    - Are the Roadmaps concrete and measurable? How would you change the Roadmaps to make them more concrete and measurable?

- Does the Plan section of the Roadmap include: Who What Where and When? How would you change the Plan to include this?
4. Ask the trainees to pair off into teams of two, to role-play a CHW and a patient. The CHW should interview his or her patient and help them to create Roadmaps, and take notes on a blank Meet the Patient Interview.
- B. Now that we have completed the Meet the Patient Interview, let's learn how to use the Patient Calendar. [Pass out copies of Patient Calendar.] This calendar is based on the Project Boost Patient Pass.<sup>1</sup> This is a little tool to help organize all the information your patient is getting in the hospital so that they can have it in one handy place after discharge. Sit down with your patient and fill in their doctor and pharmacy contact information. Write your patient's appointments on the calendar. Ask them if they have any questions for the nurse, and with the nurse's help, complete the Boost Pass and give it to the patient.
- C. Let's go back to the Step-by-Step guide in your manual to see what to do next. Can I have volunteers read steps 6, 7, 8, 9?
1. After reading Discharge Day, pass out a copy of a discharge summary from your healthcare facility, with all identifying information blacked out. Show the CHW trainees where to locate the discharging attending, medication list, primary and secondary diagnoses, discharge instructions and follow-up appointments.
  2. It is important for IMPACT CHWs to know the difference between a discharge summary and discharge instructions:
    - Discharge summary: for other medical providers, explains procedures and tests completed during the hospitalization and should be brought to any follow-up medical appointments after discharge.
    - Discharge instructions: less detailed, provides information for the patient. This is useful for the patient, but if you bring only this to follow-up medical appointment instead of the discharge summary, the doctor may not get all the important information that they need.
- D. Now that we understand how to read discharge instructions and

- summaries, let's practice the Discharge Interview.
1. The two facilitators (manager and senior CHW) should do a pre-prepared role-play of a Day of Discharge Interview using the prior CHW and patient characters. Ask trainees to take notes on a blank Discharge Interview script.
  2. Allow time to answer any questions.
  3. Ask the trainees to pair off into the same teams of two as earlier, to role-play the Discharge Interview and take notes.
- E. Let's go back to the Step-by-Step guide in your manual to see what you do next. Can I have volunteers read steps 10 and 11?
1. After reading Step 11 on following up with the patient, the two facilitators (Manager and Senior CHW) should complete a pre-prepared role-play of the Follow-up Interview using the prior CHW and patient characters. Ask trainees to take notes on a blank Follow-up script.
  2. Allow time to answer any questions.
  3. Ask the trainees to pair off into the same teams of two as earlier, to role-play the Follow-up Interview and take notes.
- F. Now that we have completed the Follow-up Interview, let's go back to the Step-by-Step guide in your manual to see what to do next. Can I have volunteers read step 12, 13, and 14? [Note: step 12 covers clinical issues and psychiatric emergencies—use this as an opportunity to review from prior session.]
1. After reading Step 14 on Pre-Doctor's Appointment coaching, the two facilitators (Manager and Senior CHW) should complete a pre-prepared role-play of the Pre-Doctor Coaching Interview using the prior CHW and patient characters. Ask trainees to take notes on a blank Pre-Doctor Coaching Interview script.
  2. Allow time to answer any questions.
  3. Ask the trainees to pair off into the same teams of two as earlier, to role-play the Pre-Doctor Coaching Interview and take notes.
- G. Can I have a volunteer read Step 15 on attending the doctor's appointment?
1. After reading Step 15, ask for a volunteer to play the role of the doctor and role-play the 'Doctor's Appointment Interview' using the prior CHW and patient characters.

2. Ask trainees to take notes on a blank doctor's appointment interview script.
3. Allow time to answer any questions.

IV. Homework: For the next session, please conduct the Follow-up Interview with one of the other CHWs in the training and enter your notes into HomeBase.

## SESSION 7. QUALITATIVE INTERVIEWING SKILLS

Time Required	2 Hours
Recommended Facilitator	IMPACT Manager
Suggested Content	Homework Review Introduction to Qualitative Interviewing Traits and Skills of the Interviewer Exercises Homework

I. Homework Review: I've reviewed each of the interviews you entered into HomeBase and provided you with some feedback.

II: Introduction to Qualitative Interviewing

A. Today we are going to talk about general skills for interviewing, which are crucial for you to learn about your patients, their health goals and all the complicated issues that are going on their lives.

B. The IMPACT model is based on interviews with patients that Tamala Carter, a Community-Based Interviewer, conducted. Ms. Carter is an expert interviewer, a longtime resident of West Philadelphia, and has a background in community outreach. She interviewed hundreds of low-income patients in West Philadelphia, in the hospital and in their homes. They described to her all the things that make it hard for them to stay healthy—not just medical issues but all kinds of life issues. They also told her their suggestions for improving healthcare. The Penn Center for CHWs used the responses that the patients gave Ms. Carter to design the IMPACT model.

1. So now I have a question for you. When you are interviewing patients about the issues they face, why might it be a good thing for the interviewer to come from patients' own community? [Write down answers from the group.]

C. Does anyone know what qualitative interviewing is? Qualitative interviewing uses a series of open ended questions as a guide for a

conversation.

1. What is an open ended question?
  - A question that does not have a yes or no answer.
  - Can you give me some examples?
2. "Qualitative interviews" are a conversation between an interviewer and an interviewee. This type of interviews lets us get detailed information in the form of stories. It allows person being interviewed to be the expert and tell their story. Allows the patient to tell us things about their life, community etc. that we might not know to ask.
  - You are not just looking for one answer
  - This is something that a survey with yes and no questions can't do.

### III. Traits and Skills of the Interviewer:

The information that we get from a qualitative interview depends on the interviewer's skills. I am going to go through the traits and skills of a good qualitative interviewer and write them down.

#### A. Traits and tips for being a good qualitative interviewer

1. Good listener
  - More listening and less talking.
  - The aim is to learn information, not share your own views.
2. Nonjudgmental
  - Be as neutral as possible.
  - Now I'm going to ask you a question. Why is it important to be nonjudgmental? [Prompt: Lets the patient be more open and honest. For example if the patient thinks you will judge them for using drugs, they may not want to tell you about it.]
3. Kind and encouraging
4. Be aware of your body language and facial expression.
  - Why is this important? [Prompt: Because if you act comfortable you make the patient feel comfortable, this allows patient to reveal more.]
  - Make eye contact
  - Smile, look friendly and interested so they can see they have your full attention
  - Be relaxed

- Sit up straight
  - Don't cross your arms; this looks defensive.
5. Friendly, calm tone of voice
6. Use your first moments with the patient to help them feel comfortable:
- Your introduction sets the tone for the interview. Be friendly and clear, explain who you are and what you want to speak with them about.
  - Chitchat: make small talk
  - Compliment them on something
  - Ask them about their day or their weekend
- This lets them feel comfortable, and also lets you get a feel for the person before you start the interview
7. Know how to use silence:
- People are uncomfortable with silence. A lot of times if a patient doesn't answer our question right away, we want to just jump in and start talking. If the patient doesn't answer right away, don't just start talking, wait seven seconds and see if they gather their thoughts. Remember the seven second rule, which is just remembering to count to seven in your mind.
  - Don't be afraid of silence. It gives the patient time to think
8. Find the fish and reel it in:
- Recognize when the patient is saying something important and ask more about it. Don't just move on to the next question in your script.
  - Use probing language:
    - \* "Tell me more about that."
    - \* "Can you explain that more?"
    - \* "Tell me the story of that."
    - \* "Then what happened?"
  - Repeat what the patient just said to prompt them.
9. Don't be afraid to ask them to repeat or explain something
10. Pay attention to the vibe—the vibe lets you know if you can dig deeper
11. Stay focused:
- Sometimes the patient will go off-topic from the questions and give you important information, but sometimes you need to keep the conversation on track
  - If you need to get the interview back on track, wait for



the patient to finish their thought, thank the patient for telling their story, politely change topic back to one on your interview guide

#### IV. Exercises

A. We are now going to watch two sample qualitative interviews conducted by Ms. Carter. [Watch sample interview videos on the Penn Center for Community Health Workers website, under the web-based features tools.]

1. Can anyone summarize the interviews? Tell us about these patients.
2. Is Patient 1 a Profile A patient or a Profile B patient? Why?
3. Is Patient 2 a Profile A patient or a Profile B patient? Why?
4. What were some of the prompts that Ms. Carter used in the interviews?
  - Can anyone find a place where she reflected the last thing that the patient said to try to get them to say more?
  - Can anyone find a place where Ms. Carter asked the patient to clarify something?
  - Can anyone find a place where Ms. Carter dug deeper or probed something that the patient said?

#### B. Practice:

1. All of the interviews in the IMPACT model that we practiced over the last two sessions are designed to be qualitative interviews.
2. Find a partner and practice using your qualitative interviewing skills to do the Meet the Patient Interview. We will walk around from time to time and give you tips and feedback.

V. Homework: Please practice the Meet the Patient Interview with 1-2 people over the next 2 days. Use your qualitative interviewing skills. Enter your notes into HomeBase.

## SESSION 8. MOTIVATIONAL INTERVIEWING, PART I

Time Required	5 Hours
Recommended Facilitator	Certified Motivational Interviewing Expert ( <a href="http://www.motivationalinterviewing.org">www.motivationalinterviewing.org</a> )
Suggested Content	What is Motivational Interviewing? The Righting Reflex Identifying Changes that the Patient Wants to Make Exploring Ambivalence about Change Reflective Listening

This session should be delivered by a Certified Motivational Interviewing Expert. A list of these trainers can be found on [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org).

## SESSION 9. REVIEW

Time Required	2 Hours
Recommended Facilitator	IMPACT Manager

Review all sections to date.

## PART THREE: THE PATIENT JOURNEY

## SESSION 10. DETERMINANTS OF HEALTH & THE SOCIAL SERVICE SYSTEM

Time Required	1.5 Hours
Recommended Facilitator	IMPACT Manager & Senior CHW
Suggested Content	Determinants of Health The Social Service System

### I. Determinants of Health

A. The first thing we are going to discuss today is all the things in people’s lives that make them feel healthy or unhealthy. Even things that affect our health the most are sometimes not the obvious ones.

1. First, I want to ask you—what do you think determines how healthy a person or a group of people feel? [Prompt for: medical conditions that they have, family history, financial situation, whether they live in a safe neighborhood or a dangerous neighborhood, whether there is a good grocery store near their house, whether they have a stable place to live, whether they are part of a strong community or isolated, the person’s own beliefs, habits and behaviors.]

B. Categories of Health Determinants: When the Penn Center for CHWs talked with hundreds of high-risk patients, they found that they could group the things that affected patients’ health under 6 categories.

#### 1. Medical Issues

- Disease and Symptoms: When we talk about whether people are healthy or unhealthy, the most obvious thing we think about are medical issues. Does this person have a disease, illness or injury?
- Mobility: Is this person mobile enough to get around, go to doctor’s appointments or exercise?

#### 2. Health System Navigation

- Insurance: How does having or not having health

insurance affect a person's health? Who might be less likely to have health insurance?

- Access to medical care or a regular doctor: How does having a primary care doctor affect someone's health? Who might be less likely to have a primary care doctor?
- Navigation: A person's ability to navigate the health system affects their health. What do we mean by this?

### 3. Psychosocial

- Trauma: How could a history of trauma affect a person's health?
- Substance abuse: If someone has substance abuse issues, how might this affect their health?
- Mental illness: How do you think our mental health affects our physical health?
- Friend/Family Relationships: How could having a really supportive family affect your health?
- Friend/Family Stress: How could lots of family drama affect your health?

### 4. Neighborhood: People and places can affect your health in positive ways and negative ways:

- Support from the neighborhood—block captains, etc: How could living on a block with a block captain affect your health?
- Neighborhood violence: How could living in an unsafe neighborhood affect your health?
- Neighborhood drug use: How could living in a community with lots of drug users affect your health?

### 5. Resources for Daily Life

- Finances: How does lacking money affect your health?
- Transportation: How do transportation difficulties affect your health?
- Employment: How does being unemployed affect your health?
- Housing: How does unstable housing affect your health?
- Food: How does the access to food affect your health?
- Childcare: How might lack of childcare affect a parent's health?

### 6. Health Behavior and Motivation

- Personal attitude towards health: How can your

attitude affect your health?

- What make some people more likely to eat healthy, quit smoking or take their medicine than other people in the same community?

C. Health Determinants in our community: Let's make this a lot more specific and talk about our own community.

1. The medical issues

- What are some common illnesses that people in this neighborhood deal with?

