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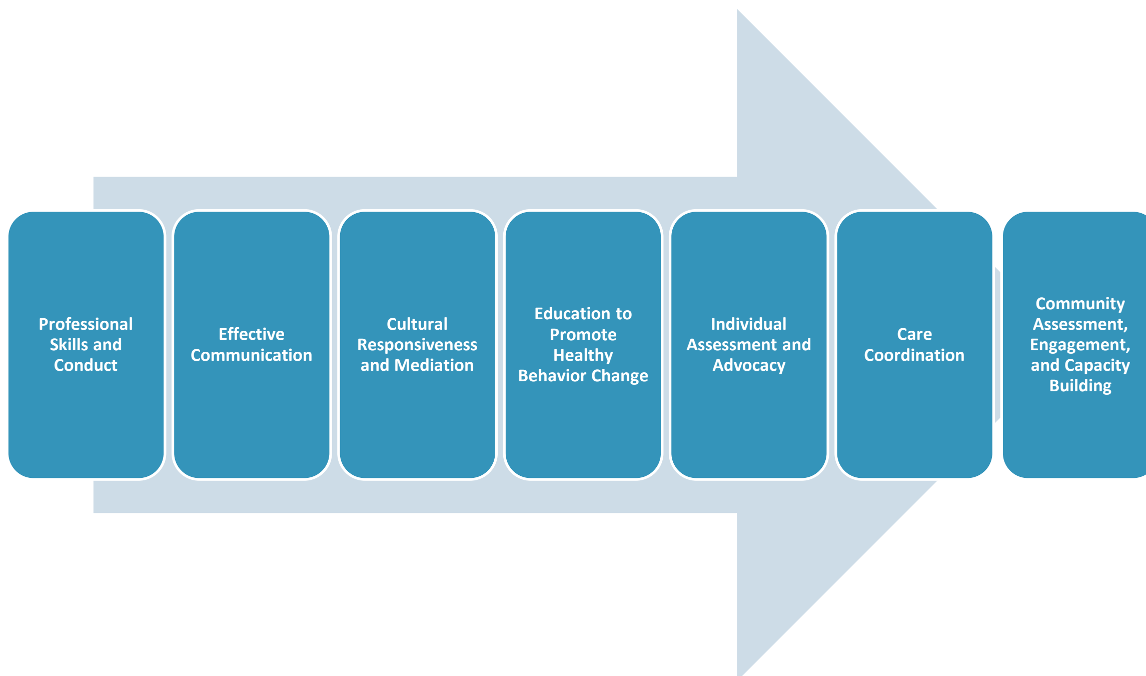
For public health innovation

Community Health Worker Competencies OJL Calendar

The following represents a suggested calendar for on-the-job learning[1] of members, apprentices, and interns, with an understanding that these can occur in tandem and overlap:



Professional Skills and Conduct

- Month 1
    - Practices in compliance with the national Code of Ethics for Community Health Workers.
    - Observes the scope and boundaries of the CHW role in the context of the workplace's team, culture, and policies.
    - Consults with other members of the healthcare team on patient/client concerns that fall outside the Community Health Worker scope of work.
    - Respects client rights under the Health Insurance Portability and Accountability Act (HIPAA) and applicable agency rules.
    - Adheres to legal standards relevant to performance of job duties such as reporting of abuse/neglect or behavior that is imminently harmful to self or others.
- Month 2
    - Maintains appropriate accurate documentation of work performed.
    - Maintains appropriate personal boundaries with health staff, patient/client, and patient/client's family.

[1] Blended list of relevant competencies from the Core Competencies for Public Health Professionals, USDOL, CDPHE, and Colorado Office of Apprenticeship standards.

- Implements healthy work practices to avoid burn-out.

Effective Communication

- Month 3
  - Uses respectful and culturally responsive language during interactions with patients/clients.
  - Uses active and reflective listening techniques and asks neutral, open-ended questions to request relevant information.
  - Identifies health communication issues and adapts oral and written communication approach to patient/client literacy level.
  - Clarifies mutual rights and obligations, as necessary, such as patient/client confidentiality or CHW reporting responsibilities.
  - Communicates the CHW role and relevant CHW services to patient/client.
  - Reiterates provider recommendations using language that is clear to the patent/client.

