Chronic Conditions Management

Tim Berthold and Jill Tregor

This chapter provides six activities and three assessments for training community health workers (CHWs) to support patients to manage their chronic health conditions. Chronic health conditions such as diabetes, asthma, high blood pressure, and heart disease are the leading causes of illness and death in the United States. Increasingly, CHWs are working as key members of patient-centered primary care teams to support patients with chronic health conditions with self-management.

This guide corresponds to, and is meant to be used with, Chapter 16, “Chronic Conditions Management,” of Foundations for Community Health Workers, Second Edition.
CHAPTER AT A GLANCE

Chronic Conditions Management

Training CHWs in chronic conditions management is an iterative process that typically unfolds over the course of a four-month semester at City College of San Francisco (CCSF). We provide learners with multiple opportunities to practice key concepts and skills by using case studies, role plays, and other learning activities. The content in this chapter is designed to be covered in six to nine classes or training sessions, depending on your training schedule.

Chronic conditions management draws upon concepts and skills addressed in several *Foundations for Community Health Workers, Second Edition* chapters including Chapter 6, “Practicing Cultural Humility,” Chapter 8, “Conducting Initial Client Interviews,” Chapter 9, “Client-Centered Counseling for Behavior Change,” and Chapter 10, “Care Management.” We strongly recommend training learners in chronic conditions management after you have provided training in these other core competency areas.

This guide is meant to be used when training Chapter 16 of *Foundations*. The guide includes a selection of step-by-step training activities from the CCSF CHW Certificate program; it is not meant to be a comprehensive list of all training activities for addressing the topic of chronic conditions management. We recommend reading Chapter 16 in *Foundations*, as the textbook provides more material about chronic conditions management, as well as a deeper explanation of concepts related to activities in this guide.

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<td>● For the Trainer 16.1 A: Key Information about Hypertension</td>
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<td>● Learner Handout 16.1 B: Case Study: Tarek and Hypertension, Part 2</td>
<td>▶ Discuss the causes, symptoms, and consequences of hypertension.</td>
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<td>▶ Discuss key client-centered concepts and skills and apply them to a client case study.</td>
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## Chronic Conditions Management

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| **Activity 16.2: Review of Depression as a Chronic Condition (60–80 Minutes)** | - Identify and explain key aspects of depression.  
- Reflect on personal experiences, values, and beliefs about depression.  
- Discuss the role and scope of practice of CHWs working with clients who have depression. |

This training activity engages learners in discussions about depression as a chronic health condition. Learners also are encouraged to reflect upon their own experiences and beliefs about depression and to analyze the role and scope of practice of CHWs working to support patients who are living with depression. Small and large group discussion

**Includes:**
- For the Trainer 16.2 A: Key Information about Depression
- Learner Handout 16.2 A: Discussion Questions: Knowledge and Beliefs about Depression
- For the Trainer 16.2 B: CHW Roles and Scope of Practice: Depression and Chronic Conditions Management

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<td><strong>Activity 16.3: Role Plays: Depression and Chronic Conditions Management (60–90 Minutes)</strong></td>
<td>- Practice facilitating a follow-up meeting to support a client with the self-management of their depression.</td>
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This activity provides learners with opportunities to analyze and practice how to support a client with the self-management of depression, including how to identify the client's strengths, risks, and priority concerns.

Role plays and small and large group discussions

**Includes:**
- Learner Handout 16.3 A: Depression Role Play Cards, Part 1
- Learner Handout 16.3 B: Depression Role Play Cards, Part 2
- Learner Handout 16.3 C: Action Plan Forms
- Learner Handout 16.3 D: Rubric for Assessing CHW Performance
### ACTIVITY 16.4: MEDICATIONS MANAGEMENT CASE STUDY (60 MINUTES)

This activity provides learners with an opportunity to discuss key concepts and skills related to medications management and to view and critique video demonstrations of a CHW working with a patient to enhance medications management.

- Define medications management and explain why taking medications properly is important to promoting health.
- Identify common barriers to medications management.
- Explain three key components of medications management.

Small and large group discussions and video presentations

### ACTIVITY 16.5: MEDICATIONS MANAGEMENT ROLE PLAY (50 MINUTES)

This activity engages learners in practicing how to read a prescription label and how to support a client to improve medications management.

- Explain how to read a medical prescription.
- Practice using client-centered concepts to support a client with diabetes while they manage their medications.

Small and large group discussions and small group role plays

**Includes:**
- Learner Handout 16.5 A: Prescription Labels for Ms. Vera Chapman
- For the Trainer 16.5 A: Prescription Labels for Ms. Vera Chapman
- Learner Handout 16.5 B: Role Play Cards: Medications Management, Vera Chapman

### ACTIVITY 16.6: ACTION PLANNING IN TEAMS OF TWO, PARTS 1–3 (1.5–3 HOURS)

This three-part activity may also be facilitated as a one-time 90-minute activity.

- Develop and implement an action plan to promote their own health.
- In the role of CHW, support a colleague to develop and implement an action plan.

**Activity 16.6: Part 1, Action Planning in Teams of Two**

The first part of this activity provides learners with the opportunity to work in pairs to develop their own action plan.

**Activity 16.6: Part 2, Follow-up Meetings**

The second part of this activity provides learners with the opportunity to implement and revise, as necessary, a personalized action plan and to practice CHW skills to support their partner in implementing their action plan.
### ACTIVITY

**Activity 16.6: Part 3, Final Check-In**

The third part of this activity provides learners with the opportunity to work in pairs to implement and revise, as necessary, personalized action plans and to debrief their experience as both client and CHW of developing and maintaining an action plan.

Learners work in teams of two over several weeks.

*Includes:
  - Learner Handout 16.6 A: Action Plan Form
  - Learner Handout 16.6 B: Discussion Questions for Follow-up Meetings
  - Learner Handout 16.6 C: Discussion Questions for Two Teams Together

### ASSESSMENTS

**Assessment 16.1: Reflective Writing Assignment**

A client case study assessment includes eight questions and covers key concepts and skills for case management.

The case study assessment may be administered as an in-class or take-home exam.

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## ASSESSMENTS

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<th>ANSWER KEY OR RUBRIC</th>
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<td>Learners conduct research on a common chronic condition affecting a local community and develop a two-page fact sheet to share with patients and families living with or affected by the chronic condition. This is a two-part assessment that takes place over the course of several weeks and requires a progress report designed to keep learners on track to complete the assignment. We have provided a handout for the assignment, a progress report, and a sample fact sheet for learners.</td>
<td>Rubric</td>
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<th>ANSWER KEY OR RUBRIC</th>
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<td>This may be administered as an in-class or take-home exam. Learners are presented with a case study about a patient—Mr. Chatterjee—who is living with chronic health conditions. Learners must respond to seven open-ended questions designed to assess their knowledge of key principles for chronic conditions management.</td>
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Activity 16.1

Case Study: High Blood Pressure

This activity provides learners with an opportunity to apply knowledge about hypertension and chronic conditions management to a case-study scenario. The activity also includes a review of knowledge about high blood pressure.

Please note that this activity is best facilitated after learners have read Chapter 9 from Foundations.

1 Introduction

Explain that this activity is designed to reinforce basic knowledge about high blood pressure and to have learners practice applying client-centered concepts and skills for managing chronic conditions with a client case study.

You may wish to introduce the activity and assess the experience and knowledge of learners regarding hypertension by posing a few questions such as these:

- Have you had a personal experience with high blood pressure such as living with hypertension yourself or having a family member who has hypertension?
- What toll does hypertension take on the health of your family or community?
- Based on your experience, how easy is it to manage high blood pressure?
- What have you learned about how to effectively manage high blood pressure?

2 Small Group Activity: Review of Hypertension

Assign learners to work in small groups of three to five. Their task is to discuss the questions about hypertension that have been posted around the room and record their answers. This is a closed book activity—learners should not have printed or electronic information about hypertension with them as they perform this activity.
Case Study: High Blood Pressure (continued)

Suggested questions to post on flip-chart paper around the room include the following:

● What is being measured when somebody’s blood pressure is taken?
● In general, when is someone diagnosed with high blood pressure? In general, what is a normal blood pressure?
● Approximately what percentage of adults in the US have hypertension?
● What factors contribute to our risk for developing hypertension?
● What are common symptoms for high blood pressure?
● What are possible health consequences of living with hypertension?
● What are common treatments for hypertension?

3 Large Group Discussion
Carefully review key information about hypertension (included at the end of this activity) and clarify any misinformation that comes up along the way. Emphasize that it is important for CHWs—especially those working in primary care settings—to master key information about the most common health conditions, including chronic health conditions, affecting the clients and communities they serve. CHWs have an ethical obligation to communicate accurate health information to those they work with.

4 Case Study Discussions, Part 1
Ask learners to continue to work in the same small group of three to five. Distribute copies of Part 1 of the case study about Tarek and high blood pressure to each group, and tell them they will have approximately 10 minutes to discuss the case study and brainstorm answers to the questions provided.

Circulate among small groups to observe their work, noting topics for large group discussion and providing guidance, as necessary.

5 Large Group Debrief
Facilitate discussion about Part 1 of the case study by reviewing the questions posed to the large group. Give each small group a chance to report back and share their ideas in response to at least one question. As each small group reports their ideas, provide the rest of the learners with an opportunity to share new ideas.

As appropriate, share your own questions and ideas, promoting the use of client-centered concepts and skills for working with Tarek, the patient featured in the case study. Draw upon your own professional training and experience and the guidelines provided in Foundations. Information that you may wish to highlight includes the following:

● Tarek’s blood pressure is 145/98. This is above the desired range of 120/80 and above the range for hypertension of 140/90. This indicates that his hypertension isn’t well
Case Study: High Blood Pressure (continued)

controlled and that further action may be necessary to lower it. Uncontrolled hyper-
tension poses serious risks to his health.

● Factors that may contribute to Tarek’s high blood pressure include smoking; not
always taking his blood pressure medications as prescribed; stress due to his loss of
employment, trying to take care of his family, managing a healthy diet on a limited
income, and so on.

● Tarek is already taking action to manage his hypertension: he is regularly monitoring
his blood pressure, taking his medication most of the time, trying to eat more health-
ily on a limited budget, and trying to quit smoking.

● Tarek identified several key health resources including his close family relationship,
his wife’s part-time job, unemployment benefits, subsidized health insurance, his
commitment to improving his own health (including his desire to stop smoking), his
creativity (such as growing food on the back porch), his knowledge about healthy eat-
ing, and his positive attitude (for example, Tarek is hopeful about finding work).

● Client-centered concepts or skills to apply in working with Tarek include these:
  ○ **Ask more than tell.** Ask Tarek to reflect on and make decisions about what else he
    wants to do—or what other services he may want to access—that will assist him in
    managing his hypertension.
  ○ **Provide affirmations.** Acknowledge Tarek’s many strengths and accomplishments
    including the actions he is already taking to manage his high blood pressure.
  ○ **Highlight past successes.** Inquire about any past successes Tarek has had in chang-
ing difficult behaviors or overcoming difficult obstacles.
  ○ **Assess motivation.** For example, Tarek states, “everything I do is for them [his
    family].” You might follow up on this by asking him to tell you more about his fam-
    ily and how they motivate him in his desire to manage his high blood pressure.

● As Tarek refines his action plan, consider using a motivation (or readiness or confidence)
scale to guide him in assessing how motivated or ready he is to take these actions.

● Talk about family. Ask Tarek how much he talks about his health with his family. To
what extent is he comfortable asking for help with tasks such as eating healthier foods
or taking his medications as prescribed? How can his family best support **him**?

● Possible referrals for Tarek may include the following local sources:
  ○ Job assistance programs
  ○ Smoking cessation programs
  ○ Accessible free or low-cost options for increased activity
  ○ Gardening programs that can teach about and share resources for maintaining
    small home gardens to grow healthy food
Case Study: High Blood Pressure (continued)

6 Case Study Discussions, Part 2
Ask learners to remain with the same small group and distribute copies of Part 2 of the Tarek case study. Inform learners that they will have 10 more minutes to discuss the case and to answer the questions provided. Circulate among small groups as you did earlier.

7 Large Group Discussion
Facilitate discussion as you did in Step 5, asking small groups to share their ideas with the large group. Here is a list of information that you may wish to highlight during this discussion:

⦁ **Provide the client with appropriate affirmations.** First, Tarek got a new job! Take time to explore this accomplishment and to congratulate him. In addition, Tarek is making very meaningful progress. He is smoking less, eating better, and taking his medications more regularly. Acknowledge these accomplishments, and ask about how it feels to be making progress.

⦁ **Ask Tarek to assess his progress.** Tarek’s blood pressure is slightly lower, but still on the border between healthy and less-healthy ranges. Start by asking Tarek to reflect on where his blood pressure is today and to share his thoughts about what he can do to lower his blood pressure even more.

This may be a time to share suggestions for other actions that Tarek may take (if he isn’t already doing so), such as keeping a journal in which he records his blood pressure around the same time each day after he has been sitting down for 5–10 minutes with his feet on the floor.

⦁ **Consult with your clinical team.** This may be a good time to talk with your coworkers, as necessary, for more support or guidance in how to support Tarek with issues such as blood pressure monitoring and medications management. Inquire about available resources. For example, can the clinic provide a pill organizer or blood pressure cuff, or will Tarek’s insurance cover some or all of these costs?

⦁ **Support Tarek’s self-determination.** Keep working in a way that supports and does not undermine Tarek’s autonomy. Apply motivational interviewing skills to support Tarek in determining what he thinks, how he feels, and what he wants (and is ready) to do to promote his health.

⦁ **Consider the role of family.** Tarek’s family supports his health in several ways, such as encouraging healthier eating and better medications management. At the same time, the family also complicates Tarek’s plans for self management. At times, for example, the family encourages less healthy choices for food and meals.

⦁ **Set realistic healthy eating goals.** It may be true that Tarek is having a difficult time shopping and preparing healthier meals that meet with the approval of his family. Tarek says about shopping, “I guess I just want to get out of there so fast that I just
Case Study: High Blood Pressure (continued)

grab the usual stuff.” Ask Tarek about this. How is he doing with shopping and preparing meals? What challenges does he face? What else might he do? And, if he seems receptive, share some suggestions. For example, perhaps you could help out by collaboratively developing some tips or guidelines for healthier shopping and some recipes for fast and affordable meals. If appropriate, you could even arrange a time to go grocery shopping together, perhaps without his daughters at first, to explore and identify healthy and affordable items for Tarek and his family.

- **Involve the family.** Ask Tarek if he and his family have any favorite healthy foods or recipes. Identifying several fairly low-cost recipes that the entire family likes will help to promote everyone’s health and to better control Tarek’s blood pressure. Perhaps the family would be open to starting a new food tradition, such as preparing and eating a favorite healthy meal on a regular schedule. Encourage Tarek to involve his wife and daughters in planning for this tradition together and deciding what types of healthy meals to prepare. This will not only benefit Tarek, but it will also help him pass on healthier traditions to his daughters.