2. Navigating the health system

- Do most people in this neighborhood have health insurance?
- Do most people have a regular doctor?
- Is it easy for people to navigate the health system and get access to care?

3. Psychosocial

- Is there untreated mental illness in the community?
- Is there a lot of substance abuse in the community?
- Are people exposed to violence and trauma?
- Do people have family or friend drama?

4. Neighborhood

- What is the community like in this part of the city?
- Are people close to their neighbors?
- Do people belong to community groups or faith groups?
- How safe are the neighborhoods?

5. Resources for Daily Life

- What kind of jobs do people have?
- Are people unemployed?
- Do they have stable housing?
- Do they have child care?

6. Motivation to be Healthy

- What are some good and bad habits that you think are common in our community?

D. Now, let's brainstorm quickly—off the top of your head, what are some things we could change to improve the health of people living in this community?

## II. Basics of the services system

- A. A lot of the ideas we came up with to address those determinants and improve health were the reasons behind creating many parts of what we call the social service system. In order to improve our patients' determinants of health, CHWs often have to help them connect to the social services system.
1. Can anyone define the social service system?
  2. What are some examples of social services a CHW could connect their patients to? [Prompt for case management, mental health and substance abuse treatment, housing, food assistance, child care.]
  3. How do you keep track of the social services you use?
- B. In the United States, social services are most often provided by four types of agencies or organizations: Public, Nonprofit, For-profit, Self-help.
1. Public agencies: How would you define a public agency?  
[Prompt: if no one answers: it is a program that is run directly by the government.]
    - Can anyone name some examples of public social service agencies?
    - Social Security Administration
    - County Assistance Office/ Department of Public Welfare
    - City Health Centers
    - City Recreation Centers
    - Some homeless shelters
    - Has anyone ever helped a family member or patient to access resources from a public agency? Which ones?
  2. Non-profit agencies: What is a non-profit agency?
    - An organization that provides social services and does not make a profit.
    - Can be faith-based or not faith-based
    - Can receive grants or funding from the government to provide services
    - Can anyone think of some local examples of nonprofit agencies?
  3. For-profit agencies: A for-profit agency or company provides services for profit
    - Often charge for services
    - Can be paid by the government to provide services



- Might contract with a public agency to provide services
  - What are some local examples? [Prompt for day care center, private therapist, etc.]
4. Self-help groups
- Groups where people come together for support or advocacy purposes, in many cases run by volunteers
  - What are some examples? [Prompt for Alcoholics Anonymous, Narcotics Anonymous.]
  - What are some local examples of self-help organizations? [Prompt for local volunteer groups e.g. to oppose gun violence in a neighborhood, to keep a local park clean.]
- C. Discuss: Many of you have had experiences with social services before. What problems have you seen with the social service system? What makes it hard for people to get the social services they need?
1. Not enough services to meet the need
  2. Narrow eligibility criteria (i.e. the patient needs to have an AIDS diagnosis or be staying in a shelter to qualify)
  3. Services are not connected to each other
  4. Services are not accessible: too far away, too expensive, not in the right neighborhood, etc
  5. What other problems have you seen?
- D. Given all the problems you just told me about, how do you think a Community Health Worker can help patients navigate the social service system?
- E. In IMPACT, we have high expectations for how we connect our patients to the social service system: Because of all the things that make it hard for patients to access social services we have to be very careful of how we connect our patients to these services. If the services we connect them to are not good or are difficult to access, we are not really helping them at all.
1. Call ahead to make sure the service exists
  2. Ask questions to make sure your patient will be eligible for the service
  3. Go with your patient or make the phone call with them. Encourage them to do the talking so they can do it on their own next time!

- Why would a CHW want to go with the patient to get the service, or make the phone call with them? [Prompt for: CHW can learn about services first hand, and also they can make sure that connection actually happens.]
4. Help your patient gather the papers and documentation they need. Make sure it gets submitted correctly.
  5. Follow up with the patient to ask if the service is working out for them
    - Why is it crucial to follow up? [Prompt for: to find out if you need to advocate for them, and to find out if the service is any good.]
  6. Advocate for your patient if needed
    - What are things you can do to advocate for your patient with a social service agency?
    - Ask your Manager for assistance as needed
  7. What are other things a CHW should do to help patients get access to the social services they need?

## SESSION 11. THE HEALTH CARE SYSTEM

Time Required	1.5 Hours
Recommended Facilitator	IMPACT Manager
Suggested Content	<p>Overview</p> <p>How does the United States Compare ?</p> <p>Who provides healthcare care?</p> <p>Where is healthcare provided?</p> <p>How do we pay for health care services in the US?</p> <p>Problems with coordination of care</p> <p>Homework</p>
Sources	<ol style="list-style-type: none"> <li>Berthold, T., Avila, A. &amp; Miller, J., Eds. (2009). Foundations for community health workers. JosseyBass Public Health, San Francisco, CA.</li> <li>Health Canada. (2012). Health care system. <a href="http://www.hc-sc.gc.ca/hcs-sss/index-eng.php">http://www.hc-sc.gc.ca/hcs-sss/index-eng.php</a></li> <li>Tufts Managed Care Institute. (1998). The health care system in the United States: Integrating cost and quality. <a href="http://www.thci.org/downloads/USHealthSystem.pdf">http://www.thci.org/downloads/USHealthSystem.pdf</a></li> </ol>

### I. Overview

A. Definition: "Health care systems" are made up of individuals and organizations that aim to meet the health care needs of groups of people

B. A health care system includes not just medical providers, hospitals and clinics but also regulators, insurance companies, pharmaceutical corporations, non-profit health care agencies, the government, etc.<sup>3</sup>

### II. How does the United States Compare?

To get a big picture sense of our healthcare system, it is useful to compare it to other countries like ours.

#### A. Canada

1. Universal health care: the government guarantees that the health care system serves all citizens on the basis of need, rather than their ability to pay for services. Access to health care is a legal right for all citizens.
2. The government uses tax money to budget what it will spend on the health care system. Taxes are typically a little higher than they are in the United States.
3. Care is coordinated between clinics and hospitals by centralized, government-run systems in each Canadian province.<sup>1</sup>
4. These government-run systems decide what services are most important for promoting the health of all people in the country.

B. What kind of health care system do we have in the U.S.?

1. The U.S. does not have a universal health care system.
2. The health care system in our country is a complicated mix of parts that are not coordinated by any kind of central leadership. It can be very hard to understand.
3. People get health care services through health insurance, paying for it directly (“out-of-pocket”), or going to hospital ERs and community health centers
4. In the United States, people who have good health insurance and the money to pay for services can get some of the best medical care in the world.<sup>3</sup>
5. On the other hand, there are many people who don’t have insurance or who are under-insured and can’t afford to pay for care, out-of-pocket. These people have a hard time getting access to medical care because of the cost. A large number of the patients CHWs work with fall into this category.
6. Influence and control comes from many places: insurance companies, government, employers, doctors, hospitals, drug companies. This creates conflict and in many cases decreases the quality of care or level of access to care for patients.<sup>1</sup>
7. Because the system is so fragmented, health care inequality is a major issue in the United States. Since it’s not a legal right, not everyone gets the same access to health care services in the U.S.
8. Because it is made up of many disjointed pieces that are not well-coordinated, our health system is not set up well for taking care of people with complicated, long-term needs like

those who suffer from chronic diseases.<sup>1</sup>

- C. What problems or frustrations have you or someone you know experienced in our health care system? What would have made it better?

III. Who provides health care services?

A. Physicians

1. Primary care physicians (most health care needs) and specialists (more complicated treatments)
2. Because of how complicated medicine is becoming, there are doctors who are experts in hospital medicine and others who are experts in outpatient medicine. This division has its pluses, but the BIG problem is when more than one doctor is taking care of a patient and the doctors do not communicate well with each other.
3. Mostly, doctors get paid in a “fee-for-service” manner. This means they are paid for each service they provide. They are paid by insurance companies and programs like Medicaid.

B. There are other types of providers who provide services in the health care system. Let’s talk about what these providers do:

1. Nurses/NPs
2. Pharmacists
3. Social Workers
4. CHWs
5. Other professional health providers include: dentists, physician assistants, pharmacists, dietitians, therapists, psychologists, chiropractors, physical therapists, optometrists, emergency medical technicians (EMTs), paramedics

IV. Where is healthcare provided?

A. Outpatient

1. Private Clinics: These clinics provide basic primary health care for medical needs that are not complicated or serious
2. Community Health Centers
  - Nonprofit outpatient clinics serving mostly uninsured and Medicaid patients: often the only affordable/ accessible source of health care for these patients
  - Most provide primary care services, and some provide dental care, mental health care, nutrition counseling, or other specialty services

- Sometimes can provide language translation, case management or other special services
- B. Emergency room: meant for life-threatening conditions, but used by many uninsured patients as a primary source of care
1. Hospitals are legally obligated to give emergency care to the uninsured and cover the costs of this care. This does not mean uninsured patients who use the ER will not get a huge bill in the mail.
- C. Hospitals' inpatient care: overnight, more complicated needs—high-tech and expensive (>\$3,000/day), and specialty care, like surgery.
- V. How do we pay for health care services in the United States?
- A. Getting health care depends on having health insurance from your job, qualifying to get it from a government program such as Medicaid, Medicare or the Affordable Care Act, or buying insurance or services with your own money.
- B. Employer-based health insurance
1. Each employer decides how much they will pay for their employees' health insurance
  2. The employee pays monthly premiums (a set amount to have coverage) to the insurance company as well as co-payments every time they get medications or services at a hospital or clinic
  3. Some businesses can't afford to buy insurance for employees, so many working families don't get insurance through their jobs. The Affordable Care Act will require businesses with more than 50 employees to provide insurance, but those with less than 50 employees are not required.
- C. Government programs: funded by money from our taxes
1. Medicare: 65 and older, disabled people who have been receiving Social Security Disability for 2+ years
    - Has different "Parts" (A, B, C, D) that cover different kinds of health care services
  2. Affordable Care Act/Obamacare: This is health insurance for adults and families who do not already receive adequate health insurance through their jobs and do not receive

Medicare or Medicaid.

- All uninsured adult US citizens are required to apply for health insurance through a health care exchange
- Health care exchanges are run by states or the federal government. Applicants use the exchange to apply for health insurance from a private company.
- People can apply to the health care exchange online or by phone. Applicants can also get help from Navigators, local groups that are receiving federal funding to help people sign up for health insurance through the Affordable Care Act.
- Many low and middle-income families qualify for subsidized premiums for health insurance through the Affordable Care Act. The subsidy comes from the federal government.
- If you have a very low income, you may not be eligible for coverage through the exchange. Your application information is passed on to the Department of Public Welfare to see if you are eligible for Medicaid.

3. Medicaid or Medical Assistance: for some low-income individuals and families

- What determines which people qualify for many low-income government assistance programs, including health insurance programs? The Federal Poverty Level (FPL), which is \$11,490 for a single person in 2014 (add \$4,020 for each additional family member)
- Must fit into one of many categories of people
- Must meet income requirements
- Services provided include hospital, nursing home care, preventive care, family planning, labs, and x-rays
- Due to new funding provided under the Affordable Care Act, some states have expanded Medicaid to cover a higher number of low-income people who did not previously qualify for Medicaid.
- Do you know if Medicaid has been expanded in your state?

4. State Children's Health Insurance Program, SCHIP or CHIP: for kids under 18

- Income limit varies from state to state, the national average for upper income limit is 241% of the federal poverty line.

- Services include well-baby & well-child care, immunizations, and emergency services. Sometimes states include dental and vision.

VI. Problems with coordination of care

- A. Information Systems: Often, the providers from one institution cannot read the medical records of another institution. So, if you go to Hospital A and see a primary care doctor that is not affiliated with that hospital, she may have no idea what happened. Patients end up having to tell their story over and over, and often, important pieces of information get missed or lost along the way.
- B. Some providers try to work closely together, but overall the different pieces in the health care system do not fit together very well.
- C. Coordination of care is especially important for people with multiple chronic diseases who may have to go to many different doctors.
- D. If I am very sick and seeing four different doctors who don't communicate very well with each other, how could that affect my medical care? What can I do as a patient to help coordinate my doctors?

VII. Homework: Read through the basic health vocabulary words (Session 12) and circle the ones that you have questions on.



## SESSION 12. BASIC HEALTH CONCEPTS

Time Required	1.5 Hours
Recommended Facilitator	IMPACT Director Medical Student/Doctor
Suggested Content	Basic health vocabulary Overview of common diseases Question & Answer Session with Director Limitations
Sources	
	1. Up to Date: <a href="http://www.uptodate.com/home">http://www.uptodate.com/home</a>

I. Basic health vocabulary. In this session, we'll be exploring basic health concepts, including health-related words you might run into as a CHW and common diseases that affect people in our community. Let's go around and talk through the questions that you all had when you read the basic vocabulary of health [Make note of anyone who did not do the homework and talk to them about this after class.]

