CHW Supervision Development & Lessons Learned

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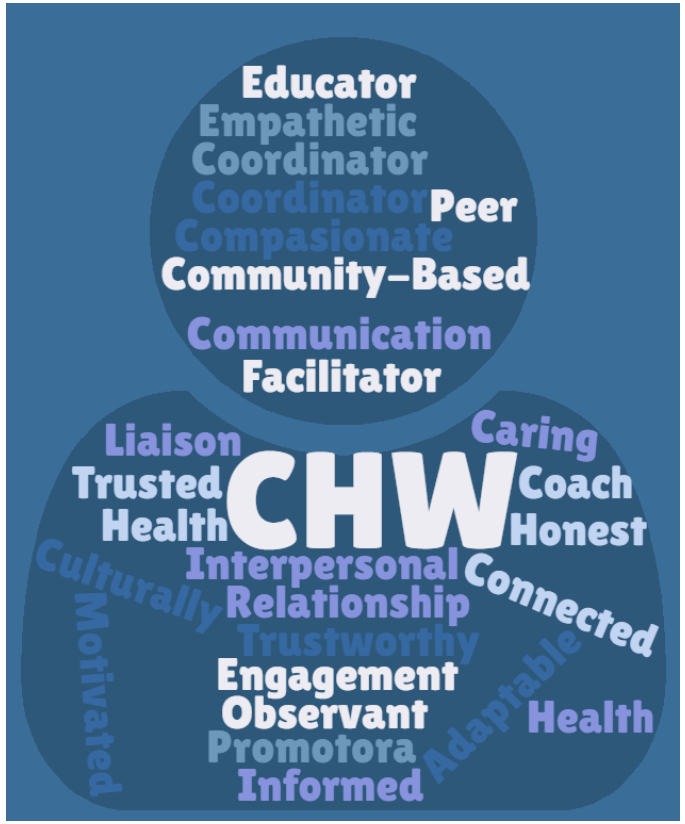
Objectives

- Define successful and experienced CHW supervision techniques
- Describe developed supervision support & retention tools
- Demonstrate support and sustainability of the CHW workforce
- Formulate how innovative tools and lessons learned could be applied in other applicable CHW models and settings

Background: CHWs in Texas



Certification in Texas

- Oversight by DSHS
- CHW or **CHW Instructor**
- 160 hour certification course on 8 core competencies **OR**
- Experiential certified with 1,000 verifiable hours (8 core competencies)
- Renewal required every 2 years
  - 20 hours of CEUs
    - 10 hours must be from DSHS certified training center
    - 10 hours can be from other development training, conferences, etc.

Texas DSHS 8 Core CHW Competencies (skills)
Communication Skills
Interpersonal and Relationship-Building Skills
Service Coordination and Navigation Skills
Capacity-Building Skills
Advocacy Skills
Teaching, Education, and Facilitation Skills
Individual and Community Assessment Skills
Outreach Skills
Professional Skills and Conduct
Evaluation and Research Skills
Organizational Skills
Knowledge Base

Background: BSWH CHWs

History at a Glance

- 2007: 1 Diabetes Educator CHW
- 2009-2011: 4+ CHWs in Community Care Navigation
- 2011: New Positions & Career Ladder Creation
- 2014: 30 CHWs & Formed CHW Development Council
- 2017 to NOW: **100+** CHWs in 7 Teams, in 5 job codes!

CHW Teams & Functions

Alliance Care Team | Comprehensive Care Mgmt | Chronic Disease Educator | Home Visits | Navigation | Outreach | Pharmacy

Assessment | Addressing social needs | Coordination, follow-up, & resource referrals | Education | Engagement | Empowerment