- **Check in about exercise.** Tarek tells you that he isn’t focused on exercise right now, saying, “I just stopped exercising.” He also lets you know that he isn’t ready to address this topic right now. You want to respect these limits. At the same time, you might say something like, “I hear that your plate is full right now with everything else that you are doing. Would you be open to revisiting the topic of activity or exercise at some point in the future?”

8 Reinforcement

Take a few minutes to reinforce key aspects of chronic conditions management, highlight the ideas shared by learners, and draw upon your own expertise and content from *Foundations* and other sources. Key messages to reinforce may include these:

- **Self-management of chronic conditions can be challenging and may be a lifelong task.** A wide range of individual, family, and social factors complicates self-management. Individual and family employment status, income, and other resources influence available choices. Cultural traditions influence health beliefs and issues such as diet and stress management. Internal resources including knowledge, past accomplishments, sources of motivation, and self-confidence also play a key role.

- **Remember the concept of the CHW with Big Eyes, Big Ears, and a small mouth.** CHWs need to ask more than tell. Pose questions and share reflective statements that permit Tarek to reflect upon his health and his life more broadly and the actions he feels confident he can implement to make meaningful changes.

- **Work in a way that is designed to transfer power to Tarek and other clients.** Your job is to support their autonomy and self-determination. A sign of your success is that you become less essential to the management of their chronic condition.
Case Study: High Blood Pressure (continued)

- Consult regularly with your supervisor and the rest of your clinical team about the clients that you work with and their progress with action planning and issues such as specific health indicators and warning signs (such as high blood pressure), medications management, dietary guidelines, and referrals for other programs and services. You also can ask any questions related to scope of practice or ethics.

- Continue to investigate and identify local resources that may be helpful to Tarek, his family, and other patients and families you work with. Ideal resources are local, culturally relevant, affordable, and possible to access in the midst of other family and life commitments.
Activity 16.1

For the Trainer 16.1 A: Key Information about Hypertension

What does blood pressure measure?

Blood pressure measures how hard our heart is working to circulate blood through our body. It is provided in the form of two numbers: systolic pressure measured while our hearts are beating, and diastolic pressure measured in between heart beats, while our heart is at rest.

(CDC, 2014)

In general, when is high blood pressure diagnosed?

⦁ In general adults receive a diagnosis of hypertension when their blood pressure is measured consistently at over 140/90.
⦁ Ideally, blood pressure should be less than 120/80.

(CDC, 2014)

Approximately what percentage of adults in the US has hypertension?

According to the Centers for Disease Control and Prevention (CDC), approximately one in three adults in the US have hypertension. Slightly less than half have their hypertension under control.

(CDC, 2014)

What factors contribute to our risk for developing hypertension?

⦁ Biology and genetics
⦁ Exposure to chronic stress
⦁ Low levels of activity
⦁ Eating a diet too high in calories, salt, sugar, dairy, and fast and processed foods
⦁ Tobacco, alcohol, and drug use

(CDC, 2014)

What are possible health consequences of living with hypertension?

⦁ Hypertension is called a silent killer because many people don’t have noticeable symptoms.
⦁ Possible consequences include damage to and narrowing of the arteries, heart attack, stroke, kidney failure, and premature death.

(AHA, 2014)
For the Trainer 16.1 A: Key Information about Hypertension (continued)

What are common treatments for hypertension?

- Improved nutrition, such as
  - Eating less in general
  - Eating and drinking less sugar, salt, fast and processed foods, dairy, and meat
  - Eating more fruits and vegetables
  - Increasing activity levels
  - Taking medications that lower blood pressure
  - Managing stress
  - Reducing use of tobacco, alcohol, and drugs

(AHA, 2014)

REFERENCES


Activity 16.1

**Learner Handout 16.1 A: Case Study: Tarek and High Blood Pressure, Part 1**

**Tarek Medwani** is 37 years old. His blood pressure today is 145/98. Tarek regularly monitors his blood pressure at home, which has been fluctuating between 118/85 (lowest pressure recorded just once) and 147/110. He takes two blood pressure medications each day but has an irregular pattern of taking his medications. “It’s not that I do it on purpose, I just forget, you know, to take them or I can’t remember if I already took them. So some months I run out early and some months I have pills still left.”

Tarek is married and the father of three girls. “My family is everything to me. My wife and my daughters—everything I do is for them.”

Tarek is recently unemployed. He lost his job when his employer closed several retail shops and laid off nearly 100 employees. Tarek receives unemployment assistance, but it will run out in three months. Tarek’s wife, Jordan, has a part-time job as an accountant for their church. The family is receiving food stamps and trying to eat as well as possible. “Since I lost my job, we are being forced to eat different because, I mean, we just don’t have the resources. We’ve even been growing stuff out on the back porch. My oldest daughter, she’s been going around to get some free or half-price food, like at the end of day, the bakery will give us something. We are trying all we can to figure out how to feed our family without just buying a lot of macaroni and cheese in a box, you know what I’m saying?”

Tarek and his family qualify for subsidized health insurance through Medicaid and pay a small premium each month.

Tarek has been trying to quit smoking. “I mean, I’ve smoked since I was 15, so I feel like I’m doing pretty good now not to smoke too much.” He smokes a pack of cigarettes every two to five days, depending largely on “what is going on and how stressed I am.”

Tarek is looking for work and remains hopeful. “I know I’ll find something. I’ve worked all my life, so I know I’ll find something. I have a good recommendation from my old supervisor, and I can do a lot of things, so I just have to keep hustling. Do you have any leads for me?”

**Discussion Questions:**

1. Tarek Medwani’s blood pressure is 129/98 today. What does this indicate about how well managed his blood pressure is?
2. What factors or challenges may be contributing to Tarek’s risk for hypertension?
3. What is Tarek already doing to manage his hypertension?
4. What resources or strengths does Tarek have (that can help him promote his health)?
5. Which client-centered concepts and skills will you use to guide your work with Tarek?
6. What additional types of actions or steps might Tarek take to manage his hypertension?
7. What types of referrals may be of interest to Tarek?
Learner Handout 16.1 B: Case Study: Tarek and High Blood Pressure, Part 2

Tarek comes to a follow-up appointment with you four weeks later. Today, his blood pressure is 127/90. “Can you take it again? Really, it’s been better most of the time…. Yesterday it was down to 125/85.”

Tarek has a new job. “I like it so far, but they aren’t paying what I used to make. But, you know, I’m just grateful to be working.”

Tarek also tells you, “I’m doing better with the meds. I’ve been using the pill box thing you gave me, and my wife, well, if I forget, my wife reminds me!”

Tarek also reports that he has smoked just three cigarettes in the past week. “Yeah, that feels good, you know, like I’m accomplishing something. Plus I don’t want to smoke so much around my kids. But the exercise thing, yeah, I just stopped. It feels like I get plenty just going to work and back and chasing after my kids and all of that. I should do more, but I guess I just feel like my plate is already pretty full, you understand what I’m saying?”

“In terms of eating, I’m doing better than I used to but, you know, I could do even better. It’s up and down. My daughter is pregnant and I guess she’s been craving, you know, fried stuff and fast food, and so sometimes we just pick that up for the family. I guess I could learn more about how to manage it. Even shopping. With the younger ones, they just reach for the chips and the soda, and it isn’t easy. Sometimes I just want to get out of there, and I just grab the usual foods, too. I guess I need more of a plan or something?”

Discussion Questions:
1. What progress has Tarek made in managing his hypertension? What might you say about this to Tarek?
2. What challenges do Tarek and his family continue to face? What might you say about this to Tarek?
3. How will you use client-centered practice to engage Tarek about managing his high blood pressure?
4. Specifically, what might you say or do?
5. What types of referrals might be relevant and helpful to Tarek?
6. How might you respond to Tarek’s last statement about grocery shopping: “I guess I need more of a plan or something?”
Activity 16.2

Review of Depression as a Chronic Condition

This activity is designed to review key information about depression, one of the most common chronic conditions. We recommend facilitating this activity before asking learners to participate in “Activity 16.3: Role Plays, Depression, and Chronic Conditions Management.”

We have provided key information about depression in For the Trainer 16.2 A. You may wish to review and update any information provided by the Centers for Disease Control and Prevention (CDC), the National Institutes of Mental Health (NIMH) or the Mayo Clinic using the links at the end of this document.

1 Introduction and Review

Explain that this training activity is an opportunity to clarify key information about depression, one of the most common chronic conditions. Write down and explain the following agenda and sequence of activities:

- Large group review of key information about depression
- Small and large group discussion of experience with and beliefs about depression
- Analysis of the roles and scope of practice of CHWs when providing direct services to clients with depression

Inform learners that in a future training they will be asked to draw on the knowledge gained from this training activity as they participate in role plays to demonstrate how to support a client with the self-management of depression.

MATERIALS NEEDED

- Flip-chart paper and markers
- “For the Trainer 16.2 A: Key Information about Depression” (included at the end of this activity).
- Copies of “Learner Handout 16.2 A: Discussion Questions: Knowledge and Beliefs about Depression” (included at the end of this activity).
- “For the Trainer 16.2 B: CHW Roles and Scope of Practice: Depression and Chronic Conditions Management” (included at the end of this activity).

TRAINER PREPARATION

- Prepare flip-chart paper with questions provided in Step 2 and Step 5.

LEARNER PREPARATION

- Ask learners to review information about depression in advance, such as fact sheets provided online by the Mayo Clinic or another reputable health organization.

LEARNING OUTCOMES

After this activity, learners will be able to:

- Identify and explain key aspects of depression.
- Reflect on personal experiences, values, and beliefs about depression.
- Discuss the role and scope of practice of CHWs working with clients who have depression.
Review of Depression as a Chronic Condition (continued)

OPTION There are many different ways to review basic information about depression or other health conditions. For example, you may ask a small group of learners to prepare and facilitate a 20-minute teach-in about depression. This could be linked to “Assessment 16.2: Chronic Conditions Fact Sheet Presentation.”

2 Small and Large Group Review of Depression

Write down each of the following three categories on a separate piece of flip-chart paper and post the three papers around the room.

⦁ Prevalence of depression
  ○ What percent of adults in the US have depression?
  ○ Which populations/communities are at a higher risk for depression?

⦁ Key symptoms of depression

⦁ Common treatments for depression

Assign learners to groups of three to five, and provide each group with colored markers. Explain that the small groups will have approximately 5 to 7 minutes to move around the room and to write their ideas for each category of information about depression on the posted sheets. Encourage learners to draw upon the reading they did to prepare for class and other sources of information about depression.

Once small groups have recorded ideas for all three categories, review the information, facilitating discussion, clarifying and adding information as necessary, using key information about depression (included at the end of this activity) as a guide. Draw upon recent research from one or more leading health organizations such as the NIMH or the CDC.

3 Small and Large Group Discussion: Experience and Beliefs about Depression

Let learners know that this is an opportunity to share and discuss their own experiences with, and beliefs about, depression. This is valuable because depression carries a widespread stigma and, as a result, it is often difficult to acknowledge or discuss this common condition. It is also important to acknowledge the ways in which culture and status influence our understanding of depression and other mental health conditions and the barriers that some individuals and communities face in accessing treatment for depression.

Explain to learners that they will be meeting in pairs for 7 to 10 minutes to discuss some of their own experiences and beliefs about depression. As always, they will decide what information they wish to share with their colleagues. It also may be useful to remind
Review of Depression as a Chronic Condition  (continued)

learners about the importance of protecting the confidentiality of any information shared within the training room or classroom, just as they would when working with a client. We recommend that you don’t circulate among pairs during this discussion in order to provide them with a greater sense of privacy.

Distribute the discussion questions about depression (included at the end of this activity). Pairs may chose two or three of these questions and make time for both parties to share their experiences and beliefs.

4 Small Group Report Back
After pairs have had sufficient time to engage in conversation, stop to facilitate a quick report back to the large group. Ask learners if they would be willing to share some of their small group conversation with their colleagues. You may wish to pose questions such as these:

● What issues did you discuss that may be significant for the challenge of working as a CHW to address the topic of depression?

● How may your own beliefs and experiences with depression influence your work with clients? What does cultural humility teach us about this challenge?

5 Large Group Discussion: The Role of the CHW
Facilitate discussion to clarify the CHW’s role and scope of practice when working with a client who has depression. Create three columns on the white board or flip–chart paper. Title them as follows:

● Within the scope of practice of CHWs

● May be within the scope of practice of CHWs

● Outside the scope of practice of CHWs

Ask learners to brainstorm a list of key roles of CHWs who are working to support a client who is managing depression. As learners identify key roles, ask them which of the three categories each role belongs in and facilitate discussion with the large group by asking the following:

● Does everyone understand what this role is?

● Does anyone think that it belongs in a different scope of practice category? If so, why?

This is an opportunity to discuss the CHW’s key roles when providing services to clients living with depression and to clarify scope–of–practice concerns. In general, the roles for working with clients who are managing depression are no different than those CHWs need when working with clients with other chronic conditions. However, because depression is a mental health condition, and due to the risk of suicide, CHWs need to work
Review of Depression as a Chronic Condition  (continued)

closely with their clinical teams and be particularly cautious about scope-of-practice concerns.

Please refer to the trainer’s scope of practice document (included at the end of this activity) to review one way of categorizing common CHW roles according to scope of practice. Spend some time discussing the second category and the roles that may be within the scope of practice of CHWs. It is important to emphasize that because the CHW field is still emerging, the CHW’s scope of practice varies between different employment settings. Some employers will support CHWs to carry out tasks and roles that other employers may view as outside of their scope of practice. Ask learners, “What can you do in this situation to clarify your scope of practice?”

This is an opportunity for learners to identify the moments when they should seek consultation from their supervisor or clinical team; provide a referral to a qualified provider, such as a licensed medical or mental health practitioner; or make a mandatory report to a supervisor or a third party (depending upon their employer’s policies and protocols).

6 Reinforcement

Take a few minutes to reinforce key messages about depression and CHW’s role when working with clients who have depression. Reinforce messages shared by learners during the training activity, information from Foundations and other resources, and your own professional training and experience. Key messages may include these:

- Because depression is so common, you are likely to work with many clients over the course of your career who have depression.

- Many clients with depression also have other health conditions, including other chronic health conditions. Depression can exacerbate or make other health conditions worse, and for some, the challenges of living with a chronic condition may have triggered the depression. Self-management of any health condition is often more difficult when the client is depressed. Additionally, some chronic conditions seem to have a particularly strong link to depression. For example, studies indicate that people with diabetes have a greater risk of depression than people without diabetes.

- Become as familiar as possible with available treatments for depression within the agency where you work (are licensed mental health providers and educational or support groups available?) and local community-based resources that may serve as valuable referrals for clients.

- If a client’s treatment includes medications, CHWs should be aware of proper use of those medications and ensure that clients are taking medications as directed.

- Keep in mind the ways in which culture and status can influence depression and the types of treatments and services that clients may access. Be aware that your own experiences with depression, and your own cultural perspectives, may be quite
different from those of your clients. The treatments that helped you with your depression may not be relevant or of interest to clients. Do your best not to impose your own standards and beliefs onto the clients you work with.