- **addiction** - being so dependent on something that it's hard to quit, even if it has negative effects on the person using it.
- **admission** - when a patient stays in a hospital for at least 24 hours
- **AIDS** - a disease that weakens your immune system and makes it easier to catch other infections
- **ambulatory** - able to walk; a patient who doesn't need to stay overnight at the hospital
- **asthma** - lung disease that cause shortness of breath, wheezing, coughing and chest tightness
- **bedsore** - a sore caused by pressure of the body against a bed that usually affects people who are bedridden
- **biopsy** - the removal of a tiny piece of a part of the body to examine it under a microscope

- **blood pressure** -the pressure that your heart has to pump against to move blood forward
- **cancer** - uncontrolled growth of tissue in the body
- **cardiac** - anything to do with the heart
- **cardiovascular** - anything to do with the heart and blood vessels
- **cellulitis** - infection of the skin
- **CHIP** - government health insurance for children with low-income families
- **cholesterol** - molecule found in food and produced by the body that can cause heart disease if it builds up
- **cirrhosis** - a disease of the liver, usually caused by alcohol
- **clinic** - a place to get health care for conditions that are not urgent, same as 'outpatient' or 'doctor's office'.
- **communicable disease** - a contagious disease
- **cutaneous** - anything to do with the skin
- **dehydration** - when the body doesn't get enough fluids
- **depression** - serious feelings of sadness that can lead to a variety of problems like loss of energy, appetite and sleep, and thoughts of hurting yourself
- **diabetes** - a disease in which the blood has too much sugar, which can cause damage to other organs.
- **diagnosis** - the process of figuring out what medical condition a person has
- **diet** - all the food a person eats; or what a person is supposed to eat in order to lose weight or become healthier
- **discharge** - when a patient is sent home from the hospital with information on what to do next in order to stay healthy
- **doctor** - someone who went to medical school and provides health care services to patients
- **ECG** or **EKG** - heart test to look for heart blockages or problems with the heart beat
- **ENT** - anything to do with the ear, nose and throat
- **fatigue** -tiredness
- **gastric** - anything to do with the stomach

- ***gastrointestinal*** - anything to do with the stomach and intestines
- ***genetic*** - traits that parents pass on to their kids
- ***geriatrics*** - the branch of medicine that deals with elderly people
- ***heart failure*** - when the heart isn't able to work properly
- ***hemorrhage*** - bleeding
- - like inheritance. Passing on of traits from parents to children
- ***hernia*** - when a part of the body sticks out where it should not be
- ***HIV*** - the virus that causes AIDS
- ***hypertension*** (high blood pressure) - when the heart has to pump against too high of a pressure. This can cause heart failure, stroke and other problems.
- ***immunization*** - a shot that protects people against an infection
- ***infectious disease*** - a disease that can spread from one person to another
- ***inflammation*** - irritation, swelling, redness, warmth and pain
- ***insulin*** - lowers blood sugar and is used to treat diabetes
- ***intravenous (IV)*** - when fluids are put directly into the bloodstream with a needle
- ***kidney*** - the bean-shaped organs in the body that filter waste and make urine
- ***liver*** - an organ in the body that filters waste and detoxifies the blood stream
- ***malnutrition*** - when someone gets sick from not getting enough nutrients
- ***Medicaid*** (also known as Medical Assistance or MA) - government health insurance for low-income people
- ***medical assistant*** - a health care worker that helps doctors with patients and office tasks
- ***Medicare*** - government health insurance for people 65 and older
- ***MRI*** - a way to take pictures of things inside the body using magnetic energy
- ***nurse practitioner (NP)*** - a nurse with enough education and training to practice a wide range of health care services
- ***nurse*** - a health care worker who works under the direction of a

doctor

- **obesity** - too much body fat
- **occupational disease** - any illness caused or made worse by a person's job
- **occupational therapy** - teaching useful skills to disabled people so that they can do everyday things
- **oncology** - dealing with cancer
- **palpitation** - a feeling that the heart is skipping beats
- **pancreas** - an organ that produces insulin
- **pancreatitis** - irritation of the pancreas, often caused by alcohol or gallstones
- **pediatrics** -deals with babies and children
- **perforation** - a small hole or tear
- **pharmacist** - a health professional who prepares and dispenses medicines to patients
- **physician** - a doctor
- **physician assistant (PA)** - a health care provider who works under the supervision of a doctor
- **prescription** - instructions written by a doctor that tell a pharmacist what kind of medicine and how much of it they should give a patient
- **radiology** - the part of medicine that deals with taking pictures of the inside of the body using x-rays, MRI, CT scans or ultrasounds
- **rehabilitation** - getting back to normal after an illness
- **relapse** - the return of an illness after it is thought to be gone
- remedy - cure
- **renal** - dealing with the kidney
- **stool** -bowel movement
- **stroke** - when the brain tissue doesn't get enough blood
- **unit secretaries** - people in the hospital who make sure the logistics (where patients should go, answering phones, etc.) runs smoothly so the nurses and doctors can focus on their patients
- **vaccination** - immunization
- **x-ray** - a picture of the inside of the body used to see things like lung diseases and broken bones

II. Overview of common diseases. [Medical student should prepare a Power Point overview of each disease]

- A. Diabetes: In a diabetes patient, an organ in the body called the pancreas doesn't work properly and doesn't make insulin. As a result, sugar builds up in the blood stream instead of getting converted into energy for the body. High levels of sugar in the bloodstream are dangerous
- B. Cirrhosis: (sihROWsis) is permanent damage to the liver.
- C. Cellulitis: (seluLLtis) is a skin infection caused by bacteria.
- D. Pancreatitis: (pankreeuhTltis) is the irritation of an organ in the body called the pancreas.
- E. Asthma and COPD: Asthma and COPD (chronic obstructive pulmonary disease) are lung diseases that block airflow and make it difficult to breathe. COPD is usually the result of smoking.
- F. Heart failure: Heart failure, also known as congestive heart failure (CHF), means the heart is too stiff or weak to pump enough blood to meet the body's needs.
- G. Renal failure/kidney failure: The kidneys filter all the fluids in the body. When they get damaged (by things like high blood pressure or diabetes), fluid and toxins build up in the body. People with renal failure need dialysis, which is basically a machine that does the filtering for them, instead of their kidneys.
- H. Hypertension: There are two blood pressure numbers, a top and bottom number. In a normal person, a normal blood pressure is 120/80. When someone is sick, their ideal blood pressure can vary, so it is better not to tell a patient what their blood pressure should be unless you are a physician.

III. Q&A Session with Director

We certainly don't expect you to memorize or even have understood all of the information we went through today. It is just a starting point to help you feel more comfortable with basic medical concepts. The easiest way

to learn is to just ask a bunch of questions. So for the next 20 minutes, I will answer any medical questions that you have.

#### IV. Limitations

- A. It is very tempting to take this information and start sharing it with others you know, and to even start providing people with basic medical advice. What are some reasons that you may not want to do this? [Prompt for patient complexity, giving wrong advice, getting people sick or even at an extreme, causing death.]
  
- B. How long do you think it takes for people to become fully trained physicians? [Prompt: college, medical school, residency, sometimes fellowship.] The reason that it takes so long is that this is complicated, specialized information. You want to make sure you were getting information from someone with the right training- your patients feel the same. In the IMPACT model, it is a serious violation to provide medical advice to any patient, even if you think you know what you are doing.
  
- C. In the United States, CHWs are not “Barefoot Doctors.” There are plenty of doctors, nurses and other medical people in most communities in the US. The gaps that patients face are in dealing with the real-life issues we have talked about. That is where you come in. Remember your strengths but also respect your limitations.

## SESSION 13. OVERVIEW OF THE PATIENT'S JOURNEY

Time Required	2.5 Hours
Recommended Facilitator	Senior CHW Patient
Suggested Content	A Day in the life of a patient Personal reflection assignment

### I. A day in the life of a patient

A. We are going to talk about the patient journey today. We have a special guest who is a former patient. He is going to help the CHW run today's session, tell you a little about his experiences as a patient of the IMPaCT model, and give you some feedback. [Note, if this is your first IMPaCT training and you do not have any former IMPaCT patients, you can invite any patient of your healthcare organization to lead the discussion and adapt accordingly.]

### B. Senior CHW questions for patient:

1. Thank you so very much for taking the time to talk with us today.
2. What was hard or frustrating for you about being in the hospital/having a chronic condition? What was hard about getting discharged from the hospital? Coming home?
3. What was the best part of coming home from the hospital for you? What was the most helpful thing anyone did for you during this time?
4. Can you please tell us about the first time you met me in the hospital/clinic? [Prompt: what happened next, etc. to get the whole story]
5. What was going through your head the first time you met me?
6. What were the goals that we worked on together?
7. What was the most helpful thing that I did as your CHW?
8. What was the least helpful thing that I did as your CHW?
9. What advice would you give new CHWs about working with

patients?

10. What advice would you give CHWs about working with patients who come home from the hospital after being very ill?
11. What advice would you give to CHWs about making patients feel comfortable?
12. What advice would you give to CHWs about helping patients who are feeling frustrated about living with a chronic illness?

What other questions do you have for the patient?

- II. Homework: Personal reflection assignment. Over the next few sessions, we will go on a patient's journey from hospital to home to the outpatient clinic. As we go, please write one paragraph about your personal reflections on each stage of the patient journey from the hospital to home to the primary care clinic. Try to imagine what it would feel like to be a patient in this stage of the journey, and how you would want a CHW to support you.



## SESSION 14. THE HOSPITAL

Time Required	4 Hours
Recommended Facilitators	Senior CHW, Hospital Social Worker Nursing supervisor
Suggested Content	Hospital Tour Introduction to Hospital Social Work & Clinical Resource Management Introduction to Nursing Debriefing session with Senior CHW Homework

### I. Hospital tour:

- A. Tour of the floor of the hospital where IMPaCT Transitions CHWs will work, including nurses' station, patient room, family room, etc.
- B. Explanation of staff roles in this setting & introductions of the following, if possible:
  - 1. Attending doctor
  - 2. Residents
  - 3. Nurses
  - 4. Medical Assistants
  - 5. Unit Secretary
  - 6. Social Work/Clinical Resources Coordinator

### II. Introduction to Hospital Social Work/Clinical Resource Management:

- A. Explanation of the functions of Social Work/ Clinical Resource Management for hospitalized patients
- B. Discussion of how CHWs can work with Social Work/Clinical Resource Management to improve outcomes for high-risk patients from low-income communities.
  - 1. Completing Medical Assistance applications
  - 2. Making sure patients have the equipment they need (e.g.

wheelchair, etc.)

3. Connecting patients with community resources

III. Introduction to Nursing

A. Explanation of the functions of Nursing for hospitalized patients

B. Discussion of how CHWs can work with Nursing staff to improve outcomes for high-risk patients from low-income communities.

1. Help make sure that patients understand and can perform discharge instructions
2. Make sure the inpatient care team understands the patient perspective and goals

IV. Debriefing session with Senior CHW:

A. I want to take some time and debrief the patient journey so far:

1. What questions do you have after the hospital tour?
2. What reflections do you have on the experience of the patient so far? (The patient who shared his story and hospital tour.)

B. Let's use the patient journey thus far to review concepts we have learned:

1. Being a CHW
  - Discussion: How did the Senior CHW use the core skills of a CHW to help this patient?
2. The IMPACT model
  - How did the Senior CHW use the IMPACT model to help the patient?
3. Health Care System
  - What parts of the health care system did our patient interact with?
  - What were their frustrations with it?
4. Hospital and health vocabulary
  - Take out your glossary and highlight any words that you heard in the hospital or from the patient.
5. Reading a discharge summary:
  - This is an example of a hospital discharge summary. (Hand out a copy of a hospital discharge summary with all identifying information blacked out.)
  - Can I get a volunteer to read it out loud?

- Can anyone locate:
- The name of the attending doctor (what is an attending doctor)?
- The primary diagnosis?
- The medication list?
- What follow-up appointments does this patient need to attend?
- Is there anything in the follow-up instructions that might be hard for the patient to do?

V. Homework: For the next session, please conduct the Discharge Interview with one of the other CHWs in the training and enter your notes into HomeBase.

## SESSION 15. HOME CARE

Time Required	1 Hour
Recommended Facilitators	Home Care Nurse Home Health Aide
Suggested Content	How a patient is referred to home care Eligibility criteria Services provided by a home care agency What to do if CHWs think their patient needs home care How CHWs can help home care agency connect with low-income patients

Content provided by Home Care Staff as outlined above.

