

**DEPARTMENT OF SOCIAL WORK**

# **Field Instructor Manual**

2020-2021

**Westfield State University**

# Field Education Program Staff Contact Information

*Terri J. Haven, MSW, LICSW*

Field Education Director  
Department of Social Work  
Office: (413) 572-8405  
Email: [thaven@westfield.ma.edu](mailto:thaven@westfield.ma.edu)

*Jamie L. Walsh, MSW, LICSW*

Assistant Field Education Director  
Department of Social Work  
Office: (413) 572-8446  
Email: [jlwalsh@westfield.ma.edu](mailto:jlwalsh@westfield.ma.edu)

College of Education, Health, and Human Services  
Westfield State University  
577 Western Ave  
PO Box 1630 Westfield, MA 01086-1630



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*“Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being”.*



DEPARTMENT OF SOCIAL WORK  
FIELD EDUCATION PROGRAM

# Overview

# Social Work Field Practicum(s) at a Glance

## A BRIEF SUMMARY:

Criteria	BSW	MSW Foundation	MSW Advanced
<b>Field Placement Hour Requirements:</b>			
Total hour requirement for academic year	480	400	500
Total hour requirement per semester	240	200	250
Senior Capstone course per semester <i>(included in total hours)</i>	18.75		
Weekly Integrative Field Seminar course per semester <i>(included in total hours)</i>	18.75	26.25	26.25
<b>Supervision/Field Instructor Requirements:</b>			
BSW or MSW from accredited school of Social Work	✓		
MSW from an accredited school of Social Work		✓	✓
Minimum 2 years post-degree Social Work experience	✓	✓	✓
Licensure requirement MA LCSW or LICSW <i>(or equivalent in another state)</i>	Preferred	✓	✓
LICSW Preferred		✓	✓
Min. 1 hour/week supervision w/ primary supervisor	✓	✓	✓
1 additional hour/week task-oriented or group supervision	✓	✓	✓
<b>Social Work Practice Focus:</b>			
Generalist foundation competencies	✓	✓	
Advanced clinical competencies			✓
Focus on generalist Social Work services and settings	✓	✓	
Focus on clinical Social Work services and settings			✓
<b>Miscellaneous:</b>			
IPT online access for all required field documents	✓	✓	✓
Westfield Campus	✓	✓	✓
Worcester Campus		✓	✓
Weekly Integrative Field Seminar Course <i>(student course in conjunction with field placement)</i>	Synchronous	Synchronous	Asynchronous
Site Visit per semester	✓	✓	✓
IBHC Student Fellowship <i>(eligible to apply, includes stipend)</i>			✓
Employment-Based Field Placement Option	✓	✓	✓

# MSW Advanced Field Practicum

## A BRIEF SUMMARY:

### Clinical Social Work Practice Focus:

- ❑ Builds on a generalist practice foundation and provides in-depth *clinical* experience.
- ❑ Includes opportunities to practice assessment, diagnosis, treatment (*including but not limited to, counseling and psychotherapy, family therapy, group work, play therapy, etc.*), client-centered advocacy, interdisciplinary teams, supervision, consultation, and evaluation.
- ❑ Placements may include mental health and addictions programs, schools, family service and child protective agencies, medical settings, forensic settings, and other settings where clinical social work services are provided.
- ❑ Some advanced placements reflect WSU program additional focus on clinical work with children and families, but are often with a different client population, particularly if the student's foundation field placement was child and family focused.
  - Employment-Based Field Placement may be developed within certain guidelines and an additional approval process.

### Practicum Includes:

- ❑ Minimum of 500 hours total (*250 minimum per semester for two full semesters*).
- ❑ Hours include:
  - Field Placement:
    - Students work in collaboration with the field site to determine weekly schedule and to be available for daytime meetings and trainings as required by the agency.
  - Weekly Integrative Field Seminar:
    - Asynchronous with WSU clinical practice course instructors.
    - Provides students with the opportunities to discuss and compare practicum experiences, learn from and teach each other, examine personal values and ethical issues in social work practice, and further integrate knowledge and experience through structured assignments and activities.
    - Full participation in the Weekly Integrative Seminar may provide up to 52.5 hours of the total 500 practicum hours (26.25 hours per semester).

### Supervision Requirement:

- ❑ Master's Degree in Social Work (MSW) from an accredited school of social work and a minimum of two years post-MSW experience.
  - Licensure requirement MA LCSW or LICSW (*or equivalent in another state*).
  - LICSW *preferred* for advanced placement.
  - MA State employees may be exempt from licensure requirement.
- ❑ Minimum of 1 hour/week of individual, face-to-face, student/client-focused supervision with primary supervisor.
- ❑ 1 additional hour/week of task-oriented and/or group supervision that may or may not be provided by primary supervisor.

# MSW Foundation Field Practicum

## A BRIEF SUMMARY:

### Generalist Social Work Practice Focus:

- Opportunity to practice and demonstrate mastery of the competency-based knowledge, values, and skills learned in the classroom through supervised practice with actual clients in a social service environment.
- Begin to develop a professional identity as a social worker.
- Placements may include schools, family service and child protective agencies, mental health and addictions programs, and other settings where generalist social work services are provided.
  - Employment-Based Field Placement may be developed within certain guidelines and an additional approval process.

### Practicum Includes:

- Minimum of 400 hours total (*200 minimum per semester for two full semesters*).
- Hours include:
  - Field Placement:
    - Students work in collaboration with the field site to determine weekly schedule and to be available for daytime meetings and trainings as required by the agency.
  - Weekly Integrative Field Seminar:
    - Synchronous with WSU clinical practice course instructors.
    - Provides students with the opportunities to discuss and compare practicum experiences, learn from and teach each other, examine personal values and ethical issues in social work practice, and further integrate knowledge and experience through structured assignments and activities.
    - Full participation in the Weekly Integrative Seminar may provide up to 52.5 hours of the total 400 practicum hours (26.25 hours per semester).

### Supervision Requirement:

- Master's Degree in Social Work (MSW) from an accredited school of social work and a minimum of two years post-MSW experience.
  - Licensure requirement MA LCSW or LICSW (*or equivalent in another state*).
  - LICSW *preferred* for advanced placement.
  - MA State employees may be exempt from licensure requirement.
- Minimum of 1 hour/week of individual, face-to-face, student/client-focused supervision with primary supervisor.
- 1 additional hour/week of task-oriented and/or group supervision that may or may not be provided by primary supervisor.

# BSW Field Practicum

## A BRIEF SUMMARY:

### Generalist Social Work Practice Focus:

- Opportunity to practice and demonstrate mastery of the competency-based knowledge, values, and skills learned in the classroom through supervised practice with actual clients in a social service environment.
- Begin to develop a professional identity as a social worker.
- Placements may include schools, family service and child protective agencies, mental health and addictions programs, and other settings where generalist social work services are provided.
  - Employment-Based Field Placement may be developed within certain guidelines and an additional approval process.