- Manage your scope of practice carefully when working with clients with depression. Check in regularly and consult with your professional colleagues and supervisor, and provide referrals to licensed providers as necessary.
For the Trainer 16.2 A: Key Information about Depression

Depression is one of the most common chronic conditions. The CDC estimates that in any two-week period, approximately nine percent of adults in the US experience depression (CDC, 2015). These populations have higher risks for depression:

- Adults ages 45–65
- Women
- Latinos and African-Americans
- People who are unemployed or unable to work
- People without health insurance

**DEFINITION**

A diagnosis of depression can be made by a licensed medical or mental health provider and is based on the patient’s symptoms. Guidelines for diagnosis are provided by the Diagnostic and Statistical Manual (DSM) of the American Psychological Association (APA) and require a patient to have five or more symptoms, with at least one of the symptoms being either a depressed mood or the loss of interest or pleasure.

**SYMPTOMS**

According to the DSM, symptoms of depression include these:

- Depressed mood most of the day, nearly every day, such as feeling sad, empty, or tearful
- Diminished interest or feeling no pleasure in all—or almost all—activities most of the day, nearly every day
- Significant weight loss when not dieting, weight gain, or decrease or increase in appetite nearly every day (in children, failure to gain weight as expected can be a sign of depression)
- Insomnia or increased desire to sleep nearly every day
- Either restlessness or slowed behavior that can be observed by others
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness, or excessive or inappropriate guilt nearly every day
- Trouble making decisions, or trouble thinking or concentrating nearly every day
- Recurrent thoughts of death or suicide, or a suicide attempt

(NAMI, n.d.)
For the Trainer 16.2 A: Key Information about Depression  (continued)

Depression may be classified on a spectrum from mild to severe. There are also different types of depression including, for example, post-partum depression and depression linked to mild or severe bipolar disorder (also known as manic depression).

Severe or major depression is disabling and symptoms disrupt the patient's day-to-day life including relationships, school, work, and other social activities.

ASSESSMENT OF DEPRESSION

Many cases of depression go undiagnosed. People who don't recognize that they are depressed may withdraw rather than seek help. Many health care providers do not regularly assess for depression, even when patients present symptoms.

CHWs can play a key role in identifying clients who may be depressed and in referring them to licensed medical or mental health providers for an assessment and possible diagnosis. Remember, only a licensed health care provider can diagnose depression or other health/mental health conditions.

A common mistake that helping professionals make is to stay silent when they suspect that a client may be depressed. Although it may feel awkward to talk about, all levels of providers should learn how to ask clients if they are experiencing symptoms of depression.

In the “References” list at the end of this information on depression, we have included a reference for The Patient Health Questionnaire (PHQ-9) (SAMHSA, 2015). It is widely used by licensed health professionals to assess depression. You may also want to check out the Depression Self-Assessment tool developed by the New York University Medical Center (NYU, n.d).

TREATMENT OF DEPRESSION

Depression is considered to be a highly treatable condition. However, many people delay or avoid seeking treatment for depression for a variety of reasons. Some avoid seeking treatment because of the stigma associated with depression and getting treated for depression; others avoid it for various cultural factors or because they lack awareness; and still others don’t get treatment because they lack the resources, the ability to get assessed, or because they don't have access to trained health care and social services providers.

Common treatments for depression include the following:

- Medications (anti-depressants)

  Recommendations for the use of medications depend on a variety of factors including a person's age and co-morbidity (the presence of other health conditions).
For the Trainer 16.2 A: Key Information about Depression  (continued)

- **Therapy**
  There is a wide range of therapies including psychotherapy, cognitive–behavioral therapy, and therapies that emphasize the use of movement, music, or other expressive arts. Therapies may be for the individual or the family or they may be group based.

- **Support from family, friends, and community**
  Many people with depression never talk with a therapist but find meaningful support by confiding in others, including peers who are also living with depression.

- **Strategies that individuals do on their own, such as exercising, taking part in spiritual practices, writing or reading, self-reflection, and many others**

  (NIMH, n.d.)

Our cultural identifies and values influence the types of treatments and therapies, if any, that we decide to access. As always, let cultural humility guide the way you support clients to decide the types of treatments that best suit them.

**REFERENCES**


The Mayo Clinic. (2014). Depression (Major Depressive Disorder). Retrieved from [www.mayoclinic.org/diseases-conditions/depression/basics/definition/con-20032977](http://www.mayoclinic.org/diseases-conditions/depression/basics/definition/con-20032977)


Activity 16.2

Knowledge and Beliefs about Depression

Take a few minutes to talk with your partner about your experiences, knowledge, and beliefs about depression, using the following questions as a guide:

- What prior experience, if any, have you or your family had with depression?
- Is depression something that is acknowledged and discussed openly in your family or community?
- What did you learn about depression and suicide as you were growing up?
- What are your beliefs today about depression? For example, what do you believe about the causes and possible treatments for depression?
Outside the CHW Scope of Practice

- Diagnosing depression (or any health condition)
- Prescribing treatment for depression
- Providing therapy
- Managing a suicidal client
- Other examples __________________________________________________________________________

May be within the CHW Scope of Practice

- Providing client-centered counseling about depression
- Reporting the risk of harm—such as suicide—directly to a third party (outside agency, as the agency’s policy states)
- Other examples __________________________________________________________________________

Within the CHW Scope of Practice

- Providing health education about depression
- Supporting a client to develop an action plan for self management
- Providing care coordination services
- Providing referrals to local programs and agencies
- Supporting clients with medications management
- Timely (immediate!) reporting of the risk of harm—such as suicide—to a supervisor or other professional colleague
- Other examples __________________________________________________________________________
Activity 16.3

Role Plays, Depression, and Chronic Conditions Management

This two-part role play provides learners with an opportunity to practice supporting a client who is living with depression. First, learners will support a client who is newly diagnosed with depression to develop an action plan. This activity uses a slightly more complicated method (a large group round-robin technique, described in “Training Techniques” for setting up and facilitating the first role play. Next, learners will meet with the same client to discuss their progress in implementing the action plan.

This training should follow Activity 16.2, which includes a review of depression as a chronic condition.

1 Introduction

Tell learners that they will participate in role plays to practice supporting a client with the self-management of depression. The first role play will focus on supporting the client to develop an action plan. The second role play will give the learner an opportunity to practice how to check in with the client on their progress in implementing their action plan.

The first role play will be done with all learners. The second role play will be conducted in pairs of two. Ask learners to draw upon their understanding of depression and managing chronic conditions from previous activities and their assigned readings.

2 First Role Play: Developing the Action Plan

Provide all learners with a copy of the first set of depression role play cards and the action plan form (included at the end of this activity). Review the role play by reading it aloud together; take time to clarify
Role Plays, Depression, and Chronic Conditions Management (continued)

information as necessary. Let learners know that for the purposes of this role play the following conditions apply:

- The client was referred to the CHW with a diagnosis of depression.
- The client has already been informed about confidentiality policies, has signed a HIPAA form, and has given informed consent to meet with the CHW and to develop an action plan.
- The CHW should use the Action Plan form to begin documenting key elements of the plan including, for example, the client’s key goal(s) regarding depression, and one or more action steps that they would like to take to reach that goal.
  - The plan should reflect the ideas and interests of the client.
  - Action steps should be detailed, providing guidance for when and where they will be taken.
  - Most importantly, the steps should be realistic and achievable.

Explain that the first role play will be done as a large group round robin. Ask learners to form a half circle or horseshoe shape in the training room. One learner will play the role of the client and will take a chair in the center of the half circle. All the other learners, collectively, will take turns playing the role of the CHW, interacting with the same volunteer client in the center. The first CHW will start by either asking one question of the client or sharing one comment (this could be an affirmation, a reflective statement, or a summarizing statement). The client will respond, and then the next learner in the circle will take over and will ask one question or make one comment. This will continue until all the CHWs have asked a question or made a comment.

**TIP** Please review guidelines for facilitating a large group round-robin role play in “Training Techniques.” You may also wish to review the video, “Training Tips: Round Robin Role Play, Training Guide” (4:18) (http://youtu.be/b1TaAcY10cg).

**OPTION** There are many different options for facilitating role play practice. We encourage you to use a variety of approaches for role play practice throughout the course of CHW training in order to keep learning fresh and engaging. You can also do this first role play practice in pairs of two or three, or as a demonstration in front of the class.

Facilitate the role play for 10–15 minutes, providing learners with time to demonstrate how to support the client in establishing an action plan they can use to self-manage their depression. This type of large group role play generally takes more time than it would to practice in small groups of two or three. You may need to keep the role play moving to stay on track, including possibly starting over at the beginning, as learners may suddenly...
Role Plays, Depression, and Chronic Conditions Management (continued)

change the nature of the developing conversation between the client and the CHW. Learners playing the CHW are challenged by multiple tasks—listening carefully not only to the client, but to their colleagues, who are also playing the CHW. It provides everyone with a common training experience and demonstrates different styles of practice to explore and discuss.

We encourage you to interrupt the role play occasionally under the following conditions:

- If the role play is stalling or learners are not making progress with the main task of supporting the client to develop an action plan to self-manage their depression.
- To identify significant teachable moments. These include moments when one of the learners does a particularly outstanding job of demonstrating a client-centered technique. For example, they may demonstrate such good listening and reflecting skills that the client makes a breakthrough in their own understanding of their chronic condition and what has been in the way of managing it. These teachable moments may also include times when learners playing the CHW fail to demonstrate strong client-centered practice, for example, times when the CHW starts to lecture or tell the client what to do, fails to lean in to the client’s story and instead changes the subject, and so on.

3 Large Group Discussion

Facilitate continued discussion with the large group by posing questions such as these:

- What is the client’s primary health goal?
- What strengths or health resources does the client have?
- What actions did the client select to manage their depression?
- How realistic do you think the client’s action plan is?
- If you were to continue this conversation with the client on your own,
  - What topics would you want to explore?
  - What questions would you want to ask?
  - What comments might you want to make?
  - What referrals might you want to offer?
- What were the strongest moments of engagement between client and CHW?
- What client-centered techniques did the CHW use during this role play?
- How did the CHW support the autonomy of the client?
Role Plays, Depression, and Chronic Conditions Management (continued)

4 Role Play, Part 2: Follow-up Meeting with Client

This role play is about a follow-up visit that takes place five weeks after the client developed an action plan. The goal for the CHW is to check in with the client about their progress and to identify successes and challenges. Assign learners to work in teams of three, and ask them to decide which of them will play the roles of the client, the CHW, and the observer. As appropriate, the client may want to modify aspects of the action plan that are not working and to consider new actions or referral resources.

Pass out only the second set of the depression role play cards (Part 2) to learners who will play the client. Without letting learners know that you are passing out different scenarios, give half the learners who will play the role of client Role Play Card 2A, and give the others 2B. Learners should read the information to themselves and not share it with their colleagues. Half of the groups will practice a scenario in which the client is making good progress in implementing the action plan and half will practice a scenario in which the client is struggling to make progress.

Provide learners who will play the role of observer with a copy of the rubric for assessing client-centered practice (included at the end of this activity). For the purposes of this role play, ask the observers to focus on the action planning and client-centered practice sections of the rubric.

Small groups will have approximately 7 to 10 minutes to do this role play. Circulate among the pairs, observing their work and noting examples of stronger or weaker practice to share during the large group discussion that follows.

5 Small Group Debrief

Stop the small groups and ask them to take a few minutes to debrief their role play by answering the following questions in the order given. We recommend posting the guidelines for debriefing the role play by using slides or by writing them on flip-chart paper or white board.

1. As a general practice, it is valuable to debrief the client first. Ask the client, “As this client, what were your primary challenges and concerns? What did the CHW do well? What could they do differently?”

2. The observer debriefs next. Ask observers to report what they think the CHW did well and aspects of practice that could be improved. Use the rubric for assessing client-centered practice as a guide, as appropriate.

3. The CHW debriefs last. Ask the CHW to discuss their experience of the role play, including what they did well and what could be improved upon. This is also a wonderful opportunity to practice professional skills in receiving constructive feedback.

Circulate among the small groups, listening for content and ensuring that learners stay on task and that both the CHW and the observer have a chance to share their feedback.
Role Plays, Depression, and Chronic Conditions Management (continued)

After 4 to 5 minutes, if necessary, remind the group to leave room for the learner who played the CHW to talk.

6 Large Group Discussion
Facilitate discussion about the role play activity with all learners. Start by letting learners know that some groups were asked to role play a scenario in which the client is making good progress in implementing their action plan, and others worked on a scenario in which the client is still struggling.

Start the discussion by asking learners who played the role of observer to share their ideas.

Start by guiding a discussion about the role play in which the client, CJ, is making progress. Discussion questions may include these:

● How has the client progressed in terms of implementing their action plan?
● How will you respond to CJ using client-centered concepts and skills?

Learners might suggest providing an affirmation for the hard work that CJ has done to implement the action plan and for reaching out to talk about the depression with a close family member or friend. Or they may suggest using open-ended questions and reflective listening to support CJ in talking about depression and any adjustments CJ may want to make to the action plan.

● What concerns do you have?
● What next steps might you take?

Next, facilitate discussion about the role play in which the client, CJ, is not making much progress. Questions may include ones similar to these:

● How is the client doing in terms of implementing their action plan?
● How will you respond to CJ using client-centered concepts and skills?

Learners might suggest using OARS (open-ended questions, affirmations, reflective listening, and summarizing) and other client-centered skills to engage CJ in talking about issues such as these:

◦ The action plan. What progress did CJ initially make in implementing the action plan? How did this feel? How did CJ get stuck? What happened? How might CJ change or simplify the plan?
◦ Key relationships. Ask CJ about how the depression is affecting key relationships with family, friends, and at work. How have things changed? How does CJ feel about this?
◦ Where is CJ now? What are CJ’s most important current concerns and priorities?
◦ Support. How can you and your clinical team best support CJ right now?
Role Plays, Depression, and Chronic Conditions Management (continued)

- What concerns do you have?
  Learners might mention that CJ isn’t making progress with the action plan and feels stuck. Depression symptoms haven’t improved and are getting in the way of CJ’s motivation to take action. CJ is worried about the effect that the depression is having on key relationships with family, friends, and at work.

- What steps might you take next?
  Learners might suggest the following:
  ◦ Express your concern and support for CJ.
  ◦ Consult with your supervisor and clinical team regarding CJ’s continued depression symptoms and difficulty implementing the action plan.
  ◦ Schedule a follow-up appointment for CJ with a licensed colleague. They may wish to reassess CJ’s symptoms, possible suicidality, and medications.
  ◦ Consider possible referrals to other quality local programs and services, such as a support group that has been helpful to other clients in the past.

7 Reinforcement

Take a few minutes to reinforce key aspects of chronic conditions management and working with a client who has depression. Highlight the good practice standards and ideas shared by learners, and draw upon concepts from Chapter 16 and other sources. Key messages to reinforce may include these:

- Use the same client-centered concepts and skills when addressing depression as you would in addressing any health condition, and take the same approach to action planning as well. Support the client in identifying a meaningful health goal, realistic actions to help reach that goal, and ways to better manage their depression symptoms.

- Use your OARS—ask open-ended questions and demonstrate reflective listening—to provide clients with an opportunity to reflect and talk about their experience of depression, symptoms and challenges, insights and other internal resources, hopes and goals, and what they feel ready and motivated to do to enhance their wellness.