## SESSION 16. REVIEW

Time Required	2 Hours
Recommended Facilitator	IMPACT Manager

Review all sections to date.

## SESSION 17. THE HOME VISIT

Time Required	4 Hours
Recommended Facilitators	IMPACT Manager Senior CHW
Suggested Content	Planning the home visit Addressing the tricky parts of home visits Home visit safety Field trip to patient's home
Sources	1. Berthold, T., Avila, A. & Miller, J., Eds. (2009). Foundations for Community Health Workers. JosseyBass Public Health.

- I. Planning the home visit. Let's start by reading a case study from your text book. [Read aloud from page 290, 'Roger'. Have a group discussion of the case using the discussion questions on pg. 290.]
  - A. What are the reasons for making a home visit?
    1. You can have a more personal conversation in a place where the patient feels comfortable.
    2. You can learn about how the patient lives their life.
    3. A home visit is a way of catching up with patients who maybe be hard to reach by phone
    4. Why else?
  - B. What are the challenges of home visits? [Prompt for answers from textbook, e.g. safety, patients may be embarrassed to show you where they live, privacy, drug use, prior bad experiences with authorities like Child Protective Services.]
  - C. We should approach home visits in a manner that respects our patient's privacy and dignity. Think about how you would feel about having a CHW visit your home, and act accordingly.
    1. When you do an intake with a new patient, always remember to ask up front how you might best protect their privacy on

home visits or when calling them at home. Ask the patient how you should introduce yourself and what you should say if someone else answers the door or phone.<sup>1</sup>

2. When you introduce yourself at the home or leave a message on the phone, don't accidentally reveal private information by saying something like, "Hi, I'm Renee and I'm here about your recent hospitalization." It would be better to say "Hey Bernadette, good to see you today, is this a good time to talk/visit?"
3. When setting up the home visit, tell the patient how long you think it might take, and ask them if that is ok.<sup>1</sup>
4. Demonstrate respect and humility in the home. Remember that your patient might feel ashamed of their living situation—you can use your body language and social skills to make them feel more comfortable:
  - Thank the patient for inviting you to their home.
  - Be friendly, non-judgmental.
  - Compliment them on something in the home, if appropriate.
5. Occasionally our patients have a pest infestation in the home. Patients often feel embarrassed about this, but do not have the financial resources to exterminate. If you feel that the patient's home is unsafe to visit, you are not required to perform home visits, but do not ever act in a way to make the patient feel ashamed of their home.

D. Be well prepared. Before leaving for a home visit, run through a checklist:

1. Did I document the time and location of this visit on the HomeBase Calendar?
2. DOES SOMEONE KNOW WHERE WE ARE?
3. Do we have transportation to and from the home?
4. Did I print out the patient's forms that I need? Review the patient's Roadmaps so that you know what you need to get done.
5. Do I have clear directions and the patient's contact number in my phone?
6. Did I call the patient prior to leaving the office to make sure that they are expecting us?
7. Do we have charged cell phones?
8. Do we have our hospital IDs?

9. Do we have our binders and manuals?
10. Did I print out the patient forms/scripts that I need?

E. While you are on the home visit:

1. At the beginning of the home visit, remind the patient what you hope to accomplish on the visit
2. Pay attention to your surroundings and the patient's environment; you can learn a lot about the assets and challenges that someone has when you are in their home. Compliment them on pretty things, show interest in pictures. This is the fun part!
3. On the flip side, never start to look around a patient's home without the person's knowledge or permission.
4. Establish professional boundaries: Sometimes patients test our boundaries on a home visit because we are in their space. Be mindful and don't answer too many personal questions. If the patient pushes your boundaries, remind the patient that this is their time and your role is to support them. Tell the patient you want to focus on them to make sure they are getting the most of their time with you!
5. At the end of the meeting, summarize what you accomplished today. Explain the next steps for your work together, and review who is going to be responsible for what. Make a plan for your next contact with the patient.
6. Say Good bye and Thank you.
7. Have business card or note ready and available, and leave it somewhere accessible if the patient isn't at home.

II. Addressing the Tricky Parts of Home Visits

- A. Lack of privacy: Some patients share their homes with many people, and do not have a private place to talk. Other patients are homeless, and will need to be visited in a shelter or on the street where others may be around to overhear the conversation. Be very respectful of the patient's privacy, and make sure you keep your voice low so that no one else can overhear. If you aren't sure that there is enough privacy, don't discuss anything confidential, and allow your patient to set the tone for what you will discuss. You can offer to meet at a more private location (like a private space in the clinic or the hospital) if the patient would prefer that.



B. Pushing boundaries: Imagine you are a CHW visiting a patient's home. He or she shows you family photos, and then begins to ask you questions about your personal life, such as whether or not you are in a relationship and your sexual orientation. What would you do? [Allow discussion and then summarize with answer]:

1. If a patient asks you personal questions, be ready with a reply like: "My role is to be here for you, to support you, to improve your health. I don't talk about my private life when I'm at work, because that will distract us—this is your time." Be clear and kind.

C. Drug and Alcohol Use: In the case study we discussed at the beginning of the workshop [Roger, p. 290 Berthold textbook], when the CHW arrived at the patient's home there were empty liquor bottles and drugs scattered around the home. How would you handle this situation as a CHW? What would you do if you arrived at a patient's home and he or she was intoxicated?

### III. Home Visit Safety:

A. Your safety is the most important thing to us. If you feel unsafe, cut short the visit and get out. Let's open our IMPACT CHW manuals and read the CHW Guidelines for a Home Visit in the Safety section. [Read this section out loud].

IV. Field trip to a patient's home: [Facilitators should arrange a visit to a patient's for the group ahead of time. Home visits should be supervised by a Senior CHW who ensures that trainees follow all safety protocol.]

## SESSION 18: OVERVIEW OF OUTPATIENT CARE

Time Required	3 Hours
Recommended Facilitators	Primary Care Physician from Safety Net Clinic and IMPACT Manager
Suggested Content	Definitions Where can people get primary care in our community? Primary care Clinic team members General tips to help you support your patients in primary care Guiding your patient through the clinic appointment Talking to Doctors Practice
Sources	<ol style="list-style-type: none"><li>1. National Academy of Sciences. (2000). America's healthcare safety net: Intact but endangered.</li><li>2. American Academy of Primary Care Physicians. (2013). Primary Care. <a href="http://www.aafp.org/about/policies/all/primary-care.html#primary">http://www.aafp.org/about/policies/all/primary-care.html#primary</a></li><li>3. Institute for Healthcare Improvement. 'SBAR Technique for Communication: A Situational Briefing Model' <a href="http://www.ihl.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx">http://www.ihl.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx</a></li><li>4. Coleman E. The post-hospital follow-up visit: A physician checklist to reduce readmissions. 2010. California HealthCare Foundation. <a href="http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist">http://www.chcf.org/publications/2010/10/the-post-hospital-follow-up-visit-a-physician-checklist</a></li></ol>

Local facilitator may alter the content of Sections I-III.

### I. Definitions

- A. What is Outpatient Medicine? Outpatient medicine is any medical care received by patients who are not currently hospitalized. This could include clinic appointments and home care.

B. What is a Primary Care Provider (PCP)? A Primary Care Provider is your patient's "regular doctor." He or she is a medical provider with broad medical training, who is skilled at recognizing undiagnosed signs and symptoms of all bodily systems.<sup>2</sup>

1. The PCP is your patient's first point of contact with the health care system, and can refer your patient to specialist doctors if a higher level of care is needed.
2. The primary care provider coordinates the care your patient receives from specialists, hospitals, home care and other parts of the health care system.
3. A primary care provider could be trained as a doctor, a physician's assistant or a nurse practitioner.

II. Where can people get primary care in our community?

- A. Private Clinics
- B. Hospital-Affiliated Clinics
- C. City Health Centers
- D. Federally Qualified Health Centers (FQHCs)
- E. Other independent community-based clinics
- F. VA practices
- G. The Emergency Department
- E. For the list above, facilitator should provide:
  1. Definitions, e.g. FQHCs are federally funded, governed by community boards, provide comprehensive services and are not allowed to turn anyone away based on ability to pay, payments are sliding scale.
  2. Local examples
  3. Range of insurances accepted
  4. Policies for treating uninsured patients
  5. Access issues such as long wait times
  6. Special services such as translation, nutritionists, case management, etc.

III. Primary Care Clinic Team Members:

- A. Customer Service Representatives or Receptionists
- B. Medical Assistants
- C. Office Managers
- D. Social Workers & Case Managers
- E. Nurses
- F. Physicians (MDs and DOs)
- G. Physician Assistants (PAs)
- H. Nurse Practitioners (NPs)
- I. Others?

IV. General tips to help you support your patients in primary care: We will review the Pre-Doctor and Doctor Interviews in a little while and these will help you navigate your patient through their clinic visit. But first, let's talk about general principles that will help you support your patient.

- A. Advocate, Support, Give Space:
  - 1. Help your patient find the right doctor (personality, location, office) and feel empowered to switch if they are not satisfied
  - 2. Encourage your patient to stick to the same doctor once they have found one they like, so that they can build a relationship
  - 3. Remind the patient about important issues to bring up (symptoms, forms to sign, health issues)
  - 4. Help the patient be heard and understood
  - 5. Always offer to leave the room for some part of the visit to give the patient privacy with the health care provider for sensitive issues. A good time to leave is just before the physical exam.
- B. Learn how the clinic works, so you can teach it to your patient!
  - 1. How does the patient schedule their next appointment?
  - 2. How can the patient get in touch with the doctor if they have a

question? What about nights and weekends?

3. What additional services does this clinic have in-house, such as a nutritionist, a social worker or smoking cessation classes?
4. How long is the visit? Understand that there's only so much that can be done in 15 minutes. The patient should be prepared to come back frequently if needed.
5. Need a form filled out? Find out the clinic rules.
6. Does the patient need a general physical? Many clinics offer longer appointments if you need a particular exam. Mention that when you book the appointment.

C. Follow-up:

1. Help arrange follow-up studies, labs, referrals, etc.
2. If possible, accompany your patient to their first follow-up event (for example, to physical therapy)
3. Remind the patient to contact the doctor for a follow-up visit if it is required

D. Seeing another doctor or specialist: How do I set up a referral appointment?

1. Call the number for the office of the referral. Have the name, date of birth, and insurance info ready.
2. Set up the appointment. Ask if the patient needs a referral (referrals have to come from the primary care doctor). If so, ask for their referral number
3. Call the primary care doctor's office and ask for a referral to be put through. Provide the date of the appointment and the referral number.

E. Empowerment

1. You won't always be there with the patient! How do you empower your patient to do this on their own? [Prompt for: make 3-way calls and let the patient talk, and just be there for back-up, etc.]

V. Guiding your patient through the clinic appointment:

A. Even the most organized person can find it hard to get the most from a doctor's appointment. When we go in to see the doctor, we might only have 15 minutes to interact. Often we forget to:

1. Ask an important question about our health

2. Mention a symptom we are having
  3. Mention a medication side-affect we are having
- B. For a person with chronic illness or many stressors in their life, it can be extra hard to get the most from a doctor's appointment. Why is this?
- C. We are going to talk about some tips to help your patient get the most out of their doctor's appointment. Remember, your job as a CHW is to teach the patient to do all these things on their own, not just do it for them. This way they can continue to get the most out of their appointments even after you are not working with them.
- D. Let's have 2 volunteers practice the Pre-Doctor Coaching Interview.  
[Ask 2 volunteers to do role-play of Pre-Doctor Coaching Interview.]
- E. Great, now let's include our guest speaker and practice going through the Doctor Appointment Interview.
- F. Great! Remember, before you leave the visit, your patient should:
1. Know the name of the doctor they just saw
  2. Be able to list all of the medications and doses prescribed
  3. Know what tests need to get and how to arrange them
  4. Know what other providers the patient needs to see, have referrals for those visits, and know how to get those appointments.
- G. This is not easy and will not always happen during the 15 minute office visit. As a CHW, you can sit with your patient in the waiting room (or ideally somewhere more private) after the office visit and recap, to make sure they can do the things listed above. If not, don't be shy and ask the doctor or other clinic staff member a question before the patient leaves the office. It is easier to get things done right at the clinic, than to address it over the phone later.
- VI. Talking to Doctors: Doctors are often incredibly busy, so as a CHW it is important to know how to talk with them in a concise manner. We recommend using SBAR.<sup>3</sup> SBAR stands for: Situation, Background, Assessment, Request. The entire SBAR summary should take no more than 2 minutes.