### Practicum Includes:

- Minimum of 480 hours total (*240 minimum per semester for two full semesters*).
- Hours include:
  - Field Placement:
    - Students work in collaboration with the field site to determine weekly schedule and to be available for daytime meetings and trainings as required by the agency.
  - Weekly Integrative Field Seminar:
    - Synchronous with WSU clinical practice course instructors.
    - Provides students with the opportunities to discuss and compare practicum experiences, learn from and teach each other, examine personal values and ethical issues in social work practice, and further integrate knowledge and experience through structured assignments and activities.
    - Full participation in the Weekly Integrative Seminar may provide up to 37.5 hours of the total 480 practicum hours (18.75 hours per semester).
  - Capstone Project:
    - Students participate in an integrative applied professional project carried out under the supervision of their capstone instructor. Depending on the particular project, students may consult with their Agency Field Instructor in the development and implementation of the project as feasible and would benefit the agency.
    - Full participation in the Capstone Project may provide up to 37.5 hours of the total 480 practicum hours (18.75 hours per semester).

### Supervision Requirement:

- Bachelors or Master's Degree in Social Work (BSW or MSW) from an accredited school of social work and a minimum of two years post-degree social work experience.
- Minimum of 1 hour/week of individual, face-to-face, student/client-focused supervision with primary supervisor.
- 1 additional hour/week of task-oriented and/or group supervision that may or may not be provided by primary supervisor.



# Field Education Calendar

Fall 2020 – Spring 2021

## ACADEMIC YEAR VIEW:

*Please refer to specific course syllabus for field-related course assignments and other due dates*

### Fall 2020:

- |   |  |
|---|--|
| <input type="checkbox"/> September 2nd                                | Classes Begin  |
| <input type="checkbox"/> Week of October 5th                          | Draft of Learning Agreement Due  |
| <input type="checkbox"/> October 12 <sup>th</sup>                     | Columbus Day – No Classes  |
| <input type="checkbox"/> October – November                           | Field Site Visits by Faculty Liaisons (remote)                         |
| <input type="checkbox"/> November 11 <sup>th</sup>                    | Veteran’s Day – No Classes   |
| <input type="checkbox"/> November 25 <sup>th</sup> – 27 <sup>th</sup> | Thanksgiving Recess (begins 12:30pm on 11/25; no classes 11/26, 11/27) |
| <input type="checkbox"/> November 30th                                | Classes Resume   |
| <input type="checkbox"/> Week of December 7 <sup>th</sup>             | Field Placement Evaluations Due  |
| <input type="checkbox"/> Week of December 14 <sup>th</sup>            | Classes End for the Semester   |

### Spring 2021:

- |   |  |
|---|--|
| <input type="checkbox"/> January 19th                             | Classes Begin  |
| <input type="checkbox"/> Week of January 25th                     | Students Continue in Field Placements ( <i>note: most students continue in field placement during some portion of the semester break as negotiated and determined in individual placements</i> ) |
| <input type="checkbox"/> February 15 <sup>th</sup>                | President’s Day – No Classes   |
| <input type="checkbox"/> March 8 <sup>th</sup> – 12 <sup>th</sup> | Spring Break – No Classes ( <i>note: most students continue in field placement during some portion of the spring break as negotiated and determined in individual placements</i> )               |
| <input type="checkbox"/> March 15 <sup>th</sup>                   | Classes Resume   |
| <input type="checkbox"/> March – April                            | Field Site Visits by Faculty Liaisons (likely remote)  |
| <input type="checkbox"/> April 19 <sup>th</sup>                   | Patriot’s Day – No Classes   |
| <input type="checkbox"/> Week of April 26 <sup>th</sup>           | Field Placement Evaluations Due  |
| <input type="checkbox"/> Week of May 3 <sup>rd</sup>              | Target for Completing Field Placement  |

# Field Education Materials

## A BRIEF SUMMARY:

In addition to materials within the Field Instructor Manual, our Field Education Program maintains a web page within the larger WSU Social Work Department website. The web page may be accessed at:

- <http://www.westfield.ma.edu/academics/social-work-department/field-education>
- Please utilize this website for direct links to most field-related materials and in-depth information regarding field policies, procedures and training videos.

### Examples of materials available on this site include:

- Student Applications for Field Practicum
  - BSW
  - MSW
- Student Application for Employment-Based Field Practicum
- BSW Field Education Manual
- MSW Field Education Manual
- FAQ BSW Field Practicum
- FAQ MSW Field Practicum
- DCF Guidelines for Employment-Based Field Practicum

### IPT specific materials available on this site include:

- SOCW Field Docs (IPT) Site
- Introduction to IPT (Video)
- Introduction to Field Timesheet and Activities (Video)
- Introduction to Field Practicum Learning Agreement & Evaluation (Video)

# Field Documentation System – IPT

## A BRIEF SUMMARY:

### **IPT:**

- Previously referred to as SOCW Field Docs
- IPT stands for *Intern Placement Tracking*
- Our web-based system for students, field instructors, and faculty liaisons
- Easy access and completion of all field-related documentation
- “Student-driven”
  - Field instructors receive an email notification anytime a document is ready for review/signature

### **Information and Documentation all in one place:**

- Contact information
- Websites
- Timesheets
- Learning Agreements
- Evaluations
- Access and information are secure, password-protected, and encrypted

### **IPT Training Videos:**

- Always available to view online on our WSU Social Work Field Education page at <http://www.westfield.ma.edu/academics/social-work-department/field-education>
- Include actual screen shots and demonstrations of how to use each aspect of the system
  - Introduction to IPT (Video)
  - Introduction to Timesheet and Activities (Video)
  - Introduction to Field Practicum Learning Agreement & Evaluation (Video)

# Interdisciplinary Behavioral Health Collaboration Project

## A BRIEF SUMMARY:

In 2017, the Department of Social Work received a 4-year HRSA (Health Resources and Services Administration) Behavioral Health Workforce Education and Training Program grant. The grant award of 1.3 million funds the Interdisciplinary Behavioral Health Collaboration (IBHC) Project. The IBHC Project improves access to advanced training in integrated behavioral healthcare for Master of Social Work (MSW) students who live and train in areas of the state that have numerous medically underserved areas and populations (MUA/Ps). Over the course of the 4-year grant, the IBHC Project has provided \$10,000 stipends to 81 MSW students in advanced year integrative behavioral healthcare field placements to build workforce capacity in MUA/Ps. The 4<sup>th</sup> cohort of IBHC Fellows are currently completing their Fellowship and the Project is scheduled to be completed in August 2021.