- Clients may not be successful in implementing their action plans for many reasons. Talk this through together. Use the motivation or confidence scale to assess the client’s readiness or motivation for making change. It may be a time to consider making revisions to the plan, perhaps simplifying some of the proposed actions to increase the chances of progress.

- Consult regularly with your clinical team and your supervisor, reporting on the client’s progress and sharing concerns.
Role Plays, Depression, and Chronic Conditions Management (continued)

- Provide referrals, as necessary, to licensed mental health professionals and other key services or resources within and outside of your own agency or program.
- Research and learn about a range of resources and treatment options for depression, including a diversity of counseling approaches and counselors, social and support groups. Keep in mind that some clients may not want to engage in therapy or counseling, and that those who do may wish to work with counselors who share their some aspect of their cultural identity, gender or gender identity, language, religion, sexual orientation, or other concern.
ROLE PLAY, PART 1

Setting: Primary Care Clinic

CJ has been struggling with depression for the past six months or so. The symptoms got worse and started to interfere more significantly with daily life. Finally, CJ met with a physician to seek help. The physician diagnosed CJ with depression and wrote a prescription for a common antidepressant medication. CJ filled the prescription and started to take the medication, which the physician explained could take between three and six weeks to take effect.

CJ feels ashamed about being depressed. It has been difficult to admit to and difficult to discuss with family and friends. However, the depression has begun to affect family life, friendships, and work. CJ wants to get better but is not sure what to do, and the depression symptoms make it more difficult to take action.

CJ isn’t making the connection, but CJ has overcome a very difficult health condition in the past. CJ has a history of substance abuse and has worked hard to gain and maintain recovery. CJ has been clean and sober for nearly five years and is very proud of this accomplishment, saying it is “the hardest thing I’ve ever done.”
Activity 16.3

Learner Handout 16.3 B:
Depression Role Play Cards,
Part 2

ROLE PLAY, PART 2A

Setting: Five Weeks Later and Doing Better

CJ has made notable progress in implementing key parts of the action plan and has noticed an improvement in one or more symptoms of depression. In general, the depression is not interfering to the same degree with CJ’s daily life and work. CJ reached out and talked about the depression with a close family member or friend (person playing CJ may choose) and received meaningful support from this individual. CJ feels somewhat relieved, but is still worried about the depression. CJ wants to continue with the action plan but may want to make one or more small adjustments.

---

ROLE PLAY, PART 2B

Setting: Five Weeks Later, Not Much Progress

CJ hasn’t experienced much change in depression symptoms. After starting to implement the action plan, CJ got stuck. Key depression symptoms (such as fatigue and hopelessness) are getting in the way and making it difficult for CJ to feel motivated or to take action. CJ is increasingly concerned about how the depression is affecting key relationships with family, friends, and employment.
Learner Handout 16.3 C: Action Plan Form

Client name and best contact information: ________________________________

CHW name and best contact information: ________________________________

Date of initial meeting: _______________________________________________

OPTIONAL: Client has been diagnosed with the following chronic condition(s): ________________________________

Client’s primary health goal(s): _________________________________________

Actions I will take to reach my health goal(s) are

1. _________________________________________________________________

   I will do this ______ times/week for ________________________________.

   I will do this (when, where, for how long, and with whom) ________________________________

   On a scale of 1–10, my confidence that I will be able to complete this plan is ________.

2. _________________________________________________________________

   I will do this ______ times/week for ________________________________.

   I will do this (when, where, for how long, and with whom) ________________________________

   On a scale of 1–10, my confidence that I will be able to complete this plan is ________.

Resources (internal and external) that will help me to promote my health are ________________________________

Challenges that may get in the way of my plans are ________________________________
Ways to overcome or resist these challenges are ________________________________

__________________________________________________________________________

__________________________________________________________________________

Referrals provided ____________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Next meeting (date/time/location) ____________________________________________________________________

__________________________________________________________________________
# RUBRIC FOR ASSESSING CHW PERFORMANCE—DEPRESSION ROLE PLAYS

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emerging</strong></td>
<td><strong>Satisfactory</strong></td>
<td><strong>Proficient</strong></td>
</tr>
<tr>
<td><strong>Welcoming and Building Rapport</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Provides warm and professional welcome and builds rapport</td>
<td>CHW is cold/not friendly. Does not greet the client or introduce themselves. Does not inquire about the client's name or calls them by the wrong name.</td>
<td>CHW says some or most of the right things to welcome the client but does not convey a sense of interest in their work or the client.</td>
</tr>
<tr>
<td>4. Shows clear communication style</td>
<td>CHW is hard to understand. Uses jargon or acronyms. Speaks too quickly, too softly, etc.</td>
<td>CHW mostly communicates in a clear fashion with few exceptions.</td>
</tr>
<tr>
<td><strong>Client Priorities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Identifies client concerns and priorities</td>
<td>CHW does not inquire about, acknowledge, or respond to client concerns and priorities.</td>
<td>CHW identifies and responds to most of the client's priorities, questions, and concerns.</td>
</tr>
</tbody>
</table>
## Learner Handout 16.3 D: Rubric for Assessing CHW Performance (continued)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Demonstrates a strength-based approach</td>
<td>CHW does not inquire about, notice, or acknowledge client strengths.</td>
<td>CHW partially inquires about and acknowledges client strengths. Does not build upon this key information.</td>
</tr>
<tr>
<td>9. Answers client questions</td>
<td>CHW ignores questions or provides partial, confusing, or incorrect answers or responses.</td>
<td>CHW responds satisfactorily to most questions, but not all. Does not provide incorrect information.</td>
</tr>
<tr>
<td>10. Allows client to talk</td>
<td>CHW talks too much and dominates the session.</td>
<td>At key times, CHW talks too much, missing opportunities to listen to the client.</td>
</tr>
</tbody>
</table>

### Client-Centered Practice

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### Learner Handout 16.3 D: Rubric for Assessing CHW Performance (continued)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Supports client autonomy</td>
<td>CHW lectures the client (without give and take) and/or gives advice, directing what the client should do, think, or feel. The CHW directly or indirectly blames or shames the client regarding health status, knowledge, or behavior.</td>
<td>On one or more occasions, CHW begins to lecture or give advice. Primarily, however, CHW listens to the client's ideas and respects their decisions. CHW supports client autonomy and determination of agenda and discussion. CHW does not lecture. Offers suggestions to a limited extent, as appropriate, and in a manner that lets the client weigh, reject, or accept them.</td>
</tr>
<tr>
<td>12. Demonstrates use of harm reduction</td>
<td>CHW misses opportunity to discuss harm reduction. CHW applies an all-or-none or abstinence-based perspective about health risks and behavior change.</td>
<td>As appropriate, CHW supports the client to make informed decisions to reduce potential harm to their own health, or to the health of others (such as family members).</td>
</tr>
<tr>
<td>13. Demonstrates cultural humility</td>
<td>CHW makes assumptions about the client, or imposes their own values, beliefs, and recommendations.</td>
<td>CHW inquires about client's experiences, values, and beliefs. CHW limits assumptions and sharing of personal perspectives. CHW does not impose personal standards and uses client-centered skills to encourage the client to explore their own experience, values, ideas, and so on.</td>
</tr>
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<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
<th>NOTES</th>
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<tbody>
<tr>
<td>14. Uses OARS: Open-ended questions, affirmations, reflective listening, summarizing</td>
<td>CHW fails to use open-ended questions appropriately and asks leading questions and/or too many closed-ended questions. CHW misses opportunities to provide affirmations and/or provides awkward, inaccurate, unclear, or inauthentic affirmations. CHW does not demonstrate reflective listening, or only repeats what the client says. CHW misses opportunity to summarize or provides an inaccurate summary.</td>
<td>CHW asks open-ended questions to solicit more information from the client. CHW does not over-use affirmations. CHW provides affirmation in key moments to identify significant aspects of the client's work and achievements. CHW demonstrates reflective listening by engaging client in relevant reflection and discussion of key issues (beyond repeating). CHW summarizes key aspects of the work, in appropriate moments, such as client's main priorities, concerns, and proposed actions.</td>
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<tr>
<td>15. Rolls with resistance or ambivalence</td>
<td>CHW responds to ambivalence by lecturing the client or trying to tell them what they should do.</td>
<td>CHW does not lecture the client but does not confidently use MI and other skills to support the client to further explore their ambivalence.</td>
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### Learner Handout 16.3 D: Rubric for Assessing CHW Performance (continued)

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<tr>
<th>CATEGORY</th>
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<tr>
<td><strong>Action Planning</strong></td>
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<tr>
<td>16. Develops relevant and realistic action plan to promote health</td>
<td>CHW misses an opportunity for action planning; guides the development of an incomplete, unclear, or unrealistic plan; or takes over the process, telling the client what they should do to manage their health.</td>
<td>CHW gently guides the client to develop a relevant action plan that includes a health goal, complete with realistic and measurable steps or actions to meet the goal.</td>
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<tr>
<td>17. Assesses client motivation, confidence, and readiness</td>
<td>CHW misses an opportunity to assess the client’s readiness for behavior change or other action.</td>
<td>CHW's well-timed assessment of client motivation results in further discussion or refinement of client's goals or plans.</td>
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Mostly proficient = A, Mostly satisfactory and proficient = B, Mostly satisfactory = C, Mostly emerging and satisfactory = D, Mostly emerging = F
Activity 16.4

60 MINUTES

MATERIALS NEEDED
- Flip-chart paper and markers
- Computer with Internet access and projection equipment
- Videos: “Medications Management, Parts 1–4: Role Play Demo, Foundations” (http://youtube.be/gleMEw0N72k)

TRAINER PREPARATION
- Review medications management in Chapter 16.
- Prepare flip-chart paper with questions from Step 2.
- Review the videos to be shown in class, if desired.

LEARNER PREPARATION
- Ask learners to review medications management in Chapter 16 and to come to the training prepared to explain and discuss the topic.

LEARNING OUTCOMES
After this activity, learners will be able to:
- Define medications management and explain how taking medications properly is critical to health promotion.
- Identify common barriers to self-management of medications taken for chronic conditions.
- Explain three key components of medication management.

Medications Management Case Study

This activity provides learners with an opportunity to review and discuss key elements of medications management. They will also watch and discuss a video demonstration of a CHW supporting a patient with managing their medications.

We recommend facilitating this activity before Activity 16.5 which asks students to engage in role plays to demonstrate medications management skills.

1 Introduction

Explain that this activity is designed to enhance understanding of medications management, including its purpose, common challenges, and key elements for providing direct services to patients living with chronic health conditions. Explain to learners that they will work in small groups to define and review medication management, and then they will watch and discuss a series of videos on the topic.

Before starting the small group discussion that follows, facilitate a brief discussion with learners about their own experience. For example, you may pose the following questions:
- What is your own experience with taking prescription medication?
- Do you ever have difficulty taking them as prescribed? If so, why?

2 Small Group Discussion and Review

Assign learners to work in small groups of three, and distribute markers. Ask them to move around the room, discussing the questions posted on flip-chart paper, and recording their answers.
Medications Management Case Study (continued)

Here are the questions for flip-chart paper:

● In your own words, what is medication management?
● What are some reasons why patients don’t take medications as prescribed?
● What is the role of CHWs in medications management?

After all groups have written their answers on the flip-chart paper, review the information, and provide clarification as necessary. Information about each of these topics is provided in Chapter 16.

You may wish to emphasize that CHWs play an important role in supporting patients to take the proper medications in the right way. But they must be careful to work closely with a prescribing physician or other health care provider to ensure that they are reinforcing the right messages and not exceeding their scope of practice. CHWs should employ a client-centered approach to medications management, which honors the wishes of and supports the empowerment of the patient.

Large Group Discussion

As described in Chapter 16, medications management has three main components. It is important for CHWs to be able to clearly explain, and to demonstrate, each of these components. To facilitate a discussion about this topic, start by writing the three components on the board:

1. Medication reconciliation
2. Medication concordance
3. Medication adherence

Ask learners to define and explain each component and how it may be beneficial to a patient’s health. Write learners’ answers on the board under each component. As necessary, add key information to clarify their understanding, using the Foundations chapter as a guide. Here is a brief definition of the terms.

1. Medication reconciliation
   ○ Compare the list of medications a patient has been prescribed to those the patient is actually taking.
   ○ Clarify the prescriptions and medications that are current and which should be taken for which health conditions.
Medications Management Case Study (continued)

2. Medication concordance
   - Check with the patient to see if their understanding about how and when to take a medication matches that of the prescribing physician (or other health care provider).
   - Clarify any misunderstandings that the patient may have about how to take their medications. It is essential that they understand the purpose of medications and how to take them to ensure that they are taking them correctly. As stated in the chapter, research indicates that up to 50 percent of patients don’t understand how to take their medications.

3. Medication adherence
   - Affirm that the client is taking their medications correctly, as prescribed.
   - Explain that taking medications correctly is essential for self-managing chronic conditions. Taking certain medications incorrectly or not as prescribed may pose health risks.

4 Video Demonstrations and Large Group Discussion

Show the four-part video series of a CHW supporting a patient with medications management, and facilitate discussion among the learners. We suggest showing each video, one at a time, and then pausing to facilitate discussion before moving on to the next video in the series.


After the video, facilitate discussion by posing questions such as these:

- What challenges is this patient facing regarding his medications?
- What does the CHW do to support the patient with medications management?
- What did you like about what the CHW did?
- What would you do differently? What else might you have done?
- Which of the three parts of medications management does the CHW address (reconciliation, concordance, adherence)?

Part 1 of the video series addresses medication reconciliation. It also partially addresses medications concordance, or the patient’s understanding of how and when to take medications.
Show “Medications Management, Part 2: Role Play Demo, Foundations” (2:41) (http://youtu.be/eLRe6wVkLuw) and facilitate discussion by posing questions such as these:

- How well is the patient doing in terms of taking his blood pressure medications?

- What aspects of medications management does the CHW identify and address with the client?

  Key information about medications concordance is addressed. It turns out that the patient did not understand the proper dosage for one of his high blood pressure medications. The prescription directed him to split the pills in half, and to take half a pill each day. However, the patient was not splitting his pills and was taking one a day (or twice the prescribed dosage).

- What could be the impact of not taking the blood pressure medications as prescribed?

- How does the CHW help the client better understanding his medication and how to take it?

Show “Medications Management, Part 3: Role Play Demo, Foundations” (1:27) (http://youtu.be/F2Mndwvfu-c) and facilitate discussion by posing questions such as these:

- What information and resources does the CHW share with the patient to help him with medications management?

- Why might a pill organizer be an important resource for a patient?

- What does the CHW do well in working with the patient in this video?

- What would you do differently? What else might you have done?

Show “Medications Management, Part 4: Role Play Demo, Foundations” (2:42) (http://youtu.be/SVWBgyEKblk) about expired medications and pain medications. Pose questions to facilitate discussion such as these:

- Why did the patient keep expired medications?

- What are the patient's concerns about pain medications and why?

- How does the CHW address the topic of the expired pain medications with the patient? What options does she provide?