A. Situation

1. Identify yourself, identify the patient (and date of birth)
2. State the problem briefly: what, when, how severe

B. Background:

1. Relevant background information (patient was admitted on X date, admitting diagnosis was Y, give a list of current medications, etc.)

C. Assessment:

1. What is the patient's assessment of the situation? What do they think is going on?
2. What is their concern?
3. What do you think is going on?

D. Request:

1. What would you like the doctor to do?
2. What does the patient want?

VII. Practice: Let's put this all together with some practice. Any brave volunteers willing to role play with our guest speaker?

A. OK, I'm going to give you a scenario: Alex Jones, a patient with diabetes and congestive heart failure, just got home after a doctor's appointment and doesn't understand how to take his new medication. He just moved to this town after living in New York for 12 years and all of his family is still there. He does not have friends in the area and is often socially isolated. His health goal is to reduce his hemoglobin A1C from 12 to 10 over the next 6 months. He wonders if he should call the doctor to ask about the medication, but doesn't know how or what to say.

1. What other information would you want to know?
2. How would you try to get in touch with the doctor?
3. OK, let's do a role play to practice SBAR [Manager should play the part of patient and ask the volunteer to play part of CHW. Guest speaker will play the doctor. Practice SBAR. An important teaching point is keeping the SBAR brief by leaving out information that may not be necessary for the doctor.]

## SESSION 19: THE OUTPATIENT CARE CLINIC TOUR

Time Required	4 Hours
Recommended Facilitator	Senior CHW Clinic Practice Manager
Suggested Content	Clinic Tour Introduction to Practice Staff Clinic Tour Debrief with Senior CHW Homework

I. Clinic tour:

- A. Tour of clinic, including nurse's desk, front desk, lab room, etc.
- B. Explanation of staff roles in this setting & introductions.

II. Introduction to Practice Staff:

- A. Focus on front desk, patient schedulers, social workers and nurses.
- B. Discussion of how CHWs can work with practice staff to improve outcomes for high-risk patients from low-income communities.

III. Clinic Tour Debrief with Senior Community Health Worker:

- A. What did you think about your tour of the clinic?
- B. What questions do you have about the clinic?
- C. How can CHWs support low-income patients in the clinic?
- D. What would you do to make sure that your patient gets to their appointment on time?
- E. What things would you remind your patient to bring with them to the



appointment? To make sure they get the care they need?

F. How can CHWs help make the check-in process go smoothly? How can you make sure that your patient asks the doctor about all the things they need to?

G. How can you make sure that your patient knows how to get in touch with their doctor when they need to?

H. How can you help your patient get referrals they need to see specialists?

IV. Homework: For the next session, please conduct the Pre-Doctor Coaching Interview with one of the other CHWs in the training and enter your notes into HomeBase.

## SESSION 20. MOTIVATIONAL INTERVIEWING, PART II

Time Required	2 Hours
Recommended Facilitator	Certified Motivational Interviewing Expert ( <a href="http://www.motivationalinterviewing.org">www.motivationalinterviewing.org</a> )
Suggested Content	Homework Review What is Motivational Interviewing? The Righting Reflex Identifying Changes that the Patient Wants to Make Exploring Ambivalence about Change Reflective Listening

This session should be delivered by a Certified Motivational Interviewing Expert. A list of these trainers can be found on [www.motivationalinterviewing.org](http://www.motivationalinterviewing.org).

## SESSION 21: STANDARDIZED PATIENT ROLE-PLAY

Time Required	3 Hours
Recommended Facilitator	Penn Center for CHWs
Suggested Content	Standardized Patient Role-Play

In order to assess the progress of the CHW trainees and identify areas that required attention, it is useful to have periodic standardized patient role-plays. These serve as assessments for this training course, rather than written “exams” which have less bearing on the actual job of a CHW. The Penn Center for CHWs can create standardized patient scenarios that are tailored to your local setting and provide trained standardized patients who can provide on-site services.

## PART FOUR: THE CHALLENGES PATIENTS FACE

## SESSION 22: MEDICAL AND HEALTH SYSTEM NAVIGATION CHALLENGES

Time Required	1.5 Hours
Recommended Facilitators	IMPACT Manager Hospitalist Physician
Suggested Content	Clinical Case Presentations Contacting a Doctor Review of SBAR and Health System Navigation Homework
Sources	1. Institute for Healthcare Improvement. 'SBAR Technique for Communication: A Situational Briefing Model' <a href="http://www.ihl.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx">http://www.ihl.org/knowledge/Pages/Tools/SBARTechniqueforCommunicationASituationalBriefingModel.aspx</a>

Local facilitator may alter the content of Section I.

- I. Clinical case presentations: Hospitalist guest speaker should present two cases and ask for discussion after each:
  - A. Emergency Case
  - B. Non-Emergency Case
  - C. Hospitalist should explain that it is often difficult to know whether something is an emergency and CHWs should not attempt to make this judgment. Rather, per the IMPACT protocol, they should allow patients to make the decision of when they should seek emergent care. The exception is if CHWs, as lay-people, feel that calling 911 is clearly necessary (e.g. if a patient is unconscious, cannot breathe, etc.).
- II. Contacting a doctor: Sometimes it can be difficult to know when to contact a patient's doctor, and which doctor to contact. Let's go over this

using your IMPACT manuals. There are slightly different guidelines for Outpatient and Transitions CHWs, so we will go over each.

- A. [Ask volunteers to read 'Step 10: Get Patients Help if Medical Issues Arise from Home' in the IMPACT Outpatient Manual. Answer any questions.]
  - B. [Ask volunteers to read 'Step 12: Get Patients Help if Medical Issues Arise from Home' in the IMPACT Transitions Manual. Answer any questions.]
  - C. Remember that as a CHW, you should never give the patient medical advice!
  - D. Now, I'd like us to practice paging a doctor because I know many of you may not have done this before. [Practice paging the guest speaker.]
- III. Review of SBAR and Health System Navigation. Next, we are going to do some practice scenarios to review SBAR and to apply what we have learned about navigating the health system.
- A. I'm going to give you a scenario: Rhonda Murphy is a 42 year-old woman with lupus and kidney failure. She recently became homeless because her abusive ex-boyfriend threw her out of his house. Sometimes she stays with friends who live far away from her dialysis center, so she misses her treatments. She was discharged from the hospital last week after an admission for "too much fluid". She was supposed to go to dialysis the next day, but has not been there yet. When you call to check up on her, she sounds a little short of breath.
    - 1. What other information would you want to know?
    - 2. What would you do next?
    - 3. OK, let's do a role play to practice SBAR [Manager should play the part of patient and ask a volunteer to play the part of a CHW. Guest speaker will play the doctor. Practice SBAR. An important teaching point is keeping the SBAR brief by leaving out information that may not be necessary for the doctor.]
  - B. Another scenario: James Roberts is a 55 year-old man with hypertension and emphysema who had an appointment. He saw his primary care doctor 1 week ago and got a prescription for a new

medication because his pressure was up. He found out that the co-pay for the medication is \$40, which he cannot afford.

1. What other information would you want to know?
2. What would you do next? [Prompt for: check to see if this medication is listed on the Walmart or other low-cost formulary. If so, the CHW should provide this information to the patient, and may not even need to call the doctor. In this scenario, the Manager should assume that the medication is not on the formulary, so the CHW will have to call doctor.]
3. OK, let's do a role play to practice SBAR [Manager should play the part of patient and ask the volunteer to play the part of CHW. The guest speaker will play the doctor. An important teaching point is keeping the SBAR brief by leaving out information that may not be necessary for the doctor.]

C. OK, here is one more scenario: Tiffany Reed is a 48 year-old woman who has multiple sclerosis. Her wheelchair recently broke and she has not been able to get around the house. She does not have a doctor's appointment scheduled for another 3 months.

1. What other information would you want to know?
2. What would you do next? [Prompt for: call her insurance company to find out whether they can replace her wheelchair. Assume they require a prescription. CHW should role-play calling the clinic and asking for a prescription or getting an expedited appointment.]

D. OK, here's the last one: You are going on a home visit to see your patient Jackie Bledsoe. She has a seizure disorder and diabetes. She lives with her mother. When you arrive, her mother tells you that Jackie has not been herself and has been staring off into space for the past day. The family thinks she is upset because "there is a lot going on." They have not gotten in touch with her doctor who knows her well. Jackie is sitting in a chair with a strange look on her face and not responding to you. This is not normal for her.

1. What other information would you want to know?
2. What would you do next? [Prompt for: call 911. Then also notify her regular doctor.]

IV. Homework: For the next session, please conduct the Pre-Doctor Coaching Interview with another CHWs in the training and enter your notes into HomeBase.

## SESSION 23. PSYCHOSOCIAL CHALLENGES: TRAUMA, MENTAL HEALTH AND SUBSTANCE USE

Time Required	5 Hours
Recommended Facilitators	IMPACT Manager Behavioral Health Expert
Suggested Content	Homework review Review of Trauma Mental health overview and resources Substance abuse overview and resources De-escalation
Sources	1. National Center on Domestic Violence, Trauma and Mental Health. (2011) Understanding traumatic triggers. <a href="http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Infosheet_Understanding-Traumatic-Triggers_NCDVTMH_Dec2011.pdf">http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Infosheet_Understanding-Traumatic-Triggers_NCDVTMH_Dec2011.pdf</a>

Local facilitator may alter content of Section II-IV.

- I. Homework Review: I've reviewed each of the interviews you entered into HomeBase and provided you with some feedback.
- II. Review of Trauma: Trauma is often at the heart of a lot of the mental illness and substance abuse that we see in our community. So, we are going to start off this session by reviewing trauma-informed care.
  - A. Can anyone remind us of what PTSD is?
  - B. Can anyone remind us of some of the symptoms of PTSD?
    1. Quick to anger/ highly irritable
    2. Difficulty sleeping
    3. Flashbacks or nightmares
    4. Hypervigilance
    5. Emotional numbness/detachment
    6. Intense feelings of guilt or worry
    7. Unable to imagine the future



- C. Some of the reasons for these symptoms are that people who have lived through trauma can sometimes re-experience the traumatic event in their mind and in their body. A “traumatic trigger” is something that reminds you of a traumatic event you experienced in the past, potentially causing you to re-experience the trauma.<sup>1</sup>
1. A trigger might be a smell, a color or a word. Here are some examples:
    - Mary was frying sausages for her daughters when her husband assaulted her. The smell of frying sausages is now a trigger for Mary.
    - Antoine’s childhood friend was shot when they were playing basketball in the street. Now the sound of a car backfiring is a trigger for him.
    - Leslie’s ex used to terrorize her if she didn’t keep the house perfectly tidy. Simply being told to make her bed by the staff of the domestic violence shelter is a trigger for her.
    - Many of us have gone through traumatic experiences. Sometimes, even talking about these triggers can be upsetting. How is everyone doing?
  2. A trigger can cause intense anxiety, a panic attack, fear or anger. Your patient might know that he or she is being triggered, or they might just feel scared or angry and not know why. Learning to recognize trauma triggers is an important skill patient can learn to further their mental health treatment.
  3. Once you learn what is triggering to a patient, you might feel like you want to get rid of all the triggers. But we cannot control the world for our patients. What we can do is:<sup>1</sup>
    - Remain calm and supportive ourselves
    - Help our patients call the domestic violence counseling hotline or get to a safe place if needed
    - Hook them up to mental health treatments for trauma, and try to help them learn new coping skills to recognize and deal with triggers when they come up
  4. Here are some useful coping skills for trauma triggers:
    - Meditation or prayer
    - Relaxation techniques (figure out what works for you, whether it is listening to music, a walk in the woods or deep breathing)
    - A friend or loved one to support you

- Knowing your triggers and making a safety plan (i.e. if my mom starts to yell at me, I will excuse myself and go for a walk or visit a friend until I cool off).
- D. Great. Now that we have talked in more detail about triggers, I just want to zoom out and review the general tips that I gave you at the beginning of this training on providing trauma-informed care.
1. Help the patient feel in control from the beginning of the encounter
    - Ask permission to enter the room/ speak with the patient
    - At the beginning of your meeting, summarize the major goals for your encounter and how long you expect it will take
  2. Use deep listening skills
    - Make eye contact
    - Use open and receptive body language
    - Use reflections to indicate that you are listening and make sure you really understand what the patient is saying
  3. Ask permission for all physical contact.
  4. Don't be afraid to ask patients about trauma history, particularly if you see possible signs of PTSD or a lot of psych diagnoses in the medical record.
    - Ask in a way that normalizes their experience: "many of my patients have had a traumatic experience when they were young. "
    - Ask permission to ask about trauma history: "A lot of my patients who are struggling with the types of issues you have had traumatic experiences when they were younger. If it is OK with me asking, how is that for you?"
  5. Normalize and validate the patient's feelings
    - Trauma can be isolating and the symptoms of PTSD can make you feel like you are crazy. Say things like:
    - "I'm so sorry that happened to you. You didn't deserve that."
    - "You are obviously a very strong and resourceful person to get through that."
    - "After what you have been through, it is so impressive that you are coming in here to take care of your

health.”