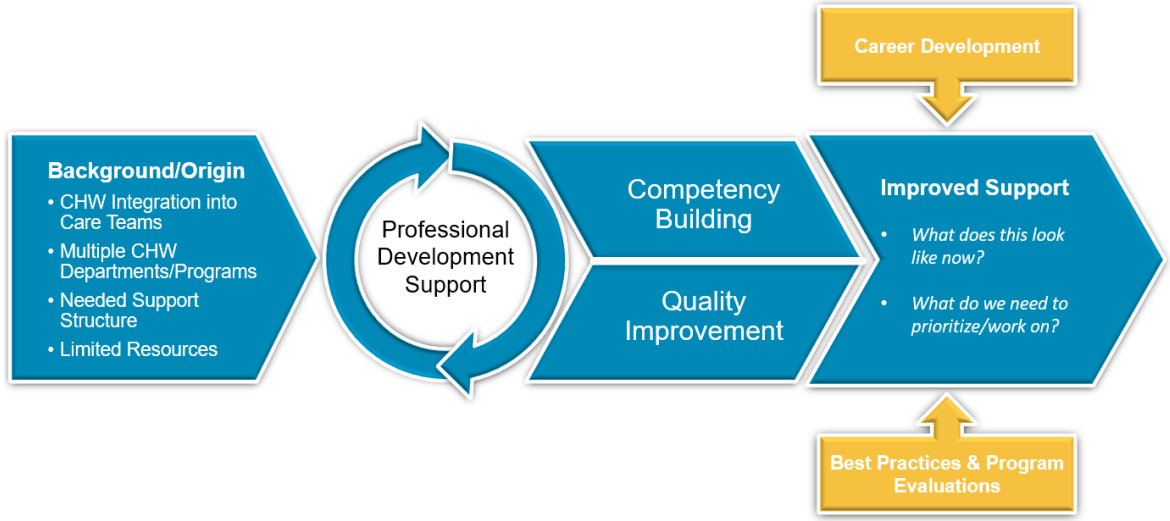
Support: CHW Development Council

Comprised of System leadership, CHW Supervisors, & CHWs

Develop Strategies | Streamline Processes

Provide Structure & Support

Development, Leadership, Continuing Education



Background: Baylor Community Care Clinics

BCC Clinics

7 clinics

- 19 providers
- 13,500 unique patients
- 41,978 encounters (FY19)

Accept at risk patients:

- Charity: 200% FPL
- Medicare, Medicare/Medicaid

Demographics:

- Race/Ethnicity: 60% Latino, 22% African American, 14% Caucasian

Clinic services at a Glance

- Primary Care (high risk/high needs)
- Address social needs
- Medication/DME
- Social work/mental/behavioral health
- Navigation (CHW)
- Chronic disease education (CHW)

BCC CHW Teams

Navigation at a Glance

- Bridge gap between community/patient/health system
- Increase access to primary care through culturally competent outreach & enrollment strategies
- Make referrals and coordinate services
- Teach people the knowledge and skills needed to obtain care
- Facilitate continuity of care by providing follow-up
- Enroll in programs such as health insurance & public assistance
- Link clients to and inform them of available community resources

Becoming a CHW Supervisor: History & Pathway

2011: Entry level CHW role

2011 -2014: 2 CHW positions

2018: Generic Supervisor

TODAY: 5 CHW Job Codes!