- **The overarching IBHC Project goal is to build integrated behavioral health care capacity in four distinct and interrelated constituencies:**
  - among MSW students
  - with faculty
  - among field supervisors
  - with existing workforces

To fulfill this goal, WSU offers an annual IBHC Conference, and our IBHC Fellows provide two Grand Rounds each year that include an interprofessional audience through emerging collaborations with the Nursing and Physician Assistant Programs at WSU. Additionally, each year the IBHC Project creates 8 virtual training modules on pertinent topics within integrated care that are also available in Spanish and CC. Every training opportunity within the IBHC Project provides complimentary CEUs for social workers and nurses. The IBHC Team works closely with field supervisors and community partner administrators to provide consultations and suggested resources for increasing their workforce capacity for providing integrated care services.

### Current IBHC Training Modules include topics such as:

- Intro to Integrated, Team-Based Care in Health
- Storytelling as a Therapeutic & Supervisory Intervention
- Caring for LGBTQ Populations
- An Introduction to Best Practices in Providing Medication Assisted Treatment (MAT) for Opioid Use Disorder
- The Neurobiology & Genetics of Addiction
- The Intersection of Nursing and Social Work & the Role of Interprofessional Education
- Psychopharmacology for Social Workers Depression and Anxiety
- Trauma Responsive Sheltering in Homelessness Work.

### For Additional Information, Contact:

Terri J. Haven, MSW, LICSW, IBHC Field Education Director 413-572-8405, [thaven@westfield.ma.edu](mailto:thaven@westfield.ma.edu)

Nora Padykula, PhD, LICSW, IBHC Project Director, 413-572-8239, [npadykula@westfield.ma.edu](mailto:npadykula@westfield.ma.edu)

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DEPARTMENT OF SOCIAL WORK  
FIELD EDUCATION PROGRAM

# Program Competencies & Observable Behaviors

# Learning Agreement – Key Points

## A BRIEF SUMMARY:

### ❑ What is a Learning Agreement?

- Describes how the student will specifically develop and apply the required Social Work Competencies in *observable* ways within the internship setting and represents the student's specific objectives for the internship.

### ❑ How/when is the Learning Agreement Developed?

- Template provided in IPT
- Developed during the first month of the internship
- Collaborative Process:
  - Student – overall responsibility to initiate the process; strengths, abilities, interests, areas for professional growth
  - Field Instructor – opportunities at the agency; expectations of student; keep the agency mission, areas of service in mind; how will you observe the student doing this? (what will you see, hear, etc.)
  - Faculty Field Liaison - support Field Instructor and Student in operationalizing the competencies, final approval of the Agreement
  - Student, Field Instructor, and/or Faculty Field Liaison may write in the Learning Agreement
- Activities should be behaviorally specific
  - Helpful verbs may include: interview, read, observe, discuss, demonstrate, take initiative, utilize, attend, distinguish between, write
- How to Acknowledge the Learning Agreement is Complete?
  - Student first signs, then Field Instructor, then Faculty Field Liaison
- What Happens if the Learning Agreement Needs to be modified after it has been signed?
  - Contact the Field Program Staff Identified on the first page of IPT and ask that signatures be removed – edit the form – re-sign

### ❑ How is the Learning Agreement Used throughout the Internship?

- This becomes the agreement about how and what the student is doing throughout the year, how the Social Work Competencies are being specifically met, and becomes the basis, the blueprint, for both the fall and spring semester evaluations.

***“TELL ME AND I FORGET. TEACH ME AND I REMEMBER. INVOLVE ME AND I LEARN.”***  
***Benjamin Franklin***



# Competency-Based Education



In 2008 CSWE adopted a competency-based education framework for its EPAS. As in related health and human service professions, the policy moved from a model of curriculum design focused on content (what students should be taught) and structure (the format and organization of educational components) to one focused on student learning outcomes. A competency-based approach refers to identifying and assessing what students demonstrate in practice. In social work this approach involves assessing students' ability to demonstrate the competencies identified in the educational policy.

Competency-based education rests upon a shared view of the nature of competence in professional practice. Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being. EPAS recognizes a holistic view of competence; that is, the demonstration of competence is informed by knowledge, values, skills, and cognitive and affective processes that include the social worker's critical thinking, affective reactions, and exercise of judgment in regard to unique practice situations. Overall professional competence is multi-dimensional and composed of interrelated competencies. An individual social worker's competence is seen as developmental and dynamic, changing over time in relation to continuous learning.

Competency-based education is an outcomes-oriented approach to curriculum design. The goal of the outcomes approach is to ensure that students are able to demonstrate the integration and application of the competencies in practice. In EPAS, social work practice competence consists of nine interrelated competencies and component behaviors that are comprised of knowledge, values, skills, and cognitive and affective processes.

Using a curriculum design that begins with the outcomes, expressed as the expected competencies, programs develop the substantive content, pedagogical approach, and educational activities that provide learning opportunities for students to demonstrate the competencies.

Assessment of student learning outcomes is an essential component of competency-based education. Assessment provides evidence that students have demonstrated the level of competence necessary to enter professional practice, which in turn shows programs are successful in achieving their goals. Assessment information is used to improve the educational program and the methods used to assess student learning outcomes.

Programs assess students' demonstration of competence. The assessment methods used by programs gather data that serve as evidence of student learning outcomes and the demonstration of competence. Understanding social work practice is complex and multi-dimensional, the assessment methods used by programs and the data collected may vary by context.

“Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being.”

The background of the cover is a photograph of a university campus. In the foreground, there are large, leafy trees with green and white blossoms. The middle ground shows a wide, green lawn with several trees, some of which have vibrant pink or purple blossoms. In the background, a large, multi-story building with a red brick facade is visible under a clear blue sky. The overall atmosphere is bright and sunny.

# Learning Agreement Guide

BSW & MSW  
Foundation  
Edition





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## OVERVIEW

### COMPETENCY-BASED EDUCATION

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Social Work education is competency-based. Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being.

The framework for competency-based education includes a focus on the assessment of the student's ability to **demonstrate** the competencies rather than only on the assessment of inputs (such as coursework and resources). Social work practice competence consists of nine interrelated competencies, with specific observable behaviors for each competency. The overall objective of the practicum is to demonstrate competency for entry level generalist practice as identified in the nine social work competencies and specific observable behaviors.

The Council on Social Work Education (CSWE) and our social work program recognize a **holistic view of competence**; that is, the demonstration of competence **is informed by the holistic dimensions of knowledge, values, skills, and cognitive and affective processes that include the social worker's critical thinking, affective reactions, and exercise of judgment in regard to unique practice situations.**

### LEARNING AGREEMENT INSTRUCTIONS

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The Learning Agreement is developed collaboratively by the student, field instructor, and faculty field liaison. The Agreement will describe how the student will specifically apply the competencies in observable ways within the internship setting. The completed Learning Agreement then represents the student's specific objectives for the internship.

Observable behaviors are listed below each competency. In the subsequent text boxes, please describe the specific activities the student will complete at the internship setting for each observable behavior listed. These activities should provide opportunities for mastery of each competency, demonstrated and informed by the holistic dimensions of knowledge, skills, values, and cognitive and affective processes.