Cultural Responsiveness and Mediation

- Month 4
  - Demonstrates understanding of whole person, culturally sensitive care.
  - Identifies individual and cultural diversity in views of wellness/illness and disability.
  - Integrates care strategies with patient/clients' personal and cultural values.
  - Advocates for and promotes the use of culturally and linguistically appropriate (CLAS) services and resources within organizations and with diverse colleagues and community partners.
  - Provides cultural mediation as needed, acting as a liaison between the healthcare system and patient/client.
  - Engages patient/client in preferred language and/or obtains as interpreter as needed.
- Month 5
  - Utilizes communication techniques that foster mutual respect.
  - Communicates with providers and service organizations to help them understand community and individual conditions, culture, and behavior to improve the effectiveness of services they provide.

Education to Promote Healthy Behavior Change

- Month 5
  - Recognizes issues and challenges that arise when caregivers and family support a patient/client through life stages and ensures they have appropriate resources.
  - Utilizes effective techniques to empower personal actions relevant to adherence to health recommendations (examples may include informal counseling, motivational interviewing, active listening, harm reduction, community based participatory research, group work, policy change, and other strategies).

    - Provides basic health information relevant to screening/diagnosis/treatment of chronic disease to patient/clients, caregivers, and family members.
- Month 6
    - Elicits and recognizes common risk factors for other physical and emotional conditions.
    - Coordinates education and behavior change activities into existing care that is provided by professional colleagues and team members (e.g., scheduling, warm hand off, reducing barriers).
    - Applies information from patient/client assessments to health education strategies.
    - Facilitates patient/client knowledge and skills for managing their health.
    - Provides ongoing support and follow-up as necessary to support healthy behavior change.

Individual Assessment and Advocacy

- Month 7
    - Identifies personal, language, culture, and system barriers to patient/client's use of the health system and communicates these to the healthcare team.
    - Identifies patient/client and family strengths for managing the patient/client's current condition.
    - Performs collaborative goal setting with patients/clients to identify and prioritize their personal, family, and community needs.
- Month 8
    - Provides continuous monitoring and follow-up to ensure that the patient/client assessment is relevant to the current situation and makes changes to plans for care accordingly.
    - Connects individuals to resources with confirmed capacity and advocates for participation/enrollment (e.g., food and housing).

Care Coordination

- Month 9
    - Applies knowledge of population health strategies/tools such as registries to reach populations to be served.
    - Participates in the development of effective care strategies as part of an interdisciplinary patient/client care team.
    - Creates and implements a patient/client-centered plan of care, integrating patient/clients' personal and family cultural values.
    - Conducts and documents appropriate referrals on behalf of the patient/client to clinical and professional staff.
- Month 10
    - Monitors clinical and social service referral processes, as appropriate, through ongoing follow-up.
    - Understands and utilizes process and outcome measures for monitoring patient/client progress and provides appropriate feedback to patient/client.

    - Communicates with patient/client and healthcare team and facilitates access to care as appropriate (e.g., addresses barriers to care).
    - Utilizes the knowledge of public and private insurance/payer programs to make appropriate referrals to payer programs.

Community Assessment, Engagement, and Capacity Building

- Month 11
    - Establishes effective patient/client relationships by building trust and open communication.
    - Fosters relationships with community leaders, particularly within communities served.
    - Establishes and maintains effective referral networks with community-based agencies, other providers, and health systems.
    - Applies information from community assessments and demonstrates effective strategies for delivering health information through community outreach and public health principles.
- Month 12
    - Participates in professional networking with other community health workers to enhance knowledge for resources.
    - Supports advocacy efforts for appropriate community and social service resources for patient/clients.
    - Assists communities in building capacity by identifying resources, enhancing community leadership, coordinating services, and support providers, and implementing strategies to address unmet needs.
    - Identifies and informs community-based agencies, other providers and health systems about community assets and challenges.

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