BSWH Positions/Job Codes
CHW in-training
CHW I
CHW II
CHW Supervisor
CHW Manager

Advantages of Promoting a CHW to a Supervisor Role

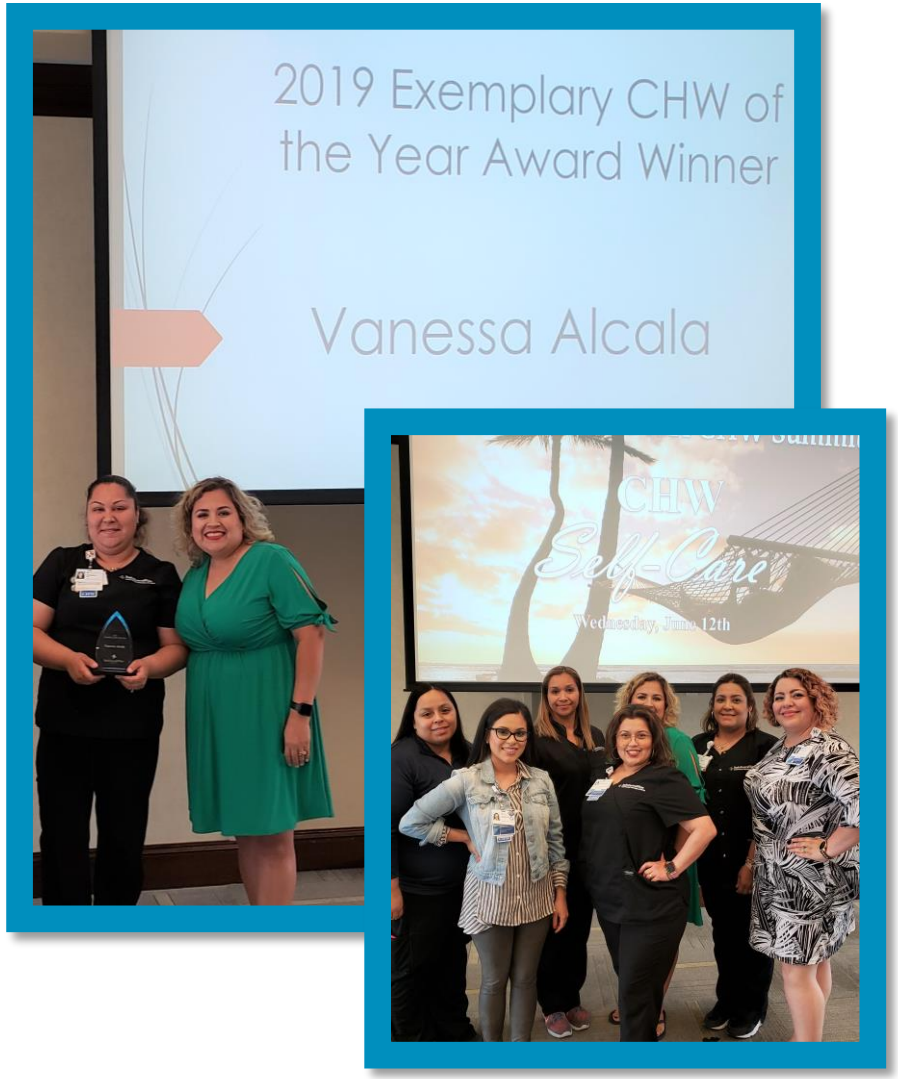
"Know" the experiences of frontline staff

Understand the "why" behind staff needs

From CHW to CHW Supervisor

Approach leadership from frontline perspective

Mentor & grow frontline staff into leadership roles



General CHW Supervisor Best Practices

Recruitment & Retention Strategies

- Reach out to recruiter(s)!
- Conduct behavioral interview(s)
- Conduct 30, 60, 90-day new hire check-ins
- Regularly round with CHW staff
- **Build a career ladder**
- Create ‘buddyship’ & mentorship opportunities

Supporting Sustainability Efforts

- **Don’t be afraid to make changes!**
- **Capture & track qualitative & quantitative data**
- Promote & share success stories
- Conduct CHW-specific feedback surveys/listening sessions/focus groups
- Create & support leadership opportunities

Leadership Opportunities

- Workgroups/Subcommittees
- Host/hold meetings with stakeholders
- Allow CHWs to be seen as the subject matter experts
- Teach care teams, other CHWs, patients& community members
- **GIVE CHWs a VOICE!**

Build Key Partnerships

- Professional CHW orgs/affiliates
- CHW Training Centers
- NPOs/CBOs/FBOs
- Healthcare orgs/systems