### PURPOSE OF THIS GUIDE

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The purpose of this guide is to provide you with general examples of activities for the observable behaviors listed under each competency to assist in supporting your development and creation of site-specific activities.

The activities associated with a specific observable behavior can look very different in working with different populations and settings. Faculty Field Liaison, Field Instructor and student should make every effort to assure a learning plan for all competencies and observable behaviors. In the rare occasion that a particular competency/observable behavior appears completely unavailable at that site, the Faculty Field Liaison should collaborate with the student and field instructor to explore the ways in which that competency may be mastered in the setting. Please consider demonstration of the behavior through simulation as a possible alternative prior to an "N/A" being utilized.

## BSW & MSW FOUNDATION COMPETENCIES

### Competency #1

#### Demonstrate Ethical and Professional Behavior

Social workers understand the value base of the profession and its ethical standards, as well as relevant laws and regulations that may impact practice at the micro, mezzo, and macro levels. Social workers understand frameworks of ethical decision-making and how to apply principles of critical thinking to those frameworks in practice, research, and policy arenas. Social workers recognize personal values and the distinction between personal and professional values. They also understand how their personal experiences and affective reactions influence their professional judgment and behavior. Social workers understand the profession's history, its mission, and the roles and responsibilities of the profession. Social Workers also understand the role of other professions when engaged in interprofessional teams. Social workers recognize the importance of lifelong learning and are committed to continually updating their skills to ensure they are relevant and effective. Social workers also understand emerging forms of technology and the ethical use of technology in social work practice.

Students will demonstrate the following behaviors by the end of their generalist field practicum:

<b>F 1.1</b>	<b>The ability to make ethical decisions by applying the standards of the NASW code of ethics, relevant laws and regulations, models for ethical decision-making, ethical conduct of research, and additional codes of ethics as appropriate to context</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Refer to the NASW Code of Ethics when encountered with an ethical issue to identify ethical dilemmas, any potential strategies to resolve those ethical dilemmas, and will demonstrate emerging knowledge of ethical decision-making models in collaboration with field instructor.</li> <li><input type="checkbox"/> Recognize ethical dilemma in practice and seek out appropriate assistance from field instructors in coming to a resolution of the dilemma and can identify all relevant ethical principles that apply to specific cases.</li> <li><input type="checkbox"/> Read and review agency Code of Ethics and compare with NASW Code of Ethics. Discuss this in supervision.</li> </ul>
<b>F 1.2</b>	<b>The use of reflection and self-regulation to manage personal values and maintain professionalism in practice situations</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Recognize the differences between a personal response to a client and a professional response during an interaction with a client and provide the rationale for your professional response.</li> <li><input type="checkbox"/> After each client interaction, reflect on what occurred and consider personal strengths and opportunities to improve when interacting with each client. During supervision time, discuss these reflections with my field instructor and identify personal values that are in agreement and/or conflict with agency and client population.</li> <li><input type="checkbox"/> Practice behaviors that demonstrate commitment to appropriate roles and boundaries, increase practice skills, increase self-awareness, and utilize feedback to develop and implement plan for self-correction (e.g. not exchanging personal contact information with clients, being mindful of use of social media, etc.).</li> </ul>



<b>F 1.3</b>	<b>Demonstrate professional demeanor in behavior; appearance; and oral, written, and electronic communication</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Use professional language (verbal/nonverbal) when dealing with clients and other professionals in the workplace, and refrain from use of derogatory language in written and verbal communication.</li> <li><input type="checkbox"/> Read and follow agency policy and procedures regarding professional behavior, dress code, and communication (e.g., case notes, memos, e-mail, etc.).</li> <li><input type="checkbox"/> Exhibit a professional attitude by arriving to the Field Practicum Site dressed appropriately, with a positive outlook, prepared mentally and emotionally to engage with staff and clients, and prepare to learn.</li> </ul>
<b>F 1.4</b>	<b>The use of technology ethically and appropriately to facilitate practice outcomes</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Demonstrate awareness of agency policy regarding use of technology and verbalize to Field Instructor.</li> <li><input type="checkbox"/> Use strategies of ethical reasoning to address the use of technology in all client and/or constituency settings and be cognizant of its effect on client rights.</li> <li><input type="checkbox"/> Evaluate the ethical and appropriate use of technology to facilitate practice outcomes with individuals, families and small groups.</li> </ul>
<b>F 1.5</b>	<b>The use of supervision and consultation to guide professional judgment and behavior</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Meet weekly for individual supervision, manage and learn from constructive feedback, demonstrate the capacity for critical thinking, self-examination, insight, insight in self-awareness, and display increasing initiative and independence within the agency structure and in keeping within the lines of authority and the student role.</li> <li><input type="checkbox"/> Discuss a case with field instructor, supervisor, or other agency staff before, during and/or after client contacts/agency activities and follow up with recommendations and listen to feedback regarding strengths and opportunities to improve.</li> <li><input type="checkbox"/> Demonstrate the effective use of consultation and supervision to guide ethical decision making in one's own practice.</li> </ul>

**Competency #2**  
**Engage Diversity and Difference in Practice**

Social workers understand how diversity and difference characterize and shape the human experience and are critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including but not limited to age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion/spirituality, sex, sexual orientation, and tribal sovereign status. Social workers understand that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim. Social workers also understand the forms and mechanisms of oppression and discrimination and recognize the extent to which a culture's structures and values, including social, economic, political, and cultural exclusions, may oppress, marginalize, alienate, or create privilege and power.

Students will demonstrate the following behaviors by the end of their generalist field practicum:

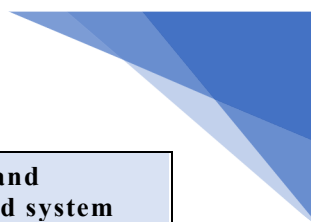
<b>F 2.1</b>	<b>The ability to apply and communicate understanding of the importance of diversity, intersectionality and difference in shaping life experiences in practice at the micro, mezzo, and macro levels</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Discuss barriers to services faced by clients, and when assessing client problems, considers impact of economic, racism, political, and social and institutional oppression on client functioning.</li> <li><input type="checkbox"/> Demonstrate knowledge and respect of differences in relation to age, class, color, disability, ethnicity, family structure, gender, marital status, national origin, race, religion, sex, and sexual orientation in social work generalist practice.</li> <li><input type="checkbox"/> Identify structures and values that contribute to oppression and marginalization. Describe with supervisor the ways in which clients have been marginalized and the cultural and societal dynamics which promote the marginalization (i.e., ethnicity, religious beliefs, socioeconomic status, rural vs. urban environment, gender, sexual orientation, ageism, etc.).</li> </ul>
<b>F 2.2</b>	<b>Presentation of themselves as learners and engage clients and constituencies as experts of their own experiences</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Participate in professional development to learn about diversity issues (i.e. Refugee populations, UNI NCBI training, poverty simulation, etc.)</li> <li><input type="checkbox"/> Engage in continuing education to develop specialized knowledge and understanding of the history, traditions, values, family systems, and artistic expressions of major client groups served.</li> <li><input type="checkbox"/> Sit quietly in an intake or waiting room area and observe the atmosphere, conversation and behaviors of persons entering the service delivery system, as well as of those who serve them.</li> </ul>
<b>F 2.3</b>	<b>The ability to apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Recognize when personal biases may impact/influence ability to serve client.</li> <li><input type="checkbox"/> Acknowledge negative emotions associated with difficult ethical decisions.</li> <li><input type="checkbox"/> Seek consultation and support from peers and colleagues and values differing opinions regarding ethical dilemma.</li> </ul>