- What does the CHW do well in this video?

- What would you do differently? What else might you have done?
Reinforcement

Reinforce key concepts about medications management, as necessary, including concepts shared by learners, from Foundations, and your own professional experience. These concepts may include the following:

- Many patients don’t understand their medications and don’t take them as prescribed.
- Patients don’t take their medications at all, skip medications, take the wrong dosage of medication (too much or too little), or take the wrong medications (such as older medications that are not currently prescribed).
- Taking the proper medications as prescribed is key to managing chronic health conditions (and other health conditions). Not taking medications, or taking them incorrectly, can pose serious risks to the patient’s health.
- CHWs have a vital role to play in supporting patients with medications management.
- Client management of their medications has three important elements:
  - Reconciliation: Ensuring that the medications that the patient is taking match current prescriptions.
  - Concordance: Ensuring that patients understand their prescriptions, which medications to take, and how to manage their health conditions.
  - Adherence: Ensuring patients are taking medications properly, as prescribed.
- The use of pill organizers can help some patients—especially those taking multiple medications for more than one chronic condition—take the right medications at the right time, each day.
- As Juanita Alvarado, a CHW in San Francisco, CA, demonstrated in the video, using client-centered concepts and skills can support a patient with medications management. She asked questions and provided guidance and resources in a way that is designed to empower the patient to manage his own medications independently over time. She never shamed the patient for what he didn’t know or was unsure about.
- Consult with the prescribing clinician, or your supervisor, as necessary to clarify any outstanding questions or concerns you have regarding a patient’s medications.
Medications Management Role Play

This activity provides learners with an opportunity to practice how to read a medical prescription and to demonstrate how to support a client who has diabetes with medications management. This activity is best facilitated after Activity 16.4, which provides a detailed review of concepts and skills for medications management.

1 Introduction
Tell learners that today you will review how to read a medical prescription, and then they will participate in a role play to support a client who has diabetes with medications management. Ask learners to draw upon their knowledge of medications management, from the reading and video demonstration in Foundations, and any other prior training or experience.

2 Large Group Discussion
Provide all learners with a copy of the prescription labels for Ms. Vera Chapman (included at the end of this activity), and give them time to read it. Ask the large group to explain the information provided for each medication, one medication at a time. For each prescription, learners should be able to explain the following:
- The name of the medication
- The dosage prescribed
- How to take the medication (for example orally, with meals)
- When to take the medication (how often and at what time of day)

Clarify the information provided in each prescription until learners are able to understand and explain it clearly. We have provided some guidance in the “For the Trainer” information (included at the end of this activity).
**Medications Management Role Play (continued)**

### 3 Role Play Practice

Assign learners to teams of two or three as you wish, depending on what role play technique you have chosen for this activity.

Pass out the role play scenario about Vera Chapman only to learners who will take on the role of the client and provide them with time to carefully review the information provided.

Pass out pill organizers to learners who will be playing the role of CHWs. Explain that for this role play, the CHW should assist Ms. Chapman in clarifying what medications she is currently prescribed and when and how she should take the medications. We encourage learners playing the role of CHWs to practice talking with Ms. Chapman about the use of a pill organizer, even though there are no actual pills or medications to use in this role play. The goal for CHWs is to support Ms. Chapman to make informed decisions about taking medications in order to better control her diabetes and blood glucose levels.

Provide learners with 7 to 10 minutes to complete this role play. Circulate among role play groups providing direction as needed and observing and noting examples of stronger or weaker practice to share during the large group discussion.

### 4 Large Group Discussion

Facilitate discussion about the role play by posing questions such as these:

- What medications has the client, Vera Chapman, been prescribed for her diabetes?
- Is she taking her medications correctly?
- What challenges is she facing in taking her medications?
- What could the consequences be to Ms. Chapman’s health if she does not take medications as prescribed?
- What did the CHW do well to support Ms. Chapman to better manage her medications?
- What client-centered techniques were used during this role play?
- What did you learn that you hope to incorporate into your practice as a CHW?
- What additional questions, comments, or concerns do you have?

**OPTION** If learners would benefit from further reinforcement, select two learners who did a good job in the role play to demonstrate for the large group. You can also take on the role of CHW yourself, demonstrating how to support Ms. Chapman to better understand her medications and to take them as prescribed using the pill organizer.
Medications Management Role Play (continued)

5 Reinforcement

Take a few minutes to clarify any outstanding questions or concerns, and reinforce key aspects of medications management. Highlight positive practice standards and ideas shared by learners, and draw upon concepts from Chapter 16 and other sources. Key messages to reinforce may include these:

- Taking medications as prescribed isn’t always easy and is often quite complicated. Many people have more than one health condition and may take many different types of medication.
- Many patients leave medical appointments without understanding how to take their medications, and they require additional support to adhere to medications or take them as prescribed.
- Start by talking with the client about the medications that they are currently taking, gradually, one step at a time; for example:
  - What medications are you currently being prescribed and for which health condition?
  - Do you have your prescriptions or the pill bottles with you? Could you bring them in next time we meet so that we can review them together?
  - Let’s go over one medication at a time. We’ll look at each prescription or pill bottle to check for this information:
    - The date of the prescription. Is it current? Which doctor prescribed it? Does your current doctor know about this medication?
    - What dosage do you take?
    - How often do you take this medication, and at what time of day?
    - Are there any specific instructions for taking this medication, such as with or without food, or only as needed?
- Inquire about how the client feels about taking their medications. For example, you might ask questions such as these:
  - What gets in the way of you taking your medications?
  - Do you notice that your diabetes (or other health condition) is better controlled when you are taking your medications?
  - Do you have any concerns or questions about your medications that you would like to discuss with the physician (or other licensed provider)?
- Support clients to come up with practical solutions that will help them keep track of their medications, such as using a pill organizer or calendar.
- To ensure that you are providing accurate information to clients, consult with your supervisor and clinical team colleagues about medications management.
Activity 16.5

**Learner Handout 16.5 A:**

**Prescription Labels for Ms. Vera Chapman**

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### Prescription Label 1

**My Local Pharmacy**  
222 Pleasant Street  
Mytown, USA 22222  
1-800-555-5555

**Rx** 06616 12345  
07/17/2016  
VERA CHAPMAN  
GLUCOPHAGE 500 MG TABLETS  
One tablet orally 2 times a day with meal for diabetes  
GLUCOPHAGE (metformin hydrochloride tablet) Qty: 30 TABS  
Film-coated white round tablet "500" "BMS 6060"  
Refills left: 3  
Use before 07/17/2017

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### Prescription Label 2

**My Local Pharmacy**  
222 Pleasant Street  
Mytown, USA 22222  
1-800-555-5555

**Rx** 345 78901  
7/17/2016  
VERA CHAPMAN  
ATORVASTATIN 80 MG TABLETS  
Take 1 tablet orally daily for cholesterol  
(FOR LIPITOR) Qty: 30 TABS  
FILM-COATED WHITE ELLIPTICAL TABLET "PD 158/80"  
Refills Left: 3  
Discard after: 7/17/2017

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### Prescription Label 3

**My Local Pharmacy**  
222 Pleasant Street  
Mytown, USA 22222  
1-800-555-5555

**Rx** 256 12543  
7/17/2016  
VERA CHAPMAN  
HUMULIN N 100 UNITS/ML VIAL (NPH)  
Inject subcutaneously 1 time a day as directed  
Mfr: ELI LILLY Qty: 20 MLS  
Cloudy milky white vial  
Refills Left: 4  
Discard after: 7/17/2017
For the Trainer 16.5 A:
Prescription Labels for
Ms. Vera Chapman

Activity 16.5

Notes for the trainer:
• Must be taken with meals.
• Ensure only 1 tablet is taken at a time, one in the morning, one in the evening.

My Local Pharmacy
222 Pleasant Street
Mytown, USA 22222

Prescription Labels for
Ms. Vera Chapman

For the Trainer 16.5 A:
Prescription Labels for
Ms. Vera Chapman

For the Trainer 16.5 A:
Prescription Labels for
Ms. Vera Chapman

Notes for the trainer:
• Should be used in combination with a low-fat diet
• Should be taken at about the same time each day
For the Trainer 16.5 A: Prescription Labels for Ms. Vera Chapman  (continued)

My Local Pharmacy
222 Pleasant Street
Mytown, USA 22222
1-800-555-5555

Rx

256 12543
VERA CHAPMAN
HUMULIN N 100 UNITS/ML VIAL (NPH)
Inject subcutaneously 1 time a day as directed

Mfr: ELI LILY
QTY: 20 MLS
Cloudy milky white vial
Refills Left: 4
Discard after: 7/17/2017

Notes for the trainer:
• Insulin is measured in units.
• Unopened insulin should be kept refrigerated, but once opened, it may be kept at room temperature for 30 days and then discarded.
• Intermediate or long-acting insulin that looks cloudy or milky-white should be rolled between the palms for 15 seconds to mix.
• Instructions from the American Association of Diabetes Educators for drawing up insulin into a syringe and injecting are here: www.diabeteseducator.org/export/sites/aade/_resources/pdf/general/Insulin_Injection_How_To_AADE.pdf
• The preferred place to inject insulin is in the abdomen (bottom of ribs to pubic line, avoiding 3 to 4 inches surrounding the navel). Tops of thighs and back of upper arms are alternatives. Use the same general area of the body but not the exact same place each time.
Vera Chapman is 55 years old and has been living with Type 2 diabetes for nearly 20 years. Her daughter was just diagnosed with Type 2 diabetes, and her mother died from complications related to Type 2 diabetes. Vera takes the following three medications every day:

1. Intermediate-acting insulin: NPH. 20 units taken by syringe once each day, at bedtime.
2. Glucophage (metformin) to inhibit the release of glucose from the liver, improving sensitivity to insulin. 500 mg taken orally twice a day in the morning and the evening, with meals. Can cause nausea and diarrhea.
3. Lipitor for cholesterol management and prevention of stroke. 20 mg once a day, any time of day, with or without food.

Vera did a great job taking her meds for many months, but skips medications now for several reasons. She sometimes forgets to inject her insulin in the evenings, or doesn't take it when her partner is in town and staying with her because, "I just don't like talking about the diabetes and I am uncomfortable using a syringe in front of him.” Vera has been skipping the Glucophage because it makes her stomach upset and sometimes gives her diarrhea. “When I am busy, I don't want to deal so much with running to the bathroom or feeling sick.”

Regarding Lipitor, Vera says, “With the cholesterol one—I can't ever remember the name—I can take it anytime so I take in the morning, but if I forget I take it in the evening. Except sometimes, in the evening, I forget whether I took it in the morning.”

Vera's blood glucose levels are generally high. Her last Hemoglobin A1c test (which gives a snapshot of her glucose levels for the recent three-month period) was 8.6 percent. A standard range for this test is 4.6–6.0 percent, and Vera confirms that when she remembers to test her own glucose levels with her meter, her numbers are regularly in the 200–250 mg/dL range. During periods when Vera has been more faithful about taking her prescribed daily insulin and Glucophage, her glucose numbers have been in a healthy (90–120 mg/dL) range. But Vera admits she has not been testing her glucose at home lately, because once the numbers start going up, “I just feel so out of control, so I don't use the meter because I don't want to see how badly I'm doing.”
### Activity 16.6

**90 MINUTES**

### MATERIALS NEEDED
- Copies of “Learner Handout 16.6 A: Action Plan Forms” (included at the end of this activity)

### TRAINER PREPARATION
- Decide whether you will facilitate this as a 1, 2, or 3 part training activity. If you are facilitating a multi-part training, determine how much time learners will have between training sessions to implement their action plans.
- Review Chapter 9.
- Review Chapter 16.

### LEARNER PREPARATION
- Ask learners to read Chapter 9, Chapter 10, and Chapter 16.

### LEARNING OUTCOMES
After this activity, learners will be able to:
- Develop and implement an action plan to promote their own health.
- In the role of CHW, support a colleague to develop and implement an action plan.

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**Part 1, Action Planning in Teams of Two**

This three-part training activity assigns learners to work in pairs and to take turns supporting each other in developing and implementing a health action plan. This activity is designed to be done over six to ten weeks (as you determine), providing participants with an opportunity to assess and plan, to experiment with implementing their plan, to monitor their progress, and to make revisions as necessary.

We estimate that it will take 3.5 hours to complete all three parts of this activity. We recommend, if possible, at least ten days in between training sessions in order to provide sufficient time for learners to take actions to implement their plans. You can also modify this activity so it can be completed in just one 90-minute session with a focus on developing the action plan only, with no follow-up sessions.

Although this training activity requires considerable time and effort from trainers and learners, it is one of the favorite activities of both at CCSF. Key benefits include these:

- **Learners have the opportunity to work intensively with one colleague over time, building a closer connection.**
- **Because learners are paired across cultural identities, they have the opportunity to enhance their understanding and practice of cultural humility.**
- **Learners have the opportunity to develop an action plan to change and promote a key aspect of their own health. CCSF students who participated in this activity reported making changes to their diet, their exercise routine, the way they managed their medications and stress level, whether they accessed new services such as counseling, how persistent they were about reducing their blood pressure, and more.**
- **By developing and working to implement their own action plan, learners have the opportunity to “walk**
in the shoes” of future clients. They spend time reflecting upon what it is like to work in a structured way with another to set health goals and to strive to take action and change behaviors to reach those goals.

- Learners have the opportunity to practice supporting another, over time, to change health-related behaviors. This unique opportunity—different from engaging in a one-time-only role play or other learning activity—provides opportunities to address in greater depth the challenges of changing behavior, promoting health, relapsing, and revising action plans.

- Learners have the opportunity to recognize and discuss how clients may respond to unsolicited advice and other well-intended mistakes by CHWs.

In the first part of this three-part activity, learners break into pairs to support each other in developing their own action plan.

1 Introduction

Take time to clearly explain this activity and the anticipated learning outcomes.

Let learners know that they will be assigned to teams of two and will work together over the course of ______ weeks to develop and implement action plans designed to promote a specific health goal.

For the activity to be successful, learners should select an authentic health goal—some aspect of their health that they truly want to improve. They should be careful to select a health goal and topic that they are ready to discuss in the training environment. Once they have selected their health goal, they will be asked to identify realistic actions they can take to change behaviors that will help them reach that goal.

This activity provides each learner with the opportunity to take on two roles:

- **Client.** They will work with their CHW to develop their own action plan to promote their own health and work to implement it over time.

- **CHW.** They will use their CHW skills to support their teammate to develop and implement their action plan and will be responsible for documenting their work on an action plan form.

Provide each learner with a copy of the action plan form (included at the end of this activity), and take time to review it carefully. The form incorporates knowledge that learners should already be familiar with, such as the use of a confidence or motivation scale, and the identification of client strengths and resources. You may wish to review the following components of the form:

- **The health issue or topic they want to address.** It is helpful to work on just one clearly defined health topic. It should be a priority concern for the client and something that is possible to address and improve in six to ten weeks.
Part 1, Action Planning in Teams of Two (continued)

- **Their primary health goal.** Again, this should be as specific as possible. What do they want to achieve in relation to the health issue they identified? Goals may include improved health indicators, such as lowered blood pressure; making specific changes to health-related behaviors, such as exercising more frequently; accessing new services, such as an educational or support group; or others.