Innovative Supervision Support Tools

CHW Scope of Practice

	Community Health Worker (CHW)	Medical Assistant (MA)	Registered Nurse (RN)	Licensed Baccalaureate Social Worker (LBSW)	Licensed Master Social Worker (LMSW)	Licensed Clinical Social Worker (LCSW)
Training	1. High School or GED 2. State Certification	1. High School or GED 2. State Certification	1. Graduation from Board of Nursing approved nursing program 2. Passing grade on RN exam	1. Baccalaureate Degree from an Accredited School of Social Work 2. Passing grade on LBSW exam	1. Master's Degree from an Accredited School of Social Work 2. Passing grade on LMSW exam	1. Master's Degree from an Accredited School of Social Work 2. ~2 years of supervision under a Board approved supervisor 3. Passing grade on LCSW exam
~ Yrs Training	Varies	1 year	2 - 4 years	4 years	6 years	8 years
Scope of Practice	Embedded, trusted peer responsible for providing culturally & linguistically appropriate health education, navigation, &/or advocacy services addressing health & social needs.	Various patient care duties & prepares patient for exams & procedures. May assist in cleaning rooms & equipment, documentation, lab functions, radiology functions, ordering supplies under supervision of physician	Licensed professional who coordinates patient care delivered by the health care team. Assesses patient, identifies nursing diagnoses based on responses to health problems, develops/implements plan of care & evaluates the patient's response.	Applies social work theory, knowledge, methods, ethics, & the professional use of self to restore or enhance psychosocial or bio-psychosocial functioning of individuals, couples, families, groups, organizations & communities.	May engage in LBSW practice, apply specialized knowledge & advanced techniques to achieve optimal outcomes for patients.	May engage in LBSW or LMSW practice. Additionally may engage in clinical practice which requires applying specialized clinical knowledge & advanced clinical skills in assessment, diagnosis, & treatment of mental, emotional, & behavioral disorders, conditions, & addictions,
Licensing or Certification Body	Can be State Recognized Entity (i.e. Department of State Health Services)	American Association of Medical Assistants	State Board of Nursing	State Board of Social Work Examiners	State Board of Social Work Examiners	State Board of Social Work Examiners
Appropriate Utilization	CHW tasks: • screens patients' needs • reviews general medical hx & known needs • identifies barriers • provides education • identifies PCP need • make follow up appt • provides navigation services • provides resource referrals (i.ee. food, transportation) • follow-up phone calls & reminders • uses tools such as motivational interviewing for education, prevention, and to promote self-mgmt • promotes personalized care plan to the patient	MA tasks: • obtains vital signs • obtains general medical hx • assists with blood draws • faxes prescriptions to pharmacy • promotes personalized care plan for the patient	RNs tasks: • assesses patient • reviews general medical hx • RN diagnosis • provide plan of care • implement treatment plan • evaluates response • provide personalized care plan for the patient	LBSW: • assess patient • provides education as needed • provide personalized care plan for the patient • ensure care plan is utilized	LMSW: • Assesses bio-psychosocial challenges • provide personalized care plan for the patient • ensure that his bio-psychosocial needs are being met	LCSW: • assesses Patient • makes diagnoses (i.e. depression & anxiety • works with Patient to identify goals & coping techniques • provide personalized care plan for the patient • follows up with PCP • recommends effective treatment as needed • ensure tx and care plan are utilized, effective • may reassess care plan and resource needs

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BSWH CHW TIERED COMPETENCIES

			Tier 1	Tier 2	Tier 3
INTERPERSONAL SKILLS	COMPETENCY 2	Cultural Competency	Recognize & respond to cultural, social, & behavioral factors in the delivery of healthcare services	Assess, Considers, & Explains cultural, social, & behavioral factors in the delivery of healthcare services	Oversees, interprets, and advises on cultural, social, & behavioral factors in the delivery of healthcare services
					Assess appropriateness of CHW cultural competency programs/training
		Relationship Building	Applies interpersonal skills such as motivational interviewing and conflict resolution to support effective communication	Assesses applied use of interpersonal skills such as motivational interviewing and conflict resolution to support effective communication	Oversees training and the applied use of interpersonal skills such as behavioral interviewing techniques, motivational interviewing, and conflict resolution
			Connects with community partners to promote population health	Facilitates collaboration & partnerships to ensure participation of key stakeholders	Ensures the collaboration & partnerships of key stakeholders through CHW development opportunities
				Maintains partnerships with key stakeholders	Oversees relationship/partnership endeavors with key stakeholders
		Team Work	Actively participates in team meetings and discussions	Promotes & leads team discussions, meetings, trainings, etc.	Develops & encourages team building through meetings, trainings, etc.
			Actively engages with people across organizations, levels and functions	Actively engages with purpose with people across organizations, levels and functions	Cultivates a network of colleagues inside and outside BSWH to support initiatives
			Communicates and supports teamwork to achieve common team goals	Communicates and support alignment of common team goals	Fosters teamwork across the organization to meet common goals
			Collaborates with peers in daily scope of work, on special projects, and other tasks that arise	Supports collaboration between CHW peers in daily scope of work, on special projects, and other tasks that arise	Reinforces collaboration among team members in daily scope of work, on special projects, and other tasks that arise
		Counseling/Coaching	Provide social support resources and/or self-management coaching	Support CHWs providing social support resources and/or self-management coaching	Evaluate CHW's use of social support services and/or self-management coaching
			Collects quantitative and qualitative community health service/referral data	Makes community-specific inferences from quantitative and qualitative community health service/referral data	Determines community specific trends, assesses community health needs from quantitative and qualitative community health service/referral data