6. Be aware of what trauma symptoms might look like as you work with patients. Realize that patients often have good reasons for doing the things they do that are not always immediately apparent
  - Angry outbursts and irritability (Ask yourself if these might be PTSD symptoms)
  - What is the reason my patient doesn't take her meds? (Survivors of sexual abuse sometimes unable to swallow large pills)
  - Drugs and alcohol abuse are often used to numb PTSD symptoms
7. Help the patient feel in control of their choices and the plan they are working on with you:
  - Always ask permission to share information with the patient.
  - Then lay out all the available options and allow your patient to choose.
  - Make it clear that the decision is ultimately up to the patient
8. Establish good boundaries throughout all encounters with the patient. Patients who have experienced trauma can have a hard time establishing boundaries. You can help by modeling good boundaries in your professional relationship.
  - If their behavior is inappropriate, let them know.

III. Mental health overview and resources: A local behavioral health expert should provide tailored content focused on:

- A. A sample mental health case
- B. Descriptions of common mental health conditions that are prevalent in a local population
- C. Overview of the local behavioral health system
- D. List of mental health resources
- E. Returning to the sample case and asking CHWs how they would handle this patient

IV. Substance abuse overview and resources: A local behavioral health expert should provide tailored content focused on:

- A. A sample substance abuse case
- B. Descriptions of common addictions that are prevalent in a local population
- C. Overview of the local addiction recovery system
- D. List of addiction resources
- E. Returning to the sample case and ask CHWs how they would handle this patient

V. De-escalation:

- A. De-escalation is when we use assertive communication skills to:
  - 1. Calm down someone who is agitated, angry or temporarily out of control.
  - 2. Take charge of a situation to minimize the potential for a dangerous reaction.
  - 3. Respond to a hurtful situation that occurred in the past by focusing on present.
- B. Here are some indicators that a patient is becoming agitated and may need de-escalation:
  - 1. Voice is raised
  - 2. Speech becomes rapid
  - 3. Patient perspires excessively
  - 4. Out of control gesturing
  - 5. Fidgeting (e.g. leg shaking)
  - 6. Trembling (body, lips)
  - 7. Voice becomes high-pitched
  - 8. Patient starts to pace
  - 9. Patient balls fists
  - 10. Patient body language is aggressive (sitting forward in chair, glaring, sneering)
  - 11. Patient abruptly stops talking
- C. Here are some de-escalation skills that may help you deal with an

agitated patient. But remember, the main thing to keep in mind is SAFETY. Protect yourself and remove yourself from an unsafe, escalating situation as soon as possible. Do not feel like you need to stick around and diffuse a situation if it feels unsafe.

1. These general strategies will help keep you poised and calm so that you are less likely to be escalated yourself:
  - Acknowledge your limitations
  - Reframe your thinking so that you are clear that these responses are not personal
  - Use self-care strategies to mitigate ongoing personal stress
2. If you are in a situation when a patient is becoming upset (but is not unsafe), here is what you can do:
  - Take 10 seconds to ground yourself before responding: assess your emotions, BREATHE.
  - If possible, ask yourself:
    - \* What is happening here?
    - \* What do I want to accomplish?
    - \* What does my patient really want/need?
    - \* Recognize when you have reached the end of your capacity to negotiate with your patient and plan your exit strategy.
  - Non-verbal Techniques for De-Escalation:
    - \* Maintain calm demeanor
    - \* Maintain eye contact
    - \* Maintain a neutral facial expression
    - \* Keep a relaxed yet alert posture (sit or stand up straight)
    - \* Avoid excessive gesturing.
    - \* Always stay at the same eye level.
    - \* Encourage the patient to be seated if patient is standing
    - \* Never turn your back to patient
    - \* Place hands in front of body in open position
    - \* Do not point finger at patient
    - \* •If changing the environment is an option, consider doing so
    - \* Try to stay out of the "Grab Zone" Be mindful of things around your neck
  - Verbal Techniques for De-Escalation
    - \* Use the patient's name

- \* Use present tense: focus on now.
- \* Try to allow the other person to “save face”
- \* Acknowledge their feelings
- \* Say what you can do right now
- \* Try to move towards a resolution
- \* Listen to your voice
- \* State the consequences of unacceptable behavior without threats
- \* Your primary goal of the conversation is to calm the patient down (without saying it)
- \* Apologize, if appropriate
- \* Consciously lower your voice and stay monotone
- \* When patient takes a breath, then speak (don't try to talk over them)
- \* Be respectful in setting limits but use an authoritative tone
- \* When answering questions: stick to factual ones
- \* Don't lie
- \* When possible give choices
- \* Use reflective, feeling comments and “I” statements

D. Trust your instincts! Again, if you feel threatened remove yourself from potential harm immediately. [Review the Safety protocol in IMPACT CHW manual].

## SESSION 24. PSYCHOSOCIAL CHALLENGES: FAMILY, FRIEND AND NEIGHBORHOOD STRESS

Time Required	5 Hours
Recommended Facilitators	IMPACT Manager
Suggested Content	Tailored approach to social stress Understanding social stress for Profile A patients Addressing social stress for Profile A patients Understanding social stress for Profile B patients Addressing social stress for Profile B patients Neighborhood and community stress
Sources	<ol style="list-style-type: none"> <li>1. United States Department of Health and Human Services. (2008a). Compassion in action: Informal caregiving. <a href="http://aspe.hhs.gov/daltcp/reports/carebro2.pdf">http://aspe.hhs.gov/daltcp/reports/carebro2.pdf</a></li> <li>2. Department of Health and Human Services. (2008b). Caregiver Stress Factsheet. <a href="http://www.womenshealth.gov/publications/our-publications/fact-sheet/caregiver-stress.pdf">http://www.womenshealth.gov/publications/our-publications/fact-sheet/caregiver-stress.pdf</a></li> <li>3. Yehuda, R., Halliga, S. L. &amp; Grossman, R. (2001). Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion. <i>Development and Psychopathology</i>, 13 (2001), 733-753.</li> <li>4. Kathryn L.S. Pettit, G. Thomas Kingsley, and Claudia J. Coulton &amp; Jessica Cigna. (2003). Neighborhoods and health: Building evidence for better policy. Submitted to: The Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services by The Urban Institute <a href="http://aspe.hhs.gov/hsp/neighborhoods-health03/index.htm">http://aspe.hhs.gov/hsp/neighborhoods-health03/index.htm</a></li> <li>5. Brown, A. F., Ang, A., Pebley, A. R. (2007). The Relationship Between Neighborhood Characteristics and Self-Rated Health for Adults With Chronic Conditions <i>Am J Public Health</i>, 97(5): 926-932.</li> <li>6. Cubbin, C., Pedregon, V., Egerter, S. &amp; Braverman, P. September 2008. Where We Live Matters for Our Health: Neighborhoods and Health Robert Wood Johnson Foundation. Neighborhood Brief 3: Neighborhoods and Health. <a href="https://folio.iupui.edu/bitstream/handle/10244/638/commissionneighborhood102008.pdf">https://folio.iupui.edu/bitstream/handle/10244/638/commissionneighborhood102008.pdf</a></li> </ol>

- I. Tailored approach to social stress: Many patients talk about the toll friend and family stress takes on their lives and health. We call this social stress. The families and communities our patients come from are often under tremendous strain, whether it is financial stress, family housing instability, health problems, or trauma from exposure to violence in their neighborhood, community or family. In the IMPACT model, we have slightly different strategies for Profile A patients versus Profile B patients.
  - A. Can anyone remind us of the differences between Profile A and B patients?
  - B. Great—of course no patient fits these types perfectly, so you will need to follow your gut about the best approach to try.
- II. Understanding social stress for Profile A patients:
  - A. This again goes back to trauma. A lot of Profile A patients have experienced trauma and this may create a cycle of family and social dysfunction, mental illness, substance abuse and physical illness.
  - B. A key point is that often, Profile A patients have friends and family who have also gone through trauma. They can often “inherit” their parents’ and family member’s approach to dealing with stressful situations. To understand this better, let’s have a discussion:
    1. Think back to when you were a small child, to a time you watched one of your caretakers handle a stressful situation. Maybe it was your mother, or your father, or a grandparent.
      - How did they handle it? How did they react?
      - You can probably think of times when they handled it calmly and confidently, and other times when they were scared, angry or really stressed out.
    2. We all learn to process stress and trauma from watching the adults in our lives. Kids are like sponges that absorb emotion from adults.
    3. If your patient grew up in a family with caretakers who have experienced a lot of repeated trauma, what examples are they likely to see of how people handle stress? Are they more likely to witness arguments? How could this affect the skills they learn for dealing with stress and trauma? Will this make it harder for them to keep their cool in a stressful situation or successfully resolve conflicts with their loved ones?



4. Imagine a calm lake. What happens to the surface of the lake when you throw a rock in it? Trauma in a community is like a rock thrown into a lake. It doesn't just affect one person, it ripples outward, affecting the family, the neighbors, the community. In some families, where there is repeated stress and violence, the trauma can ripple through the whole family over and over again.
  - Not only can families end up with dysfunctional ways of relating to one other, but kids are more likely to grow up with stress and trauma themselves in their adult lives. Studies have shown that kids whose parents have PTSD are more likely to get PTSD.<sup>3</sup>
  - Trauma & "drama" are often connected. When you have a patient with a lot of friend drama or family drama, keep in mind that there could be some trauma under the surface

### III. Addressing social stress for Profile A patients

- A. Profile A patients may not be ready to do much about their social stressors, or even talk about them with you at first. Why do you think this might be? [Prompt: because this can be a trigger, or because they never learned to talk about difficult emotions, etc.]
- B. The key to approaching a Profile A patient is use the principles of trauma-informed care. Trauma-informed care includes really listening to the patient and being very empathic and supportive, as well as letting the patient feel in control of what is happening to them. Building trust and creating a safe and supportive relationship with the patient is the most important thing. Tell the patient what they can expect from your conversation, ask permission as much as possible and give them control and choice in the interaction. Focus on taking it slow, building trust and not being controlling. Do not try to make this person create Roadmaps that they are not ready for.
- C. Your goals for a Profile A patient with social stress should be to:
  1. Try to slowly get an understanding of the relationships the Profile A patient has. Identify any healthy and positive relationships and try to foster them. The reason for this is that Profile A patients will need support well beyond any intervention that a CHW can provide, even if the intervention

lasts 6 months. So you should focus on helping the patient build lasting relationships that can offer them support even when you are gone.

2. Help the Profile A patient connect with a sense of joy or purpose in life. Ask the patient: “When was the last time you felt joy?” “What gives you joy or used to give you joy?” Help them to reconnect with these things (e.g. going to a music class if they used to enjoy music, joining a bowling league, etc.). Connecting people with joy and purpose can help them to be motivated to do other things, like rebuild relationships.
3. Conflict resolution skills: Model positive ways of communicating, dealing with conflict, and relating to the people who cause them stress. Help the patient think about the things they can and cannot change in their relationships. You can’t make another person change, but you can change the way you react to them.
4. Model good boundaries. Type A patients may have trouble with boundaries, and once they trust you, they might test your boundaries. Make sure to give the patient firm boundaries but unconditional support.
5. Recognize and plan for triggers: You want to start helping the patient learn some basic skills for dealing with the triggers of stress, anger or trauma and make a plan to address triggers before they cause a problem. Ask the patient to think about what triggers them to feel really stressed or angry, or to have an argument with a loved one. For example, if your patient gets in a lot of fights with his mother and has trouble controlling his anger, you can ask him to make a plan for next time his mother says something that upsets him. His plan could include things like:
  - Going for a walk around the block
  - Listening to relaxing music
  - Leaving the house and calling a supportive friend

#### IV. Understanding social stress for Profile B patients

- A. Profile B patients are usually informal caregivers of their family and friends. An informal caregiver is a person who helps another person in need, with tasks such as grocery shopping, cooking, cleaning, bathing, paying bills, giving medicine, dressing, using the toilet and doesn’t get paid for it. Sound familiar? CHWs themselves are often

Profile B patients. What do you all think about that?