- **One or more actions to take that are designed to reach their goal.** These should be specific, measurable, and achievable. These are the actions that clients take to change behaviors and promote health. They could include, for example, walking their dog regularly, cutting back on sodas and other sugary drinks, or doing deep breathing for 5 minutes a day to help with stress.

- **Details about this action (or actions), including when and where they are to be taken.** For example, “I will start by walking to the corner/end of my street and back three times a week with my dog, after dinner. I will gradually increase until I am walking around the block.” Again, these details should be possible for the client to achieve. A client who is not currently very active probably should start with walking a short distance before walking for long distances, jogging, or playing soccer.

- **The client’s confidence, from 0–10, of implementing these actions as planned.** This is an important measure of how realistic and achievable the plan is. Ideally, we hope that clients develop a plan that they can rank as an 8 or higher on the confidence scale. If they are a 7 or less on the confidence scale, stop and ask them to explain why and explore what would help them to increase their confidence to an 8 or higher.

- **Key resources—both internal and external—that will support successful implementation of the action plan.** What key external resources may support the client to make positive changes in their life? This may be family and friends, work, a counselor or therapist, or membership in a group, organization, or community. Don’t forget to identify key internal resources that will support the client’s success. These may include, for example, faith, a source of motivation, past successes, specific knowledge and skills, and so on.

- **Possible challenges to success, and a plan for how to respond to these challenges.** Guide clients in anticipating the challenges that they may face that could get in the way of their success. What might these challenges be? Have they experienced them before? What might they do to address or overcome these challenges?

- **CHW Notes.** This is a place on the form for the CHW to document any other information or concerns about the client’s action plan. This should be information that you want to remember and will come back to in future sessions.

Assign learners to teams of two. Don’t assign learners to work with their best friends from the class; instead, have them work with someone who they don’t yet know as well and, ideally, someone with a different cultural identity and experience. For this activity,
it is useful for the trainer to assign teams rather than allow learners to select partners on
their own.

2 Develop the First Action Plan
Ask learners to decide who will go first in developing an action plan and who will take on
the role of CHW. The pairs will have approximately 15 minutes to develop and document
the first action plan.

Learners taking the role of the CHW should use client-centered practice to support their
colleague in developing a plan to improve their health that is relevant and realistic. They
should take the lead in documenting or writing up their colleague’s action plan.

We don’t recommend circulating among pairs of learners during this activity. Some
learners may require greater privacy in order to talk comfortably about personal health
issues. Ask learners to raise their hand if they would like guidance or clarification about
the exercise.

3 Debrief in Teams of Two
Provide learners with a few minutes to debrief the development of their action plans.
Post the following questions to guide discussion on the board or flip-chart paper:

Developing your own action plan
  • What was it like to develop your own health action plan?
    How easy or difficult was it to determine a health goal and actions to meet that
goal? Why?
    Have you worked to reach this goal before?
  • Is the plan that you developed truly relevant to your life and health? If you are suc-
cessful, will it improve your health and well-being?
  • How realistic is your plan? On a scale from 0–10, how confident are you that you will
    be able to put it into action?

Supporting a colleague to develop an action plan
  • How did you support your colleague to develop their plan? What seemed to work
    well, and what might you do differently next time?

4 Develop the Second Action Plan
Ask learners to switch roles, and repeat Step 3. This is an opportunity for the second
learner to develop an action plan.
Part 1, Action Planning in Teams of Two (continued)

5 Debrief in Pairs
Provide learners with an opportunity to debrief their work, as in Step 3.
Before moving on to the next training step, ask learners to schedule a check-in meeting within the next week. They may meet in person or by phone and should be sure to document this meeting on the action plan and in their planner/calendar/phone so that they won’t miss it. If they don’t already have each other’s phone numbers or other reliable ways to be in contact, such as e-mail, encourage them to exchange this information now.

6 Large Group Discussion
Guide a discussion with all learners by posing questions such as these:
● Do the action plans truly reflect the ideas of the client?
● How realistic are your action plans? Are the goals and actions achievable in your given time frame?
● What types of challenges may get in the way of implementing an action plan?
● What types of resources do you think will be most important to your success?
● What did you learn about how your clients may feel when you work with them to develop their own action plans?
● What role or approach did your CHW take to support you as their client to develop an action plan?
● What challenges did you face as the CHW?
● How well did you take notes and document your client’s action plan?

7 Reinforcement
Take a few minutes to reinforce messages about action planning based on the comments provided by learners, your own knowledge and experience, and Chapter 16. Key messages may include the following:
● Here are key elements of an effective action plan:
   ○ Make clear goals and actions that are realistic and achievable in one to three months. We don’t want clients to set themselves up for failure. It is important that clients experience early success in implementing their plans. Rather than starting by running three miles a day, it may be wiser to try walking for a short distance, depending upon the fitness level, health issues, and past experience of the client.
   ○ If a client is not highly confident in achieving their action plan (scores it as a 7 or less on the confidence scale), revisit the plan. Encourage the client to select actions that they are more confident of successfully implementing in the near future. Help the clients to think of bite-sized actions or steps to take.
Part 1, Action Planning in Teams of Two (continued)

- Change doesn’t need to happen all at once, or in dramatically big ways. Success is much more likely to come in a slow, steady, and incremental fashion: step-by-step and one day at a time.
- A truly effective action plan not only results in behavior change and improved health status but also builds the client’s autonomy and their confidence to direct their own health decisions.

- Incorporate the following client-centered practices throughout action planning:
  - **Client-centered practice.** Use motivational interviewing, the motivation scale, self determination theory, and harm reduction.
  - **Strength-based practice.** Support clients to identify and make good use of their own internal and external resources. Affirm these key health resources.
  - **Support and facilitation.** Don’t direct! Be wary of imposing your own standards, beliefs, ideas, and cultural values.

**8 Next Steps**

Take a few minutes to review the next steps in this training activity:

- Remind learners that they will have ______ weeks to work on implementing their own action plans.
- The action plans will be revisited two more times (or as specified) as part of the training or class. These will be opportunities for pairs to talk together about their progress in implementing their action plans and to offer client-centered support.
- Each learner will do their best over the next ______ weeks to implement their action plan.
- Remind learners politely that the action plan will be revisited on ____________________ (specific training date), so they should remember to bring their action plans to the training/class on that day.

Make sure that learners have an opportunity to clarify any outstanding questions or concerns about their next steps in this training activity.

**OPTION** At CCSF, we implement this training activity over the course of ten weeks and ask pairs to schedule regular phone or in-person progress meetings in between the first and second and second and third training sessions. These meetings should also be documented on the action plan form under Progress Notes.
Activity 16.6

Part 2, Follow-up Meetings

In the second part of this three-part activity, learners practice CHW skills to support their partner in implementing their action plan.

1 Introduction

Explain that this is an opportunity for learners to support their teammate with the implementation of their action plan. Pairs will meet together for 20 minutes and use the action plan form to review progress they have made so far, challenges they have faced, and whether they need to make any revisions.

Remind learners to take out a copy of the action plans that they developed before. Have blank copies of the form on hand in case some learners forget to bring theirs. Tell learners that this training activity will best support their learning if they are each honest about their own attempts to change behavior and promote their health. Not everyone will have made progress with implementation. Not everyone who attempted to put their plan into action will have had a positive experience. Encourage learners to be honest about their experiences, how they feel about them, and what they have learned—just as they would want their clients to be honest with them.

Remind learners to document key information on the action plan form under “Progress Notes” as they check in with their teammate. Finally, encourage learners to apply their client-centered skills.

2 Progress Meetings in Pairs

Provide learners with approximately 20 to 30 minutes to take turns checking in with each other regarding their progress in implementing their action plans. Ask learners to use the action plan form to discuss and document the action plan.

Provide learners with the discussion guide (included at the end of this activity), and let the learner playing the
Part 2, Follow-up Meetings (continued)

CHW take the lead in facilitating the discussion. Key points to address, as highlighted in the action plan form, include these:

- What actions have been taken so far to implement their plan?
- What has gone well? What helped them to achieve this success?
- What challenges have they faced?
- What, if any, ambivalence or resistance to implementing their action plan emerged?
- What changes, if any, do they want to make to their action plan?
- On a scale from 0–10, how confident are they, moving forward, in achieving their action plan?
- What is their client’s need and interest in referrals to new resources?
- How else might the CHW support their health?

After 10 to 15 minutes, ask learners to switch roles.

OPTION Ask each team to schedule another check-in meeting, in person or by phone, to be held before the next training session scheduled for ____________.

3 Progress Meetings, Two Pairs Together

Ask two pairs of learners to meet together (four learners in each small group) to discuss their experience with action planning. Provide each group with a discussion guide (included at the end of this activity) or post discussion questions where all learners can read them. Questions for discussion may include these:

- What progress have you made so far in implementing your action plans (what have you accomplished)?
- How does it feel to have made this progress?
- What challenges are you facing in implementing your plans?
- On a scale from 0–10, how confident are you about continuing to implement this plan?
- What have you learned that may help you to empathize with the clients that you work with?
- Which client-centered concepts and skills have you used to support your colleague’s action planning?

4 Large Group Debrief

Engage all learners in a large group discussion by posing questions such as the following:

- What have you learned so far about the process of changing behaviors to reach a specific health goal?
Part 2, Follow-up Meetings  (continued)

- What aspect of behavior change has been particularly difficult, and why?
- What factors have supported your progress or success? How does success feel?
- What about this experience may inform your work with future clients?
- What did the CHW do or say that helped you implement your action plan?

- How, specifically, are you using client-centered practice to support the client to develop and implement an action plan? What else might you do to deepen your use of client-centered concepts and skills?

5 Reinforcement and Next Steps

This is an opportunity to reinforce key messages learned and to highlight the next steps for learners in this multipart activity.

- Behavior change is often difficult to achieve.
  - It is often a process that takes place over time and includes progress, set-backs and relapse, and revised strategies.
  - Support clients to plan for modest behavioral changes that they have a good chance of achieving.
  - Normalize the difficulty of behavior change, and help clients to anticipate challenges such as not being as successful as they would like, relapsing, and needing to modify plans.

- Self-determination is essential to this process. Make sure that all aspects of the plans reflect the ideas and desires of the client. Support clients to empower themselves along the way, gaining new knowledge, skills, and confidence.
Part 3, Final Check-In

In the third part of this three-part activity, learners have a final opportunity to support their partner in implementing their action plan, and to debrief their experience as both client and CHW in developing and maintaining an action plan.

1 Introduction

Inform learners that this is the final part of this training activity on action planning. This is their last opportunity to check in and support each other in creating change to promote their health.

2 Checking in on Progress, in Pairs

Provide learners with approximately 20 minutes to take turns checking in with each other regarding their progress in implementing their action plans. Ask learners to use the action plan form to discuss and document the action plan. Provide pairs with the discussion guide (included at the end of this activity) and let the learner playing the CHW take the lead in facilitating the discussion and in documenting key information on the action plan form.

After about 10 minutes, ask learners to switch roles. As usual, circulate among teams, providing guidance as necessary and noting issues for large group discussion.

3 Two Teams of Two and Gallery Walk

Post discussion questions you have prepared around the training room. These discussion questions may include the following:

- What have you learned about the process of behavior change?
- What is the value of action planning in terms of promoting health outcomes?
- How would you measure the success of action planning?

Activity 16.6

90 MINUTES

MATERIALS NEEDED

- Copies of “Learner Handout 16.6 C: Discussion Questions for Two Teams Together” (included at the end of this activity)

TRAINER PREPARATION

- Write discussion questions listed in Step 3 on flip-chart paper, as a handout, or as a slide.

LEARNING OUTCOMES

After this activity, learners will be able to:

- Develop and implement an action plan to promote their own health.
- In the role of CHW, support a colleague to develop and implement an action plan.
- Analyze the use of client-centered concepts and skills for supporting behavior change.
Part 3, Final Check-In *(continued)*

- What elements of client-centered practice are most important to implement to support a client to develop and implement an action plan?
- What lessons have you learned from this activity that will inform your future work with clients?

Ask two pairs of learners (four learners in all) to work together. Their task is to move around the training room together, writing down their ideas in response to questions posted on the wall or whiteboard.

4 Large Group Debrief

Review the information shared by learners during the gallery walk. Ask one volunteer at a time to read the ideas posted under each category. When the volunteer has read the information posted in response to that question, provide other learners with the opportunity to pose questions, clarify information, or add one or two burning ideas.

Ask for a different volunteer to read the information posted in response to the next question. And so on.

5 Reinforcement

This is your final opportunity to reinforce key messages from the gallery walk and about action planning more broadly. The balance of this time should be spent affirming the essential ideas shared by learners. Here is some other information that you may want to reinforce:

- You were each asked to develop and implement your own action plan in part so that you would have a recent experience of “walking in the shoes” of the clients you will work with. Please try to remember these experiences, including the challenges you faced in changing behaviors, the insights you uncovered, and the types of resources you relied upon. Challenge yourself to carry these lessons with you throughout your career as a CHW.
- Remember that changing behavior is complex and challenging. If it were easy, we wouldn’t have epidemics of diabetes, HIV, and heart disease. If it were easy, we would have less need for the very services that you are being trained to provide.
- Essential characteristics for supporting clients to successfully change behaviors include patience, kindness, and generosity. We also need faith in the abilities of others to guide their own health, to make their own decisions, and to create change over time. This is a matter of respect.
True success is measured in several ways. First, it is measured in terms of improvements to clients’ health, such as increased activity or stamina, lowered blood pressure or blood glucose, less need for the use of “rescue” asthma inhalers, and fewer visits to the emergency department. Second, success is measured by the clients’ growing independence from you. If you do your client-centered practice well, clients will learn to manage their own chronic conditions over time and gain valuable knowledge, skills, and confidence so they can guide and direct not only their own health but other key aspects of their lives.
Learner Handout 16.6 A: Action Plan Form

Client name and best contact information: _______________________________

CHW name and best contact information: _______________________________

Date of initial meeting: _________________________________

OPTIONAL: Client has been diagnosed with the following chronic condition(s): __________

Client’s primary health goal(s): _______________________________

Actions I will take to reach my health goal(s) are

1. ___________________________________________________________________________________

I will do this _______ times/week for _________________________________________________.

I will do this (when, where, for how long, and with whom) ________________________________

On a scale of 1–10, my confidence that I will be able to complete this plan is __________.

2. ___________________________________________________________________________________

I will do this _______ times/week for _________________________________________________.

I will do this (when, where, for how long, and with whom) ________________________________

On a scale of 1–10, my confidence that I will be able to complete this plan is __________.