### **Competency #3**

#### **Advance Human Rights and Social, Economic, and Environmental Justice**

Social workers understand that every person regardless of position in society has fundamental human rights such as freedom, safety, privacy, an adequate standard of living, health care, and education. Social workers understand the global interconnections of oppression and human rights violations and are knowledgeable about theories of human need and social justice and strategies to promote social and economic justice and human rights. Social workers understand strategies designed to eliminate oppressive structural barriers to ensure that social goods, rights, and responsibilities are distributed equitably, and that civil, political, environmental, economic, social, and cultural human rights are protected.

Students will demonstrate the following behaviors by the end of their generalist field practicum:

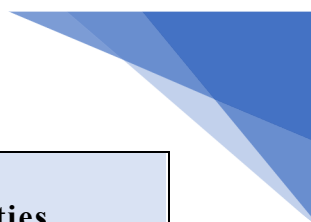


<b>F 3.1</b>	<b>The ability to apply their understanding of social, economic, spiritual, and environmental justice to advocate for human rights at the individual and system levels</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Use knowledge gained in the classroom about the effects of oppression, discrimination, structural social inequality and historical trauma on clients and/or constituencies to guide intervention and/or project planning.</li> <li><input type="checkbox"/> Apply principles of social, economic, and environmental justice to advocate for human rights within the scope of the organization’s mission.</li> <li><input type="checkbox"/> Identify agency population being served and social policies that have created and/or continue to create oppressive circumstances for the life course of the individuals/group.</li> </ul>
<b>F 3.2</b>	<b>The ability to engage in practices that advance social, economic, spiritual, and environmental justice</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Explore agency initiatives regarding gaps in access to services for underserved populations (e.g., attend NASW LEAD Day, attend NASW Advocacy Day, etc.).</li> <li><input type="checkbox"/> Evaluate needs of clients, barriers in meeting them, and establish creative, cost-effective solutions consistent with agency mission/goals.</li> <li><input type="checkbox"/> Attend relevant trainings, community outreach events, and public policy meetings.</li> </ul>

<b>Competency #4</b>	
<b>Engage in Practice-informed Research and Research-informed Practice</b>	
<p>Social workers understand quantitative and qualitative research methods and their respective roles in advancing a science of social work and in evaluating their practice. Social workers know the principles of logic, scientific inquiry, and culturally informed and ethical approaches to building knowledge. Social workers understand that evidence that informs practice derives from multi-disciplinary sources and multiple ways of knowing. They also understand the processes for translating research findings into effective practice.</p> <p>Students will demonstrate the following behaviors by the end of their generalist field practicum:</p>	
<b>F 4.1</b>	<b>The use of practice experience, theory, and multiple perspectives, to investigate the social world and practice efficacy</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Use a client situation or issue to research scholarly information (i.e., domestic violence, juvenile delinquency, truancy) and begin to connect underlying issues.</li> <li><input type="checkbox"/> In consultation with field supervisor, identify an agency problem or issue that needs to be addressed and formulate a problem statement.</li> <li><input type="checkbox"/> Through observation of staff workers and field instructor, learn about planned change process and be able to understand the definition and discuss how it is implemented in helping clients achieve their goals.</li> </ul>
<b>F 4.2</b>	<b>The ability to apply critical thinking skills to analyzing research methods and findings</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review, evaluate, and appraise current agency services, as well as needs and trends in the communities in which services are being provided.</li> <li><input type="checkbox"/> Take initiative to locate a peer reviewed article that provides research information on population served at internship, using material learned from Research Methods class, critically analyze the findings and share thoughts with field instructor.</li> <li><input type="checkbox"/> Apply critical thinking to engage in analysis of quantitative and qualitative research methods and research findings, and develop informed practice initiatives, while working with individuals, families, and small groups.</li> </ul>

<b>F 4.3</b>	<b>The ability to use and translate research evidence and integrate evidence-based approaches to improve practice, policy, and service delivery</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Take initiative to locate peer reviewed articles that provide research evidenced-based practice interventions and share with field instructor the implications for practice on the agency, assigned clients and/or projects.</li> <li><input type="checkbox"/> Gain knowledge on state/national policies relevant to agency and discuss implications of policies with field instructor.</li> <li><input type="checkbox"/> In supervision with field instructor, discuss best practices and evidence-based approaches used in the agency and how they could potentially be improved or how they have evolved.</li> </ul>

<b>Competency #5</b>	
<b>Engage in Policy Practice</b>	
<p>Social workers understand that human rights and social justice, as well as social welfare and services, are mediated by policy and its implementation at the federal, state, and local levels. Social workers understand the history and current structures of social policies and services, the role of policy in service delivery, and the role of practice in policy development. Social workers understand their role in policy development and implementation within their practice settings at the micro, mezzo, and macro levels and they actively engage in policy practice to effect change within those settings. Social workers recognize and understand the historical, social, cultural, economic, organizational, environmental, and global influences that affect social policy. They are also knowledgeable about policy formulation, analysis, implementation, and evaluation.</p> <p>Students will demonstrate the following behaviors by the end of their generalist field practicum:</p>	
<b>F 5.1</b>	<b>Identify social policy at the local, state, and federal level that impacts well-being, service delivery, and access to social services</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Describe social policies, laws, and practices that impact the client system or delivery of services.</li> <li><input type="checkbox"/> Review federal, state and/or local policies that impact agency services/activities and (process it during supervision and/or apply it to a case/example.</li> <li><input type="checkbox"/> Identify the evolution of social policies at the local, state, and federal level and analyze how they impact well-being, service delivery, and access to social services for individuals, families, and small groups.</li> </ul>
<b>F 5.2</b>	<b>Assess the impact of social welfare and economic policies on the delivery of and access to social services</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Recognize the relationships between funding sources, public policies and client systems that are served by placement and discuss with supervisor the impact on client's and constituencies served.</li> <li><input type="checkbox"/> Identify and apply a framework that assesses how social welfare and economic policies impact the delivery of and access to social services for individual, families, and small groups.</li> <li><input type="checkbox"/> Identify both the intended and unintended consequences of policies for clients and how policies impede access to services and/or service delivery.</li> </ul>
<b>F 5.3</b>	<b>Critically analyze, formulate, and advocate for policies that advance human rights and social, economic, and environmental justice</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Collaborate with agency to identify tasks to help resolve an identified social problem that is impacted by policy at the agency, community, local, state or federal level.</li> <li><input type="checkbox"/> Use information from policy classes to apply critical thinking and analysis on the best way to advocate for services needed by clients and/or clientele.</li> <li><input type="checkbox"/> Anticipate development of barriers to service delivery (e.g., budget cuts, negative publicity regarding target population) and propose strategies to prevent disruption of services.</li> </ul>



**Competency #6**  
**Engage with Individuals, Families, Groups, Organizations, and Communities**

Social workers understand that engagement is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers value the importance of human relationships. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge to facilitate engagement with clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand strategies to engage diverse clients and constituencies to advance practice effectiveness. Social workers understand how their personal experiences and affective reactions may impact their ability to effectively engage with diverse clients and constituencies. Social workers value principles of relationship building and interprofessional collaboration to facilitate engagement with clients, constituencies, and other professionals as appropriate.