- B. The following are some statistics on informal caregivers:<sup>2</sup>
1. Most of us will be informal caregivers at some point in our lives. 31% of adults in the US provide care to an elderly or disabled person
  2. 80% of the care for the elderly and disabled is provided by unpaid family members or community members.
  3. About 60% of caregivers are female and 40% are male
  4. Most informal caregivers are middle-aged
  5. More than half of informal caregivers also have a job
- C. So, Profile B patients are often the ones that people “depend upon” to bring home a paycheck, care for a sick family member, or deal with a crisis. While this can be a really special role, it can also be very stressful. The stress that comes with having to care for friends and family stress is called caregiver burden.
1. “Caregiver burden” is the emotional and physical stress of caring for another person. It can make you feel good and give your life meaning to care for another person. However, caregivers can feel frustrated, isolated, stressed out and physically exhausted from caring for another person. This is more likely to happen when caregivers themselves are not getting the support they need.
    - What do you think are some reasons that Profile B patients may not get the support they need as caregivers?
    - One reason is that Profile B patients themselves, and their family and friends have limited income and often struggle with poor health. If everyone in the patient’s family and community are low-income and sick themselves, then they can’t do much to help. This can leave the caregiver feeling very stressed out and exhausted. Research shows that informal caregivers who suffer the greatest caregiver burden are racial minorities and people from low-income communities.<sup>2</sup>
  2. Caregivers are likely to :
    - experience stress, anxiety or depression more frequently
    - to have a chronic medical issue, such as diabetes, heart disease or cancer

- have higher levels of stress hormones
  - Get sick more often and have a weaker immune response
  - Have slower wound healing
  - Have higher levels of obesity
3. One reason why caregivers may have health problems is that it is difficult for them to focus on their own health and wellbeing. Compared to those who are not caring for a disabled or elderly person, caregivers report that they are less likely to:
- Get medical care they need for themselves
  - Fill their own prescriptions because of the cost
  - Get preventative health care such as a mammogram or colonoscopy
  - Get sufficient sleep at night
  - Eat healthy meals
  - Get a healthy amount of physical exercise

#### V. Addressing social stress for Profile B patients

- A. The ways to help Profile B patients with social stress are:
1. Find resources in the community that help them with care giving. Provide “instrumental support” by actually helping them to get these resources, rather than just handing them a referral. Examples of such resources are:
    - Transportation for themselves and the person they care for
    - Childcare resources such as subsidies through the county assistance office
    - Meal delivery such as Meals on Wheels
    - Help them set up home health care or homemaker services
    - Legal and financial counseling
  2. Encourage self-care activities such as:
    - Creating “me-time,” even if it lasts just 15 minutes per day.
    - Getting involved in faith or community groups
    - Being physically active, eating a healthy diet, and getting enough sleep.
    - Attending a support group for caregivers or single parents

3. Help your patient develop skills to deal with caregiver stress:<sup>2</sup>

- Help the patient identify what they can and cannot change. They may not be able to change someone else's behavior, but they can change the way that they react to it.
- Help the patient set realistic goals. Break large tasks into smaller steps that they can do one at a time.
- Help the patient prioritize, make lists, and establish a daily routine
- Help the patient learn how to ask for help
- Help the patient set limits with friends and family members

VI. Neighborhood and Community Stress

A. The environment we live in can have huge effects on our health.

1. Think about the neighborhoods your patients live in.

What is the community like? What businesses are in the neighborhood? Are there grocery stores? Places for people to work? Is there gun violence? Drug use? Are the houses and apartments well kept?

2. Studies have shown that these kinds of neighborhood conditions are very closely related to chronic illness, disability, health behaviors and mental health.<sup>4,5,6</sup> Can you give me some examples of how the neighborhood and environment can affect health?

- For example, low-income neighborhoods often have fewer places to buy fresh fruit and vegetables, and more places to buy cigarettes. This doesn't mean that everyone who lives there chooses to smoke, but it can make it harder for someone to make a healthy choice.
- Another example could be air pollution. If a neighborhood is close to a factory, there might be chemicals in the air that could make a patient's asthma worse.
- Another way that the place we live in affects our health is through stress. A neighborhood with violence or drug activity, or next to a highway with a lot of noise from traffic can be a stressful environment.
- How do you think this affects the mental health of the people who live there?

- Now imagine a patient who has already experienced a lot of trauma in her personal life, a woman who is a domestic violence survivor. How might living in a neighborhood with gun violence affect a woman who was a domestic violence survivor?
- B. Addressing neighborhood stress: Sometimes patients tell us they would like to move out of their neighborhood. You can help them think about their options, which might include moving in with family or filling out applications for housing programs. But sometimes it does not make sense for a patient to move, so we have to find other solutions to the problem of neighborhood stress.
1. Connect the patient to positive neighborhood resources. Help the patient get involved with neighborhood activities, at places such as recreations centers and senior centers; this can help them tap in to the positive and supportive social networks in their neighborhood.
  2. Connect patients to advocacy. If there is a neighborhood advisory committee or a neighborhood association in the area where the patient lives, you can help the patient find out if there are ways they can participate to fix the problems in their neighborhood.
  3. What else would you do to help address neighborhood stress?

## SESSION 25. RESOURCE CHALLENGES: PUBLIC BENEFITS OVERVIEW

Time Required	2 Hours
Recommended Facilitator	Legal Aid Attorney
Suggested Content	Overview of public benefits Medicaid Medicare Affordable Care Act SCHIP Common legal issues

Local facilitator may alter content of all Sections

### I. Overview of Public Benefits

- A. Temporary Assistance for Needy Families (TANF)
- B. General Assistance
- C. Food Stamps
- D. Low Income Home Energy Assistance Program (LIHEAP)
- E. Child Care Information Services (CCIS)
- F. Social Security Disability Insurance (SSDI)
- G. Supplemental Security Income (SSI)

### II. Medicare

- A. Background

B. Eligibility

C. Parts A, B, C, D

D. Managed Medicare

III. Medicaid

A. Background

B. Eligibility

C. Managed Medicaid

IV. Affordable Care Act

A. Background

B. Eligibility

V. SCHIP

A. Background

B. Eligibility

VI. Common legal issues: For each of these issues, provide a brief overview and explain how to get legal aid:

A. Foreclosure

B. Landlord/Tenant issues like eviction or poor housing conditions

C. Utilities shut off

D. Family law (child support, custody, child protective services, elder abuse, etc.)

E. Domestic Violence

F. Debt Collection



G. Criminal Cases

H. Expungement, pardon, criminal records issues

I. Worker's compensation

J. Unemployment Compensation

K. Wrongful termination of employment

## SESSION 26. RESOURCE CHALLENGES: APPLYING FOR BENEFITS

Time Required	2 Hours
Recommended Facilitator	Social service provider skilled at completing benefits applications
Suggested Content	General strategies Forms Appeals Legal advocacy

Local facilitator may alter content of Sections I-IV.

### I. General strategies

- A. Building relationships with Department of Public Welfare (DPW) administrators
- B. Chain of command within the local County Assistance Office
- C. Documenting and creating a paper trail

### II. Forms. Facilitator should supply trainees with copies of public benefits application form, and any common supplemental forms (eligibility forms filled out by doctors, etc.).

- A. Proof of Disability: Instructions for doctors who are filling out this form
- B. Proof of Residence: Supply proof of residence for patients with unstable housing.
- C. Proof of Income: Supply proof of income for patients who do not receive formal paychecks

D. Proof of identity: How to obtain if missing

III. Appeals: Description of process if the application is denied

IV. Legal advocacy: How to access this if patients feel that their applications are denied unfairly

## SESSION 27. RESOURCE CHALLENGES: OVERVIEW OF COMMUNITY RESOURCES

Time Required	2 Hours
Recommended Facilitator	Senior CHW
Suggested Content	Cases Review of connecting patients to resources Community Resource Database Locating new community resources

I. Cases: We are going to talk about how to connect patients to community resources. Let's start with a case:

A. Wilma Mack is a patient of your outpatient practice. She recently delivered a baby, and you are doing a home visit to check in on her. During the home visit, Wilma indicated that her Public Assistance check had been cut off; she is low on food and has used all her food stamps. Wilma was also concerned about obtaining additional items for her infant as she delivered early and asked if she can borrow money from you. In further assessing the situation, it is also apparent that she is having difficulty managing her utility bills.

1. What issues need to be addressed?
2. What referrals would you suggest?

B. Robert Truly was recently discharged from the hospital. You have tried to contact him by phone, but have been unsuccessful, so you do a home visit. When you arrive, you find him at home, where he tells you that his phone has been disconnected. He further indicates he has not made a follow up appointment with his primary care doctor after getting out of the hospital because he doesn't have a phone.

1. What would you do?
2. Who would you contact?

II. Review of connecting patients to resources. Let's take this time to review

how we connect our patients to resources in the IMPACT model.

- A. Call ahead to make sure the service exists
- B. Ask questions to make sure that your patient will be eligible for the service
- C. Go with your patient or make the phone call with them. Encourage them to do the talking so they can do it on their own next time!
- D. Help your patient gather the papers and documentation they need: Make sure it gets submitted correctly
- E. Follow up and ask the patient if the service is working out for them
- F. Advocate for your patient if needed

### III. Community Resource Database:

- A. You are in this room because you have a long history of working with the community. You have been hired in part because of your wealth of knowledge of community resources. What we are going to do together is update our Community Resource Database (CRD). This CRD is a database of local resources for our patients. [See example CRD page in the back of this manual.]

[If this is your first training, you can create this database during the training with the help of the CHWs].

- B. Hand out copies of the Community Resource Database:

Example Database:

1. Let's go over a few things about the form's layout:
  - How to locate a resource by keyword
  - How the information on each resource is organized
  - How resources are grouped
  - This is a working document—there are always new resources, and places are always losing funding
  - We would love if you had any suggestions for resources to add to the community resource database
2. Now let's go back to the cases we talked about earlier. Are there any more resources on the CRD that would be useful for

these patients?

IV. Homework: Your homework is to add 5 resources to the CRD that have not already been listed.

## SESSION 28. HEALTH BEHAVIOR CHALLENGES: RESEARCH TESTED INTERVENTION PROGRAMS

Time Required	1 Hour
Recommended Facilitator	IMPACT Director
Suggested Content	Homework Review RTIPS
Sources	
	1. Research-tested Intervention Programs (RTIPs) <a href="http://rtips.cancer.gov/rtips/programSearch.do">http://rtips.cancer.gov/rtips/programSearch.do</a>

- I. Homework Review: Did everyone add 5 resources to the CRD? Please hand them in [Make note of anyone who did not complete homework and talk to them about this after class].
  
- II. RTIPS: When we are working with a patient on health behavior change, it is always a good idea to examine what has worked well for other people in the past. If your patient wants to quit smoking, for example, you may want to check out quit smoking techniques that have been proven to work.
  - A. What are RTIPS? RTIPS are Research Tested Intervention Programs. These are strategies for behavior change that have been tested on patients and found to be effective. You may be able to apply some of these strategies to your work with IMPACT Patients. RTIPS can save us from having to reinvent the wheel when we work with patients.
  
  - B. There is an online RTIPS database that is a very useful tool. Let's go through it together. [Project the RTIPS website: <http://rtips.cancer.gov/rtips/programSearch.do>]
    1. Let's say we are trying to work on healthy eating habits with patients in the community we serve. What search terms should we enter on the RTIPS website? [Conduct search on the RTIPS website for tested interventions that are relevant

to your local patient population and health goals. Select a relevant intervention and read the web page as a group.]

2. What other RTIPS are you curious about? [Conduct the searches together.]

III. Homework: For the next session, please conduct the Meet the Patient Interview with a friend or family member and enter your notes into HomeBase.