Resources (internal and external) that will help me to promote my health are __________

Challenges that may get in the way of my plans are ________________________________________________________________________
Ways to overcome or resist these challenges are ________________________________

________________________________________________________________________

________________________________________________________________________.

Referrals provided ________________________________

________________________________________________________________________

________________________________________________________________________

Next meeting (date/time/location) ________________________________

________________________________________________________________________
Activity 16.6

Learner Handout 16.6 B: Discussion Questions for Follow-up Meetings

Take a few minutes to discuss the following questions, drawing upon your experience so far with action planning:

⦁ What actions have been taken so far to implement their plan?
⦁ What has gone well?
⦁ What helped them achieve this success?
⦁ What challenges have they faced?
⦁ Have they experienced moments of ambivalence or resistance to implementing their action plan?
⦁ What changes, if any, do they want to make to their action plan?
⦁ On a scale from 0–10, how confident are they, moving forward, in achieving their action plan?
⦁ What is their need and interest in referrals to new resources?
⦁ How else might the CHW support their health?
Take a few minutes to discuss the following questions, drawing upon your experience so far with action planning:

- What progress have you made so far in implementing your action plans (what have you accomplished)?
- How does it feel to have made (or not made) this progress?
- What challenges are you facing in implementing your plans?
- On a scale from 0–10, how confident are you about continuing to implement this plan?
- What have you learned that may help you empathize with the clients who you work with?
- Which client-centered concepts and skills have you used to support your colleague's action planning?
Training with Videos from Chapter 16 of Foundations

In addition to the videos that accompany the activities in this guide, we have developed videos that accompany Chapter 16 of Foundations. We encourage you to use the textbook videos as training resources. These videos highlight key concepts and skills related to chronic conditions, and they may be used to facilitate discussion about these concepts among learners.

At CCSF, we show the videos in our CHW certificate courses. The students feel more free to critique and discuss the video role plays because they are not the actors. As they discuss the role plays, they enhance their ability to analyze and explain key concepts for client-centered practice. We often show these videos right before we ask students to participate in their own role play scenarios and demonstrate the same client-centered skills.

All of these videos can be found on the Foundations YouTube channel (www.youtube.com/channel/UCKSB1-LQsSfsRp24Q9W2Jlw) and are described in the Video Directory included in the appendix of Foundations.

There are three videos in Chapter 16 that show a CHW working with a client to address chronic conditions:

⦁ Action planning, diabetes and exercise, demo and counter role plays
⦁ Revising an action plan, role play demo

When we show video demonstrations of CHWs working with clients, we tend to use the plus/delta (+/Δ) framework to guide discussions. Very briefly, the +/-Δ framework (described in greater detail in “Training Techniques”) asks learners to identify and discuss positive examples of CHW practice in role plays or videos, as well as areas for improvement. The delta symbol (Δ) represents change. For example, you may pose the following types of questions to generate discussion:

⦁ What happened in this role play?
⦁ What did the CHW do well in terms of supporting this client (+)?
⦁ What could the CHW have done differently to better support the client (Δ)?

In addition, there are three video interviews with CCSF faculty and experts on issues related to chronic conditions:

⦁ Self-management: finding reasons to live
⦁ How to support a client to develop an action plan
⦁ How to support a client to revise an action plan
You can use the video interview to facilitate discussion, as well, by posing questions such as these:

- What were the central messages conveyed in this interview?
- How might these concepts be helpful to your work as a CHW?
- What additional information do you want to highlight about this topic?
We have included a selection of assessments that cover important skills for this chapter. There is not an assessment for every activity or for every learning outcome in this chapter. We encourage you to adapt these or add any other assessments from your own resources.

**ASSESSMENT 16.1: Reflective Writing Assignment** . . . . . . . . . . . . 854
- Learners write a brief essay on the topic of chronic conditions, incorporating key concepts from their training.

**ASSESSMENT 16.2: Chronic Conditions Fact Sheet and Presentation** . . . . . . . . . . . . 857
- Learners conduct research on a common chronic condition affecting a local community, and develop a two-page fact sheet to share with patients and families living with or affected by the chronic condition.
  
  This is a two-part assessment that takes place over the course of several weeks and requires a progress report designed to keep learners on track to complete the assignment.

**ASSESSMENT 16.3: Case Study Assignment, Mr. Chatterjee** . . . . . . . . . . . . 867
- This may be done as an in-class or take-home exam. Learners are presented with a case study about a patient—Mr. Chatterjee—who is living with chronic health conditions. Learners must respond to seven open-ended questions designed to assess their knowledge of key principles for chronic conditions management.
Assessment 16.1 Reflective Writing Assignment

Your assignment is to write a brief essay (no more than two single-spaced pages) on the topic of chronic conditions. Don’t forget to incorporate key concepts from your CHW training, including concepts addressed in the Foundations and other resources.

This reflective writing assignment is due ______________ and is worth _______ points. Clearly type or print your full name at the top of the assignment.

Your essay should address the following three topics. The bulleted points are intended as questions that might help you in your thinking. You are not required to respond to every bullet.

1. **Consequences of Chronic Conditions.** What are the most common chronic health conditions affecting your community?
   - What consequences have you witnessed and how do these chronic conditions affect the health of the community?
   - How have chronic conditions affected your own health or the health of family members?

2. **Experience with Health Care Systems and Providers.** Reflect on experiences you or your family members have had in seeking health care for the diagnosis and treatment of chronic health conditions.
   - How would you rate the quality of the health care services?
   - What has been most frustrating about these experiences?
   - What has been most beneficial to promoting improved health?
   - If you have received services from a CHW, how do you rate the quality of these services?

3. **Challenges of Chronic Conditions Self-Management.** Reflect on your own experiences—or the experiences of a family member or close friend—with the self-management of chronic health conditions.
   - What have been the greatest challenges to self-management?
   - What has been most helpful or successful in terms of managing these conditions?
   - What have you learned or witnessed that you hope to remember as you work with clients living with chronic conditions?

*Please keep our grading or assessment rubric in mind as you write.* For example, we are looking for you to respond directly and clearly to the questions asked, to demonstrate the ability to reflect on your own life experiences, and to link your reflection to key concepts and skills from the CHW training program.
Reflective Writing Assignment (continued)

RUBRIC FOR ASSESSING OR GRADING REFLECTIVE WRITING ASSIGNMENTS

These assignments ask learners to reflect on their own life experiences and identities as they write about a specific public health topic or CHW competency area. We grade these assignments based on six different performance categories and possible scores ranging from 0 to 20 points each. At CCSF, a passing grade is generally 70 percent of possible points.

Acceptable performance may vary from trainer to trainer. We are including our version of a grading rubric, but feel free to adjust this to fit your unique situation.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
<th>POINTS</th>
</tr>
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<tbody>
<tr>
<td><strong>EMERGING Less than 70%</strong></td>
<td>Essay does not respond to the questions and topics posed in the assignment.</td>
<td>____/15</td>
</tr>
<tr>
<td><strong>SATISFACTORY 70–89%</strong></td>
<td>Essay is partially responsive to the assignment.</td>
<td>____/15</td>
</tr>
<tr>
<td><strong>PROFICIENT 90–100%</strong></td>
<td>Essay clearly addresses the main questions and topics presented in the assignment.</td>
<td>____/15</td>
</tr>
<tr>
<td>1. Responsiveness to assignment</td>
<td>Essay makes no connections to key training concepts and skills.</td>
<td>____/20</td>
</tr>
<tr>
<td></td>
<td>Essay makes limited or vague connections to key training concepts and skills.</td>
<td>____/20</td>
</tr>
<tr>
<td></td>
<td>Essay provides clear and relevant connections to key training concepts and skills.</td>
<td>____/20</td>
</tr>
<tr>
<td>2. Connections to key CHW and public health concepts and skills (such as client-centered practice)</td>
<td>Essay is poorly organized and the ideas presented are difficult to follow or understand.</td>
<td>____/15</td>
</tr>
<tr>
<td></td>
<td>Greater clarity of organization or writing would strengthen this essay to the level of proficiency.</td>
<td>____/15</td>
</tr>
<tr>
<td></td>
<td>Essay is well organized, clearly written, and easy to follow.</td>
<td>____/15</td>
</tr>
<tr>
<td>3. Clarity</td>
<td>Essay does not present any evidence to support arguments or ideas. It fails to properly cite the ideas of others. Plagiarizes.</td>
<td>____/15</td>
</tr>
<tr>
<td></td>
<td>Essay shows an incomplete or unclear connection between evidence and the writer’s point of view, ideas, and arguments.</td>
<td>____/15</td>
</tr>
<tr>
<td></td>
<td>Essay clearly presents evidence (including personal observations) to support the learner’s point of view, ideas, and arguments.</td>
<td>____/15</td>
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Reflective Writing Assignment (continued)

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<tr>
<th>CATEGORY</th>
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<tbody>
<tr>
<td><strong>EMERGING</strong></td>
<td>Less than 70%</td>
<td>50/100</td>
</tr>
<tr>
<td><strong>SATISFACTORY</strong></td>
<td>70–89%</td>
<td>60/100</td>
</tr>
<tr>
<td><strong>PROFICIENT</strong></td>
<td>90–100%</td>
<td>70/100</td>
</tr>
<tr>
<td>5. Self-reflection</td>
<td>Essay fails to reflect upon learner's own life experiences, study, or CHW practice.</td>
<td>5/20</td>
</tr>
<tr>
<td></td>
<td>Essay shows limited self-reflection or application of insights to the work of CHWs.</td>
<td>10/20</td>
</tr>
<tr>
<td></td>
<td>Essay demonstrates reflection on personal experiences, cultural identity, values, etc., and applies to the work of CHWs.</td>
<td>15/20</td>
</tr>
<tr>
<td>6. Originality</td>
<td>Essay closely repeats ideas from class or training, textbook, or assigned readings.</td>
<td>5/15</td>
</tr>
<tr>
<td></td>
<td>Essay reframes ideas or analysis from class or training.</td>
<td>10/15</td>
</tr>
<tr>
<td></td>
<td>Essay presents an original analysis of the ideas of others or original ideas and perspectives.</td>
<td>15/15</td>
</tr>
<tr>
<td><strong>Total points</strong></td>
<td></td>
<td>100/100</td>
</tr>
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Grading guidelines for reflective writing assignments are as follows: Passing = 70 points or above.

Letter grades are as follows: A = 90–100 points; B = 80–89 points; C = 70–79 points; D = 60–69 points; F = below 60 points.
Chronic Conditions Fact Sheet and Presentation

This assessment asks learners to conduct research and develop a two-page fact sheet on a chronic condition that affects their communities. It provides learners with an opportunity to practice how to research, summarize, and present information about a common chronic condition in a well-organized and accessible manner.

OPTION In addition to requiring learners to conduct research and develop a chronic conditions fact sheet, you may ask learners to also prepare and facilitate a 3 to 5 minute oral presentation about the chronic health condition they researched.

We recommend doing this assessment in three stages, as follows:

1. Pass out and carefully review the assignment with all learners, making time to answer questions and respond to concerns. We emphasize the following elements:
   - The information provided about a chronic condition must be accurate. Use reputable and updated sources.
   - The information in the fact sheet should be relevant for a patient who has been newly diagnosed with the chronic health condition. Consider what a patient will need to know in order to make informed decisions about their health.
   - Present the information in the fact sheet in a manner designed to be accessible and understandable by patients. Don't use medical jargon, acronyms, or terms that are confusing (or introduce and explain them in plain language).

2. Ask all learners to submit a brief progress report approximately two weeks later. This helps to keep learners on track for completing the assignment. The half-page report requires the following information:
   - Clearly identify the chronic health condition that you will be researching. Be as specific as possible. State the reason why you selected this chronic condition.
   - Identify at least three reputable resources (books, journal articles, websites, etc.) that you will use as research sources for your assignment.
   - As necessary, review the importance of learning to properly cite the sources of information that CHWs provide and guidelines for citations, such as those from the American Psychological Association (APA): www.apastyle.org/. Note that the guidelines require slightly different information for different types of sources such as books, journal articles, online reports, and newspaper articles.
   - Identify at least two local resources—programs and services—that could serve as the basis for referrals to clients who are affected by the chronic health condition you have selected.
3. When learners submit their final fact sheet, facilitate a discussion about the assignment by posing questions such as these:
   - What challenges did you face in conducting research about the chronic health condition you selected?
   - What did you learn about how to conduct effective online research? What tips do you want to share with your fellow CHWs?
   - Did you discover any online health resources that you would use in the future or recommend to fellow CHWs? What are these online resources?
   - Did you discover any local resources—programs and services—that you would want to share with the clients and communities you work with? What are these resources, and how might they benefit clients?
   - What key information did you discover about the chronic health condition you researched that you hope to share with the colleagues, clients, or communities you work or volunteer with?
Chronic Conditions Fact Sheet and Presentation  

(continued)

LEARNER HANDOUT: CHRONIC HEALTH CONDITION FACT SHEET

Your name: ____________________________________________________________

This assignment is due on ___________________________ and is worth ________ points.

Please select a chronic health condition to serve as the topic of your research and fact sheet. We recommend that you select a chronic health condition (remember that this includes mental health conditions such as bipolar disorder and disabling conditions such as multiple sclerosis) that affects a community that you belong to, work with, or hope to work with in the future. This may require some preliminary online research to discover which chronic conditions affect local communities (the websites of city, county, or state health departments are good places to search for this information).

Once you have selected a topic, conduct online research using at least three reputable sources of information such as local, state, or national health organizations. Make sure to identify good sources of information that help you understand the definition of the chronic condition, how it is diagnosed, key signs and symptoms, and available treatments.

In addition, find at least two local sources of treatment or support services for people living with the chronic health condition. This could include health care of social services provided by government or public sector agencies, or by private non-profit agencies.

Write a two-page fact sheet about the chronic condition. Please think of the fact sheet as a resource that you could use when working with patients at a clinic. Include all (or most) of the key information that you would want to have at hand when working with a new patient who has been diagnosed with the specific disease you decide to focus on. Write the fact sheet using language that clients can understand: don’t include too much jargon, too many medical terms that most people don’t understand, or acronyms (such as STI instead of sexually transmitted infection).

Start by reviewing the sample Fact Sheet, “Key Messages about Asthma,” that has been distributed as part of this assignment. The key topics for your fact sheet must include the following categories of information:

- Definition of the chronic condition
- Basic health statistics such as prevalence, mortality (death) rates, or risk factors
- Primary causes and contributing factors
- Common symptoms
- Common treatments
Chronic Conditions Fact Sheet and Presentation  (continued)

- Local resources (please add this category as described momentarily)
- References: Use at least three reputable resources (such as books, journal articles, websites, etc.) for your assignment. Properly cite all sources in accordance with American Psychological Association (APA) citation.

**NOTE** For your fact sheet, your job is to determine the level of detail for the information that you include in each category.

Your fact sheet must not be on the topic of asthma, because the example provided already covers that topic.

**Common Treatments**

Describe common treatments that would be widely available to patients in your community. For example:

- What are the most common types of medications prescribed?
- What sorts of additional treatments, such as therapy, educational or support groups, or medical interventions (such as radiation, chemotherapy, or surgery) are offered by local health care organizations?

**Local Resources**

Provide information about local resources that may be available to the clients/patients you might work with. You must present a minimum of two local resources. These may include the following, for example:

- Education or support groups, sources of free food, drug treatment programs (outpatient and residential), housing resources, mental health services, and any groups that may be taking collective action to change policies and the social and political circumstances that contribute to high rates of chronic conditions locally.