Students will demonstrate the following behaviors by the end of their generalist field practicum:

<b>F 6.1</b>	<b>The use of knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks to engage with clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Apply preparing skills prior to engagement activities at the micro, mezzo and/or macro levels and process it during a supervisory session and/or apply it to a case/example.</li> <li><input type="checkbox"/> Identify and integrate theoretical frameworks to prepare for and build relationships with individuals, families, and small groups.</li> <li><input type="checkbox"/> Read case files and any other pertinent information to prepare for engagement with individuals, families, groups, organizations, and communities.</li> </ul>
<b>F 6.2</b>	<b>The use of empathy, reflection, and interpersonal interviewing skills to effectively engage diverse clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Receive feedback from field instructor during supervisory sessions regarding engagement skills (attend, seek, clarify, reflect) and follow through with recommendations.</li> <li><input type="checkbox"/> Establish rapport with the client system and “start where the client is.”</li> <li><input type="checkbox"/> Listen attentively to clients and work to accurately grasp feelings and understand circumstances of client.</li> </ul>

**Competency #7**  
**Assess Individuals, Families, Groups, Organizations, and Communities**

Social workers understand that assessment is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in the assessment of diverse clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand methods of assessment with diverse clients and constituencies to advance practice effectiveness. Social workers recognize the implications of the larger practice context in the assessment process and value the importance of interprofessional collaboration in this process. Social workers understand how their personal experiences and affective reactions may affect their assessment and decision-making.

Students will demonstrate the following behaviors by the end of their generalist field practicum:

<b>F 7.1</b>	<b>The collection and organization of data, and the application of critical thinking to interpret data gathered from clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Be aware of, and appropriately utilize, standardized measurement and diagnostic tools.</li> <li><input type="checkbox"/> Effectively articulate summaries of assessments, and auxiliary documentation to assist in the development of a tentative treatment plan for clients.</li> <li><input type="checkbox"/> Be able to display the ability to collect and organize data by utilizing tools such as genograms and Eco maps, and correctly interpret data gathered from assessment tools as evidenced by discussions during meetings with field instructor.</li> </ul>
<b>F 7.2</b>	<b>The use of knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the analysis of assessment data from clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Applies knowledge of multi-disciplinary theoretical frameworks (i.e., human behavior, person-and-environment, among others) in assessing information from clients and constituencies.</li> <li><input type="checkbox"/> Identify conceptual frameworks that explain development and impact on a client system.</li> <li><input type="checkbox"/> Do role-playing with the field instructor or others to try out new skills and techniques.</li> </ul>
<b>F 7.3</b>	<b>The development of mutually agreed on service plans (intervention goals and objectives) based on the critical assessment of strengths, needs, and challenges within clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Engage client participation verbally and have client state goals and objectives.</li> <li><input type="checkbox"/> In collaboration with client system, be able to develop clear and timely service goals and develop measurable objectives designed to meet agreed upon goals.</li> <li><input type="checkbox"/> Observe, reflect, and apply practice skills that assist individuals and/or groups to enhance their well-being from a strengths-based perspective.</li> </ul>
<b>F 7.4</b>	<b>The selection of appropriate intervention strategies based on the placement agency, assessment, research knowledge, and values and preferences of clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Select an intervention strategy. Documentation of the strategy will include an informed consent form signed by the client that defines the intervention, why it was mutually selected, and a contract that specifies a tentative duration of the treatment.</li> <li><input type="checkbox"/> Understand developmental stages of client population and integrate into the assessment.</li> <li><input type="checkbox"/> Considers possible levels of intervention (micro, mezzo, and macro) and articulates reasoning behind choice of intervention target.</li> </ul>

## **Competency #8**

### **Intervene with Individuals, Families, Groups, Organizations, and Communities**

Social workers understand that intervention is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Social workers are knowledgeable about evidence informed interventions to achieve the goals of clients and constituencies, including individuals, families, groups, organizations, and communities. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge to effectively intervene with clients and constituencies. Social workers understand methods of identifying, analyzing and implementing evidence informed interventions to achieve client and constituency goals. Social workers value the importance of interprofessional teamwork and communication in interventions, recognizing that beneficial outcomes may require interdisciplinary, interprofessional, and interorganizational collaboration.

Students will demonstrate the following behaviors by the end of their generalist field practicum:



<b>F 8.1</b>	<b>The ability to critically choose and implement interventions, including use of self, to achieve service plan goals and enhance capacities of clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Selects appropriate intervention strategies based on assessment, research knowledge, values and preferences of clients and constituencies.</li> <li><input type="checkbox"/> Initiate and implement interventions to achieve client-directed goals.</li> <li><input type="checkbox"/> Identify and apply social work theories as they may apply to the process of assessment, intervention or evaluation of clients within the agency.</li> </ul>
<b>F 8.2</b>	<b>The use of knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in interventions with clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Apply contracting phase skills during intervention activities at the micro, mezzo and/or macro levels and (select one or more) reflect on it in a summary of learning(s), process it during a supervisory session and/or apply it to a case/example.</li> <li><input type="checkbox"/> Use a strengths and empowerment perspective as well as the bio-psycho-social-cultural-spiritual theoretical frameworks learned in the academic classroom to collaboratively develop interventions with clients and/or constituencies.</li> <li><input type="checkbox"/> Identify and discuss with Field Instructor, Faculty Field Liaison, or peers in practicum seminar, various theories about human behavior as may be observed when working with clients (biological, social, cultural, psychological, and/or spiritual).</li> </ul>
<b>F 8.3</b>	<b>The use of interprofessional collaboration as appropriate to achieve beneficial practice outcomes</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Effectively collaborate with other professionals, such as through interprofessional treatment teams, to achieve beneficial practice outcomes for individuals, families, and small groups.</li> <li><input type="checkbox"/> Connect client to community resources.</li> <li><input type="checkbox"/> Utilize collaborative relationships formed with other providers to secure beneficial services.</li> </ul>
<b>F 8.4</b>	<b>The roles of negotiator, mediator, and advocate with and on behalf of diverse clients and constituencies</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Help clients identify interpersonal strengths, as well as network of familial and community resources to address problems.</li> <li><input type="checkbox"/> Demonstrate knowledge of community resources and facilitate referral process of client to another agency, when appropriate.</li> <li><input type="checkbox"/> Distinguish when it is appropriate to advocate rather than broker on behalf of individuals, families, and small groups to build client capacity to negotiate and advocate for their selves.</li> </ul>
<b>F 8.5</b>	<b>The facilitation of effective transitions and endings that advance mutually agreed on goals and appreciate the nature of the professional relationship</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Actively discuss with clients and/or constituencies potential transitions and terminations from the beginning of the treatment process in order to be prepared for, planned or unplanned transitions or terminations.</li> <li><input type="checkbox"/> Actively plan for termination process with clients by anticipating common responses among clients (e.g., feeling of loss, anxiety, recurrence of old problems, development of new problems).</li> <li><input type="checkbox"/> Assist clients in developing maintenance strategies (e.g., relapse prevention strategies, utilize other formal resources, utilize informal support systems)</li> </ul>