## PART FIVE: ENDING AND CONNECTING

## SESSION 29. FACILITATING A HEALTHY LIVING GROUP

Time Required	3 Hours
Recommended Facilitator	IMPACT Manager
Suggested Content	Homework Review Introduction Preparing to run a group Beginning stage of a group The middle stage of the group. Ending stage of the group
Sources	<ol style="list-style-type: none"><li>1. Berthold, T., Avila, A. &amp; Miller, J., Eds. (2009). Foundations for community health workers. JosseyBass Public Health, San Francisco, CA.</li><li>2. Shulman, L. (2009). The skills of helping individuals, families, groups and communities, Sixth Edition. Brooks/Cole; Belmont, CA.</li><li>3. Yalom, I. &amp; Leszcz, M. (2005). Theory and practice of group psychotherapy, Fifth Edition. Basic Books; New York, NY.</li></ol>

- I. Homework Review: I've reviewed each of the interviews you entered into HomeBase and provided you with some feedback.
- II. Introduction: One of the exciting things that IMPACT Outpatient CHWs do is facilitate a support group along with me.
  - A. How do you feel about facilitating a group? What are you excited about? What are your fears?
  - B. What are the benefits of a group, from your own experience or from your work with patients in the past?
  - C. [Prompt for answers from the Berthold textbook, p 482]
  - D. We are going to talk through the phases of a group and your core

tasks for each phase:

1. Preparing for the group
2. Beginning
3. Middle
4. End

### III. Preparing to run a group:

- A. Preparation is a very important stage. This is the work you do with your patients to get them ready for the group. Many patients will have fears about being in a group, or will not understand how the group will help them. Some patients have had negative experiences with groups in the past.
- B. The goals for a CHW at the preparation stage of the group are to help the patient know what to expect, understand how the group might help them reach their own goals, and get excited about the group.<sup>2</sup>
- C. CHWs should meet with the patient individually, to discuss the group and invite them to participate in the group. Explain the purpose of the group, and ask the patient what they think about the idea of participating. Listen carefully for any concerns or fears the patient may have about attending the group—concerns that you do not address may make them decide not to attend. At this stage, you can also help the patient think about reasons the group might be helpful to them.
- D. If possible, the group facilitators should meet patients individually or call patients to discuss the group and give them a chance to get to know the facilitators individually. This can be very helpful in making the patient feel comfortable enough to attend the group.<sup>2</sup> CHWs should call the patient to remind them about the group beforehand and help arrange transportation, the same way you would for a doctor's appointment.
- E. Let's read the Preparation section of the IMPACT Healthy Living Group Manual together [Ask for volunteers to read this section.]

### IV. Beginning stage of a group:

- A. The beginning stage sets the tone for all the work that the group will do together. It can be a scary experience for patients, so the group facilitator needs to be inviting, encouraging and nonjudgmental. It is also important to establish what the purpose of the group will be and how it will work.
- B. The goals of the first group meeting are to have a clear purpose for the group, make ground rules for the group, encourage the group members to talk to each other instead of the group leader, help make a safe space for people to talk, and give the group members a chance to give feedback on the group<sup>1,2</sup>
- C. To get a sense of the structure of the group meeting, let's read through Session 1 in the IMPACT Healthy Living Group Manual together [Ask for volunteers to read this section.]
- D. Here are a few tips to keep in mind for the first group meeting:
  - 1. At this stage, the group members are testing each other and you, to see if they can trust the group enough to share the real issues. You may notice that some people talk a lot, and some people are quiet. Use this as a chance to listen and get to know the people in the group. Don't try to make people talk yet if they're not ready.
  - 2. Be aware of your facial expression and body language. You have a position of authority as a group leader. At the beginning, group members are watching you to see if you play favorites, or if you are judging them. Use your eye contact and body language to support everyone in the room equally. Take extra care not to appear judgmental.

V. The middle stage of the group.

- A. The middle of the group is the real meat, the work that the group does together. This is where you have created a little community, with trust, support and conflict. They group members know each other well enough to support each other and also get on each other's nerves. The group becomes a little universe, so if people learn a good way to handle stress and arguments in the group, they take this skill home with them to their friends and family.

- B. Your goals for the middle stage are to build the community by encouraging group members to interact with and support one another, and to address conflicts as they arise.<sup>1</sup>
- C. Here are some times to keep in mind for the middle stage:
1. Watch and listen to the group to see how roles emerge. Some of the roles that members of the group might take on are the leader, the scapegoat, the rebel, the caretaker, the monopolizer, the quiet member.<sup>2</sup>
    - Why might it be important to think about the roles that people have in the group?
  2. Watch and listen to see how relationships emerge. If two people become friends outside of the group, how could this affect the group as a whole? How might it be a positive thing?
  3. Encourage the group members to talk to one another and not to you. You can do this by saying things like, "Can anyone else relate to what Mike is saying?" "Does anyone have any thoughts about the story Oscar just shared?"
  4. Draw out the quiet members, or even better, encourage other group members to draw them out. You can do this by asking them to respond to things others have already shared: "Michelle, how does it feel to hear about the frustrating time Marla is having? What would you say to Marla?"
  5. Get the group to enforce the ground rules. "Robert, you came in to group about 30 minutes late today. How did the rest of you feel about Robert missing the first half of the group?"
  6. At this stage, it is also likely that group members will get frustrated with you, the facilitator. This can be a great thing for the group and can build stronger relationships between group members, depending on how you handle it.
    - Regularly give members a chance to give feedback about the group. If group members express frustration with you, reflect what they are saying, and take it to the group for discussion: " Marla, I hear you saying that you feel Sharon and I have been talking too much in the group today. That is a totally reasonable concern. Does anyone else have thoughts about this?"
    - If the group teams up on you, why could this be a good thing?
  7. Attendance can start to slip during the middle section of a group. Try to build the sense that group members are

accountable to one another and need to “show up for each other.”

8. Encourage group members to take on leadership roles. This means calling each other (with permission) and reminding people to attend group.

## VI. Ending stage of the group.

- A. The IMPACT Health Living Group has the option of continuing beyond 6 weeks if the group members so choose. Let’s read about that in Session 6 of the IMPACT Healthy Living Group Manual [Ask for volunteers to read this section.]
- B. If the group does not choose to continue, it will come to an end after 6 weeks. The ending stage is a powerful time to process the time spent together, and have group members really recognize and use the skills they learned in the group. Endings also bring up strong emotions like denial, anger, mourning or grief. Another risk at the ending stage is that participants tend to focus only on positive things and not the conflicts that came up in the group.
- C. Your goals as the group facilitator in the ending stage are to help everyone prepare for the ending and be ready for it when it comes, as well as to help people reflect on all they accomplished in the group. If you do a good job of using the ending as an opportunity to reflect on what was learned, people will be ready to use their new skills after the group is over.
  1. Get the group to talk about how they feel about the group ending. Ask them how they feel.
  2. Encourage group members to share negative reflections on the group, not just positive ones.
  3. Set an example by sharing a little bit of your own feelings about the group ending, but also remember to give an example of setting good boundaries while doing this. If you feel a little sad about the group coming to an end, or proud of the work people have done, or moved by the things people have shared, then say so. But always remember that you are there to support your patients and not the other way around.
  4. Get the group to summarize and reflect on the progress they made and the work they did. You can do this both by asking questions, and by summarizing things that were learned in

the group. Celebrate the progress that everyone made by recalling specific things group members did that impressed you.

## SESSION 30. ENDING THE PATIENT RELATIONSHIP

Time Required	1 Hour
Recommended Facilitator	IMPACT Manager
Suggested Content	Discussion Reasons for ending the relationship Strategies Connecting
Sources	<ol style="list-style-type: none"><li>1. Berthold, T., Avila, A. &amp; Miller, J., Eds. (2009). Foundations for community health workers. JosseyBass Public Health, San Francisco, CA.</li><li>2. Shulman, L. (2009). The skills of helping individuals, families, groups and communities, Sixth Edition. Brooks/Cole; Belmont, CA.</li><li>3. Yalom, I. &amp; Leszcz, M. (2005). Theory and practice of group psychotherapy, Fifth Edition. Basic Books; New York, NY.</li></ol>

- I. Discussion. Ending the relationship is a VERY difficult thing to do for both the CHW and the patient. Tell us about your past experiences of ending the patient relationship.
- II. Reasons for ending the relationship. CHWs often continue to maintain some contact with their patients even after an intervention ends, and that is completely fine. However, there are two reasons for bringing the intensive stage of your intervention to a clear end:
  - A. We want to be able to help patients learn to manage their own health, and we only have a set amount of time to get them to that point. Our focus is on teaching them skills so they can manage better once they are on their own.
  - B. Ending the relationship at a set time helps establish boundaries.



- C. Being “on the clock” gives you and the patient some pressure to get things done. That can be a very good thing because it avoids procrastination.

III. Strategies. What are some strategies that you all have come up with to end the patient relationship?

- A. Remind the patient early and often about how much time you have together. This will help them process feelings of sadness or loss about the end of your relationship.
- B. Endings are a valuable time for reflection. At the end of your time with the patient, ask them to reflect on the progress they made and the skills they gained. You should think about this, and summarize these for the patient as well. This way, you reinforce the idea that the patient has learned skills that will enable them to manage their health on their own.

IV. Connecting. Before you end your relationship, try to make sure you have connected your patient to some longer term source of support:

- A. For IMPACT Transitions CHWs, this means connecting a patient to primary care. You should make sure they like their primary care clinic and know how to get help there if they need it. Make sure you have given the clinic the information they need to continue to support your patient, including copies of the patient’s Roadmaps (with the patient’s permission).
- B. For IMPACT Outpatient CHWs, this means encouraging the patient to continue to attend group. This is a way of being able to continue a lower “dose” of your relationship for as long as the patient would like.

## SESSION 31. FINAL REVIEW.

Time Required	2 Hours
Recommended Facilitator	IMPACT Manager

Review all sessions to date.

## SESSION 32: STANDARDIZED PATIENT EXAM AND FEEDBACK

Time Required	3 Hours
Recommended Facilitator	Penn Center for CHWs
Suggested Content	Standardized Patient Role-Play

In order to assess the progress of the CHW trainees and identify areas that required attention, it is useful to have periodic standardized patient role-plays. These serve as assessments for this training course, rather than written “exams” which have less bearing on the actual job of a CHW. The Penn Center for CHWs can create standardized patient scenarios that are tailored to your local setting and provide trained standardized patients who can provide on-site services.

## SESSION 33. GRADUATION CEREMONY

Time Required	3 Hours
Recommended Facilitator	IMPACT Director and Manager
Suggested Content	Graduation Certificates Celebration Party!

Congratulations!

SAMPLE COMMUNITY RESOURCE DATABASE

Keywords	Organization	Website / Email	Purpose	Services	Eligibility	Application Process	Cost	Notes
<b>Sample</b>	<b>PaCT Partners of Philadelphia</b> 423 Guardian Drive, Philadelphia, PA 19104 Ph: 215-555-5555 Fax: 215-555-5555 Mon. – Fri. Hrs: 9am – 5pm	Web: www.pactphilly.org Email: pactpartner1@pactphilly.org	-to aid uninsured or underinsured patients of HUP and Presby in the transition from hospital to primary care follow-up appt	-help pt. understand discharge info -prescription-filling assistance -transportation assistance -social service referral	-under 65 -uninsured or Medicaid -resident of West or Southwest Philly	N/A	Free	
<b>Childcare</b>	<b>Sally Watson Center</b> 5128 Wayne Avenue Phila. Pa. 19144 Ph: 215-844-6931 Fax: 215-844-7104 Hrs: 24 hrs. emergency childcare for children	Web: www.youthserviceinc.org Email:		Short term childcare for sick moms in Germantown	From birth to 5 years of age	Must provide: referral, birth certificate, proof of income, medical insurance, pre-registration application	No fee required	
<b>Childcare</b>	<b>Baring House</b> 3401 Baring Street Phila. Pa 19104 Ph: 215-386-0251 Fax: 215-222-2352 Hrs: 24 hrs. emergency childcare for children	Web: www.ysiphila.org Email: info@ysiphila.org	Offer accessible, responsive, high-quality services to at-risk children and their families	Provide community-based, shelter and counseling to any age child, teen or family in crisis restoring self-sufficiency,	From birth to 5 years of age	Must provide: referral, birth certificate, proof of income, medical insurance, pre-registration application	No fee required	
<b>Childcare</b>	<b>(CCIS) Childcare Information Services of Philadelphia County</b> <b>5548 Chestnut St.</b> <b>Phila. Pa 19139</b> Ph: 215-382-4762 Fax: 215-382-1199 Ph: 888-461-KIDS Hrs: 8am – 6pm	Web: www.philadelphiacchildcare.org Email:	-helps families find, select and pay for childcare	Subsidized child care financial assistance for parents	-Working at least 20 hrs. per wk. -Work 10 hrs. wk. and go to school -Certain income guidelines -Live in Phila. -Teen parent under 22 in school -Parent receiving TANF	-Online services through COMPASS -Local CAO	Free	-call to find a location (5 in Philly) near you
<b>Community Health Centers</b>	<b>Fairmount Health Center</b> 1412-22 Fairmount Ave. Phila. Pa 19130 Ph: 215-235-9600 Fax: 215-684-5360 Hrs: Monday 8:00 am – 6:30 pm	Web: www.dvch.org Email: pdeitch@dvch.org	Provide services to the uninsured and to others on a sliding-fee scale, based on an individual's or family's ability to pay.	-Adult and Family Medicine -Pediatrics -Prenatal Care -Gynecology -Dental -Behavioral Health -Health Education	Patients must register for services and provide information to verify their identification, income and		Co-pays sliding scale \$20-40	

THE PENN CENTER FOR COMMUNITY HEALTH WORKERS  
is available for consultation to aid you with implementation, work practices,  
and evaluation of your Community Health Worker program.

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