Provide detailed information such as the following for each local resource:

- The type of service provided
- The agency that sponsors these services
- The address where services are provided (along with contact information, such as phone number and website address)
- Any key eligibility guidelines or limitations that you want to remember, such as the cost of services, income guidelines, whether the program is open to women and men, children, and so on.
Chronic Conditions Fact Sheet and Presentation  (continued)

Chronic Condition Fact Sheet Progress Report

A progress report is due on _____________________________.

Your name: __________________________________________

Date: ______________________________

1. The chronic condition I have selected for my fact sheet is (remember that asthma cannot be selected as the topic for your fact sheet) ____________________________________________

2. The reason why I selected this health condition is ____________________________________________

3. List three research sources for your fact sheet here. These may include articles, reports, books, or other reputable sources. Provide complete information about the author, title of the resource, date that the resource was published, the name of the publisher or organization, and the name of the website and the URL (web address www._________________________ or http://_________________________) as appropriate.

   1. ____________________________________________

   2. ____________________________________________

   3. ____________________________________________

4. List two (2) local resources that provide services for people living with or affected by the chronic condition here.

   1. ____________________________________________

   2. ____________________________________________
SAMPLE FACT SHEET: KEY INFORMATION ABOUT ASTHMA

Definition
Asthma is a lung disease that causes the airways (the paths that carry air to your lungs) to swell, inflame, and narrow. The lungs of a person with asthma are always inflamed. When something triggers symptoms, such as smoke, pets, exercise, changes in temperature, dust, mold, or other triggers, the airways become even more swollen and the muscles around the airways can tighten. Less air gets in and out of the lungs, and the mucous that is made by the body obstructs the airways even more.

Asthma is considered a manageable chronic condition. Though a person with asthma has it all the time, asthma attacks only happen when something irritates or bothers the lungs. An asthma attack is when a person has a very difficult time breathing. An asthma attack can be very scary, and the person having the attack may feel like they can't breathe or won't be able to keep breathing.

Prevalence
The Centers for Disease Control and Prevention (CDC) estimate that approximately 8.2 percent of adults and 9.4 percent of children in the US has asthma. More females (9.9 percent) than males (7.0 percent) have asthma, and the prevalence is higher among African Americans (12.1 percent) than among other ethnic groups (7.3 percent of Latinos and 8.1 percent of Caucasians).

(CDC, n.d.)

Death Rates from Asthma
- More women than men die from asthma.
- African Americans are two to three times more likely than any other racial or ethnic group to die from asthma.

Risk Factors
- Gender: Women are more likely than men to have asthma.
- Age: In children, boys are more likely to have it than girls. Adults aged 18–24 are more likely than older adults to have it.
- Race/Ethnicity: Multirace and African American adults are more likely than Caucasian adults to have it. African American children are two times more likely than Caucasian children to have asthma.
Chronic Conditions Fact Sheet and Presentation (continued)

- Education level: Adults who didn't finish high school are more likely than adults who graduated high school or college to have asthma.
- Income: Adults with an annual household income of $75,000 or less are more likely than adults with higher incomes to have asthma.
- Smokers are more likely than nonsmokers to have it.
- Obese adults are most likely to have it.
- African American adults are hospitalized for asthma more than Caucasians are.

(CDC, n.d.)

Causes and Contributing Factors

The exact cause of asthma has not been identified, but the triggers that can create asthma symptoms (asthma attacks), while different for each person, often include the following:

- Allergens like pollen, mold, animal dander, dust mites, cockroaches
- Tobacco smoke
- Outdoor air pollution
- Smoke from fires
- Infections such as flu and colds
- Physical exercise
- Strong emotions (may lead to hyperventilation, which can also cause an attack)

Common Symptoms

- Coughing and wheezing
- Breathlessness
- Chest tightness
- Nighttime or early morning coughing

Symptoms such as wheezing and difficulty breathing well can interfere with and limit daily activities. Severe asthma attacks can be very frightening and may result in hospitalization or death.

(American Lung Association, n.d.)
Chronic Conditions Fact Sheet and Presentation (continued)

Common Treatments

Asthma can be treated by the following:

- Recognizing and avoiding triggers; knowing warning signs of an attack
- Quick relief and long term control medications, taken as directed
- Learning how to manage asthma
- Having an individualized asthma management plan

(AAAAI, n.d.)

Local Resources

- Bayview Hunters Point Health and Environmental Resource Center (HERC) 415-468-4372
- Asthma education classes for Bayview Hunters Point residents and schools in 94124. Free.
- Chinese Community Health Resource Center 415-677-2573
- Asthma management classes, library, Cantonese and English. Free.
- Stop smoking programs at San Francisco General Hospital 415-206-6074 or information@sfsmokefree.org

References


RUBRIC FOR ASSESSING THE CHRONIC CONDITIONS FACT SHEET ASSIGNMENT

The following rubric may be used to assess and grade the Chronic Conditions Fact Sheet Assignment. The rubric includes five criteria that can be assessed on a spectrum from Emerging (not yet satisfactory), Satisfactory (acceptable but not outstanding work), and Proficient (equivalent to a grade of A). For each criterion, possible scores range from 0 to 10 points each. For us, a passing grade is generally 70 percent of possible points or, in this example, 35 out of 50 possible points.

Note that acceptable responses may vary from trainer to trainer. Please revise and customize this rubric as you wish.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Definition and basic health statistics</td>
<td><strong>EMERGING</strong> Less than 70%</td>
<td></td>
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<td></td>
<td><strong>SATISFACTORY</strong> 70–89%</td>
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<tr>
<td></td>
<td><strong>PROFICIENT</strong> 90–100%</td>
<td></td>
</tr>
<tr>
<td>1. Definition and basic health statistics</td>
<td>Fact sheet does not clearly or accurately define a specific chronic condition. Health statistics are missing, are not cited, are incomplete, or are unclear.</td>
<td>___/10</td>
</tr>
<tr>
<td></td>
<td>Fact sheet provides basic and accurate information. However, a more complete definition and health statistics would have improved the quality and usefulness of the fact sheet.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fact sheet clearly defines a specific health condition and provides updated health statistics (such as prevalence and mortality rates) for a local city, county, or state population.</td>
<td></td>
</tr>
<tr>
<td>2. Causes, symptoms, and treatments</td>
<td>Fact sheet does not provide common causes, symptoms, and treatments or they are unclear, lack citations, and/or are inaccurate.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fact sheet provides incomplete information about causes, symptoms, and treatments. Information is only partially cited.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fact sheet provides clear and accurate information about causes, symptoms, and treatments. Data is current and comes from reputable sources.</td>
<td></td>
</tr>
<tr>
<td>3. Local resources</td>
<td>Fact sheet does not provide local resources, they are unclear, or they are not local.</td>
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<tr>
<td></td>
<td>Fact sheet provides partial information about local resources. Less than three resources are provided and/or information is incomplete.</td>
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<tr>
<td></td>
<td>Fact sheet provides three local resources that could be of benefit to clients. Information is complete and easy to follow.</td>
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</table>
### Chronic Conditions Fact Sheet and Presentation (continued)

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CRITERIA</th>
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</thead>
<tbody>
<tr>
<td>4. Clarity of information</td>
<td><strong>Fact sheet is not well organized, and the ideas presented are difficult to follow or understand. This fact sheet should not be shared with clients or colleagues.</strong></td>
<td>____/10</td>
</tr>
<tr>
<td></td>
<td><strong>Greater clarity of organization or writing would strengthen the fact sheet to the level of proficient.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Fact sheet is well organized, clearly written, and easy to follow. This fact sheet could be shared with colleagues and clients alike.</strong></td>
<td></td>
</tr>
<tr>
<td>5. Use of proper citations</td>
<td><strong>Information presented does not include proper citations. Citations provided are incomplete, significantly outdated, do not apply to local populations, or do not come from professional and reputable sources.</strong></td>
<td>____/10</td>
</tr>
<tr>
<td></td>
<td><strong>Some citations are provided but others are missing. Citations are incomplete. Some citations do not apply to local populations, or do not come from reputable, professional sources.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Key information presented in the fact sheet is properly and clearly cited, following the example and guidelines provided. Citations are current and come from reputable sources.</strong></td>
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</table>

**Total points** ____/50

Suggested grading guidelines for the Chronic Conditions Fact Sheet are as follows: Satisfactory or Passing = 35 points or above.

Letter grades are as follows: A = 45–50 points; B = 40–44 points; C = 35–39 points; D = 30–34 points; F = below 30 points.
Case Study Assignment, Mr. Chatterjee

Your name: ____________________________

Date: _________________________________

Please carefully read the attached case study about a client named Mr. Dipesh Chatterjee. Do your best to respond to each of the questions posed, applying client-centered concepts and skills related to conducting an initial interview with a new client. Write your answers in the space provided, or on a separate document with each answer numbered (1, 2, 3, etc). This exam is worth _______ points.

Mr. Chatterjee is a new patient at the Hillside Family Clinic. This is his second visit. Mr. Chatterjee is 64 years old. He has hypertension, asthma, and was newly diagnosed, today, with depression. The physician has prescribed four different medications to be taken each day. The physician also told Mr. Chatterjee to start exercising every day, to stop eating fried foods, and to cut back on eating so much rice (carbohydrates) and salt (sodium).

Mr. Chatterjee was referred to meet with you to set up an action plan to better manage his chronic health conditions.

Mr. Chatterjee tells you he is disappointed in how his appointment with the physician went. He feels that the doctor assumed he didn’t know anything and gave him suggestions that weren’t very helpful.

Mr. Chatterjee wants to take care of his health and does a good job of taking his medications. But he is struggling with issues of diet, exercise, and his depression.

Mr. Chatterjee came to the US last year, after the death of his wife. He is living with his son and daughter-in-law. They are not aware of his dietary needs and are frustrated by his depression. His daughter-in-law cooks for the household and makes traditional Indian food that is delicious, but often fried and heavily salted. Mr. Chatterjee doesn’t want to offend his daughter-in-law by asking her to cook differently. He doesn’t want to be a burden.

Living in America is different than Mr. Chatterjee expected. He feels lost and misses his village in India where he was a teacher for almost 40 years. Mostly, however, Mr. Chatterjee misses his beloved wife of 40 years. “She was my wife and my best friend. We did everything together.”

Back home, Mr. Chatterjee and his wife used to take long walks every evening. But in America, he doesn’t feel comfortable in the neighborhood and rarely goes outside. He tells you, “In India, the blood pressure wasn’t so high. My wife cooked healthy foods, and we walked every day. And I was never depressed before she got cancer. But then the cancer came and there was nothing, nothing I could do to protect her...."
Case Study Assignment, Mr. Chatterjee (continued)

Case Study Questions:
Based on the information presented in the case study, how would you answer the following questions?

1. What resources and strengths does Mr. Chatterjee have?
2. What are the key challenges that Mr. Chatterjee is facing in terms of managing his health?
3. What will you do to try to create a better connection with Mr. Chatterjee?
4. Provide an example of an affirmation that you might offer to Mr. Chatterjee, and explain why you would offer it.
5. Identify two open-ended questions that you would ask Mr. Chatterjee, and explain why you feel these questions would be important to your work.
6. Identify two suggestions you might share with Mr. Chatterjee for actions that could help him better manage his health conditions.
7. Identify two types of referrals you might share with Mr. Chatterjee, and explain why.
Case Study Assignment, Mr. Chatterjee  (continued)

CASE STUDY, MR. CHATTERJEE: ANSWER KEY FOR TRAINERS

Assign each question a value, such as 10 points, and a total value such as 70 points. Typically, we use 70 percent as the line between passing and failing, with 70 percent representing satisfactory work and a grade of C or better. The 70-percent mark would be 49 out of 70 points, in this case.

Acceptable answers may vary from trainer to trainer. We are including our version of what the “correct” answer may be to these questions, but feel free to adjust this answer key to fit your unique situation.

Case Study Questions:

Based on the information presented in the case study, how would you answer the following questions?

1. What resources and strengths does Mr. Chatterjee have?
   - Family (is currently living with son and daughter-in-law)
   - History of exercise and a healthy diet
   - Desire to take care of his health
   - Strong marriage and a happy career as an educator

2. What are the key challenges that Mr. Chatterjee is facing in terms of managing his health?
   - Feels depression and grief over the loss of his beloved wife, home, culture, and status
   - Has poor communication with physician
   - Feels “lost” in the US
   - Doesn’t feel in control of his diet and is worried about offending his son and daughter-in-law by asking for dietary changes
   - Lacks easy access to a comfortable or safe place to walk or engage in other physical activity

3. What will you do to try to create a better connection with Mr. Chatterjee?

   Use client-centered concepts and skills. Use OARS. For example:
   - Ask open-ended questions that provide Mr. Chatterjee with opportunities to talk more about his current and former life, his health, and his priorities and concerns.
   - Listen, and then listen some more.
   - Support his autonomy and his right to decide what to do to manage his health.
   - Acknowledge the loss of his wife, as well as his sense of being “lost” in the US.
4. Provide an example of an affirmation that you might offer to Mr. Chatterjee, and explain why you would offer it.

There are many opportunities to provide an authentic affirmation to Mr. Chatterjee. For example:

- Acknowledge his desire to take care of his health and/or the fact that he made and kept an appointment at the Hillside Family Clinic.
- Mr. Chatterjee's long and loving marriage is valuable and significant.

5. Identify two open-ended questions that you would ask Mr. Chatterjee and explain why you feel these questions would be important to your work.

Many open-ended questions would work well. For example, learners might ask Mr. Chatterjee about one of the following topics:

- Ask him to tell them more about his wife, his life in India, his current living situation, his relationship with his son and daughter-in-law, and what his move to the US has been like.
- Ask him to describe how he spends his day and ask questions that link his past to the future, such as asking him about the long walks he used to take and his current interest in walking again.
- Ask him to tell them more about his support network—is there anyone who Mr. Chatterjee can talk to and confide in about issues such as the loss of his wife and his current depression?

6. Identify two suggestions you might share with Mr. Chatterjee for actions that could help him better manage his health conditions.

These, of course, should be written as suggestions rather than directions. They may include the following:

- Talking with his son and daughter-in-law about his high blood pressure and dietary concerns
- Exploring opportunities for walking in places where Mr. Chatterjee would feel safe and comfortable
- Connecting with others such as local South Asian communities or other new immigrants, seniors, or whoever Mr. Chatterjee may view as compatible for developing new friendships
Case Study Assignment, Mr. Chatterjee  (continued)

7. Identify two types of referrals you might share with Mr. Chatterjee, and explain why.

Ideally, learners will discuss how to assess Mr. Chatterjee’s interest in possible referrals. Referrals should be based on the information provided in the case study and should not reflect the assumptions or interests of learners.

For example, possible referrals may include the following:

- Opportunities to connect with agencies or programs serving South Asian communities
- Social or support groups addressing issues of grief, loss, or depression
- Opportunities to engage in physical activity such as walking or hiking groups or programs
- Programs or classes on shopping for healthy and affordable food and/or cooking (culturally relevant foods)
- Opportunities for Mr. Chatterjee to share some of his skills and expertise (such as teaching or mentoring)
- A referral to a new physician who has greater client-centered skills