## Competency #9

### Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities

Social workers understand that evaluation is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals, families, groups, organizations and communities. Social workers recognize the importance of evaluating processes and outcomes to advance practice, policy, and service delivery effectiveness. Social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in evaluating outcomes. Social workers understand qualitative and quantitative methods for evaluating outcomes and practice effectiveness.

Students will demonstrate the following behaviors by the end of their generalist field practicum:

<b>F 9.1</b>	<b>Select and use appropriate methods for evaluation of outcomes defined in service plans</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Identify specific measurements for evaluating progress for each activity on intervention plan at micro, mezzo and/or macro level.</li><li><input type="checkbox"/> Identify alternative evaluation methods that factor in qualitative outcome measures, in addition to only quantitative measures.</li><li><input type="checkbox"/> Apply knowledge of family and group development/dynamics to design proactive services (e.g., marital enrichment programs; parenting education, classes; social skills groups for teens, etc.).</li></ul>
<b>F 9.2</b>	<b>Use knowledge of human behavior and the social environment, person-in-environment, and other multidisciplinary theoretical frameworks in the evaluation of outcomes</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Identify variables in the social context that could potentially impact evaluation process or outcomes.</li><li><input type="checkbox"/> Apply various stage theories to assess development of strengths and psychopathology (psychodynamic, object relations, family life cycle, stages of change, group formation and process).</li><li><input type="checkbox"/> Demonstrate knowledge of self-determination and various aspects of human behavior on evaluation and outcome measures.</li></ul>
<b>F 9.3</b>	<b>Critically analyze, monitor, and evaluate intervention and program processes and outcomes</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Continuously evaluate intervention, not only at termination, but also throughout process, and be able to evaluate results that test the efficacy of interventions used and monitor successes, failures, and progress in achieving outcomes.</li><li><input type="checkbox"/> During supervisory sessions, discuss and evaluate an intervention technique in a field program and identify evaluation mechanisms at agency.</li><li><input type="checkbox"/> Evaluate results that test the efficacy of interventions used and monitor successes, failures, and progress in achieving outcomes.</li></ul>
<b>F 9.4</b>	<b>Apply evaluation findings to improve practice effectiveness at the micro, mezzo, and macro levels</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Identify strengths and potential future changes with evaluation process at the agency that could lead to improved outcomes for clients and client systems.</li><li><input type="checkbox"/> Apply data interpretation to changes at the agency at the micro, mezzo and/or macro levels.</li><li><input type="checkbox"/> Synthesize the process and outcome data from practice with individuals, families, and small groups to improve program and agency practice.</li></ul>

# Learning Agreement Guide

MSW  
Advanced  
Edition





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## OVERVIEW

### COMPETENCY-BASED EDUCATION

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Social Work education is competency-based. Social work competence is the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being.

The framework for competency-based education includes a focus on the assessment of the student's ability to **demonstrate** the competencies rather than only on the assessment of inputs (such as coursework and resources). Social work practice competence consists of nine interrelated competencies, with specific observable behaviors for each competency. The overall objective of the practicum is to demonstrate competency for entry level generalist practice as identified in the nine social work competencies and specific observable behaviors.

The Council on Social Work Education (CSWE) and our social work program recognize a **holistic view of competence**; that is, the demonstration of competence **is informed by the holistic dimensions of knowledge, values, skills, and cognitive and affective processes that include the social worker's critical thinking, affective reactions, and exercise of judgment in regard to unique practice situations.**

### LEARNING AGREEMENT INSTRUCTIONS

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The Learning Agreement is developed collaboratively by the student, field instructor, and faculty field liaison. The Agreement will describe how the student will specifically apply the competencies in observable ways within the internship setting. The completed Learning Agreement then represents the student's specific objectives for the internship.

Observable behaviors are listed below each competency. In the subsequent text boxes, please describe the specific activities the student will complete at the internship setting for each observable behavior listed. These activities should provide opportunities for mastery of each competency, demonstrated and informed by the holistic dimensions of knowledge, skills, values, and cognitive and affective processes.

### PURPOSE OF THIS GUIDE

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The purpose of this guide is to provide you with general examples of activities for the observable behaviors listed under each competency to assist in supporting your development and creation of site-specific activities.

The activities associated with a specific observable behavior can look very different in working with different populations and settings. Faculty Field Liaison, Field Instructor and student should make every effort to assure a learning plan for all competencies and observable behaviors. In the rare occasion that a particular competency/observable behavior appears completely unavailable at that site, the Faculty Field Liaison should collaborate with the student and field instructor to explore the ways in which that competency may be mastered in the setting. Please consider demonstration of the behavior through simulation as a possible alternative prior to an "N/A" being utilized.