Support & Retention Tools: CHW Buddy Program

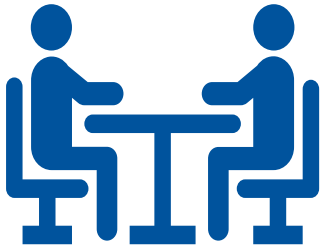
CHW Buddy Program

Partner new hire CHW w/ veteran CHW

- Within 1st 90 days
- Provided general guidelines & recommended topics of discussion

Veteran CHW shows new hire CHW " the ropes"

- Guide as needed
- Share resources
- Act as social contact



Meet monthly for 90 days (min)

- Teach BSWH culture & values
- Review boundaries guidelines
- Capacity building

Program Feedback

"Made me feel supported."

"Gave me an opportunity to ask questions with someone who has answers."

"Being able to connect with a fellow CHW was helpful!"

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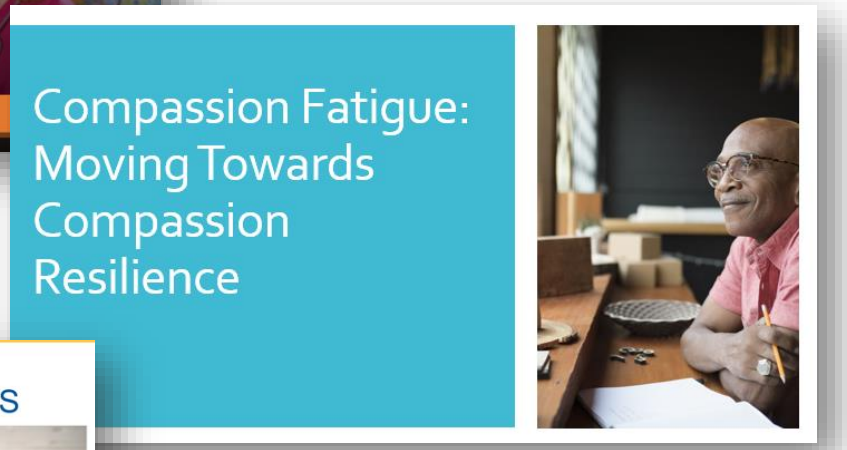
Support & Retention Tools: CHW Continuing Education

CE Opportunities

- Based on feedback from CHWs & Supervisors
- Developed with input from CHWs
- Through organizational partnerships
- Taught by CHW Instructor(s)
- Taught online or in-person



Support & Retention Tools: Success Story Capturing

*1 Describe the situation that was addressed and **why** it's important*

*2 Use any data to frame the problem, including **health burden** and/or financial*

*3 Include **where** and when it took place.*

*4 Describe the program/ activity that was **implemented***

*5 How this **addressed** the barrier/challenge*

This success story is of a patient with Diabetes who had an A1c of 9.7 in January 2018.[1] He had an accident at work about 4 years ago that left him with vision issues and unable to work. This accident led him to be at home alone most of the time. His wife became the sole provider for their home.[2]

We had a home visit with patient in March 2018 and I have continued to have close follow ups with him since.[3] During our visits we focused on meal planning and patient motivation.[4]

A1c has continued to decrease after the home visit. His A1c in July 2019 was 6.6![5] He expresses how now he gets motivated with a handout we provided and always gets excited when his glucose readings are at goal or as he calls it in the green zone.

He comes into every visit with a big smile knowing his A1c will be at goal and telling me how he strives to keep improving. His success makes us all proud!

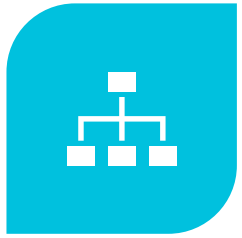
- Maira Loera, CCHW II

CHW Supervision Lessons Learned

SPEAK UP TO RECRUITER(S)

HIRE THE RIGHT PEOPLE FOR CHW ROLE

DEFINE CLEAR WORK PRACTICES



CENTRALIZED MANAGEMENT, TEAM STRUCTURE

TRACK OUTCOMES
(FROM THE BEGINNING!)

CHWS SHOULD DOCUMENT IN THE EHR

BE PATIENT CENTERED

OUTLINE A CAREER TRACK FOR CHWS WITHIN A PROGRAM

Questions? Contact Us at:

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