## MSW ADVANCED COMPETENCIES

### Competency #1

#### Demonstrate Ethical and Professional Behavior

Clinical social workers understand that the professional relationship and professional ethics are the foundation of clinical practice. Clinical social workers recognize the importance of the therapeutic relationship, the person-in-environment and strengths perspectives, the professional use of self with clients, and adherence to ethical guidelines of professional behavior. Clinical social workers understand their role and the role of other professionals on interprofessional teams and the ethical use of technology for clinical social work practice. Clinical social workers understand and apply ethical standards and model the ethical use of treatment modalities in practice.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

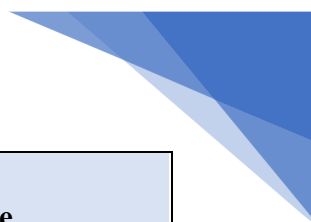
<b>A 1.1</b>	<b>Apply ethical decision-making skills to issues specific to clinical social work, including responding to ethical dilemmas</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Demonstrate the ability to resolve complex ethical dilemmas in clinical practice from multiple perspectives.</li> <li><input type="checkbox"/> Review agency's policy manual and apply the NASW Code of Ethic to identify points of opposition, agreement and points not addressed by agency policy.</li> <li><input type="checkbox"/> Identify ethical dilemmas that may arise during organizational planning and formulate responses that are consistent with NASW Code of Ethics.</li> </ul>
<b>A 1.2</b>	<b>Demonstrate professional use of self with clients that integrates an awareness of their own professional strengths, limitations, and challenges</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Use self-reflection and seek feedback from field instructor about personal strengths, limitations and challenges in clinical practice.</li> <li><input type="checkbox"/> Recognize and avoid dual relationships, discuss with field instructor in supervision.</li> <li><input type="checkbox"/> Identify how personal and professional values impact work within the organization/community.</li> </ul>
<b>A 1.3</b>	<b>Develop, manage, and maintain therapeutic relationships with clients that reflect understanding of relationship dynamics, including power differentials</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> In both oral and written communication, demonstrate sensitivity to level of expertise and understanding of intended audience and convey ideas in a manner that is sensitive to the level of knowledge and degree of sophistication of others.</li> <li><input type="checkbox"/> Appropriately adjusts choice of words in communicating with different groups (e.g., board members, clients, professional colleagues).</li> <li><input type="checkbox"/> Identify and discuss relationship dynamics with clients as well as discuss them and challenges with power differentials with field instructor.</li> </ul>
<b>A 1.4</b>	<b>Use strategies of ethical reasoning to address the use of technology in clinical practice and its effect on clients' rights</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Evaluate the ethical and appropriate use of technology to facilitate practice outcomes with individuals, families and small groups.</li> <li><input type="checkbox"/> Become familiar with the use of various technological platforms (computers, databases, GIS, social media, etc.) to advance effective client outcomes and agency governance and protocol efficiency.</li> <li><input type="checkbox"/> Review agency technology policies and process it during supervision and/or apply it to a case.</li> </ul>

## Competency #2 Engage Diversity and Difference in Practice

Clinical social workers build on the generalist foundation competency to further understand how diversity and difference characterize and shape the human experience and are critical to the formation of identity. The dimensions of diversity are understood as the intersectionality of multiple factors including, but not limited to, age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion /spirituality, sex, sexual orientation, and tribal sovereign status. Clinical social workers also understand the forms and mechanisms of oppression and discrimination and recognize the extent to which a culture's structures and values, including social, economic, political, and cultural exclusions, may oppress, marginalize, alienate, or create privilege and power. Clinical social workers understand and integrate into their assessments and interventions the effects on clients of oppression, poverty, marginalization, and alienation, as well as privilege, power, and acclaim.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 2.1</b>	<b>Identify the structural and systemic dynamics present in the client’s context and implications for clients’ intersecting identities and experiences</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Recognize societal conditions that contribute to individual psychopathology and intervenes at micro, mezzo, and macro levels.</li> <li><input type="checkbox"/> Demonstrate knowledge of and critically analyze ethical issues arising in community organization practice, and identify barriers that prevent services from reaching target population and proposes change in service delivery.</li> <li><input type="checkbox"/> Expand use of basic engagement skills to include understanding of culturally specific norms, customs, and values regarding interpersonal interaction.</li> </ul>
<b>A 2.2</b>	<b>Explore with clients the meanings they attribute to their various social identities, such as race, ethnicity, culture, gender, etc.; how their understanding of who they are interacts with dominant societal perceptions of the self; and the effect these identities and perceptions have on their lives</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Engage in continuing education to develop specialized knowledge and understanding of the history, traditions, values, family systems, and artistic expressions of major client groups served.</li> <li><input type="checkbox"/> Demonstrate knowledge of when and how to address issues of diversity in clinical practice.</li> <li><input type="checkbox"/> Explore culturally relevant issues when conducting assessments and planning interventions.</li> </ul>
<b>A 2.3</b>	<b>Engage in self-reflection to examine their own values and personal biases and the possible effects these may have on their clinical relationships.</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups.</li> <li><input type="checkbox"/> Apply self-awareness and self-regulation to manage the influence of personal biases and values and recognize when personal biases may impact/influence ability to serve client.</li> <li><input type="checkbox"/> Identify and manage personal values and distinguish them from professional values that guide practice.</li> </ul>



**Competency #3**  
**Advance Human Rights and Social, Economic, and Environmental Justice**

Clinical social workers build on the generalist foundation competency to advance human rights and social, economic and environmental justice through their clinical practice. They understand that every person regardless of position in society has fundamental human rights such as freedom, safety, privacy, an adequate standard of living, health care, and education. Clinical social workers understand the global interconnections of oppression and human rights violations and are knowledgeable about theories of human need and social justice, as well as strategies for promoting social and economic justice and human rights. Clinical social workers identify and integrate strategies for practice that recognize with clients the oppressive structural barriers present in their lives and work to ameliorate the impact of those structural dynamics on the client system.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 3.1</b>	<b>Engage in clinical practices that promote social justice</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Understand specific contributions of social work in achieving agency mission and goals.</li> <li><input type="checkbox"/> Understand agency, local, state and federal guidelines for addressing oppression and discrimination and apply it to a case/example and identify underserved needs of population served by agency.</li> <li><input type="checkbox"/> Identify and describe forms and mechanisms of discrimination and oppression that adversely affect client systems.</li> </ul>
<b>A 3.2</b>	<b>Identify systemic and structural barriers in field placement and work settings that bar specific groups from full societal participation and examine how social inequality operates at the macro, mezzo and micro level of society, as well as within multiple social work service contexts</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identify groups/classes of clients who are disproportionately represented in systems (e.g., African Americans in the child welfare and legal systems), who receive substandard treatment, who are given particular diagnoses, etc. and discuss with field instructor the ways in which these things can/should be addressed systemically.</li> <li><input type="checkbox"/> Help clients reflect upon/sort out experiences in which discrimination and oppression play a role.</li> <li><input type="checkbox"/> Function in multiple macro roles (e.g., community planning, community organizing, administration, program development, and evaluation, policy analysis, legislative advocacy, etc.) that promotes empowerment with in the capacity and context of the community organization.</li> </ul>
<b>A 3.3</b>	<b>Demonstrate an understanding of systemic and structural oppression and their effects on those with dominant and subjugated identities and integrate this knowledge into direct clinical practice with individuals and families</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Use knowledge gained in the classroom regarding systemic and structural oppression to help direct clinical practice with clients, discuss identified barriers with field instructor and solicit feedback on ways to help eliminate these barriers.</li> <li><input type="checkbox"/> Identify and use methods of practice that are designed to work against systemic and structural oppression.</li> <li><input type="checkbox"/> Elicit information from clients regarding the ways in which they have been oppressed and use that information to inform practice in a way that combats those oppressors.</li> </ul>

## Competency #4

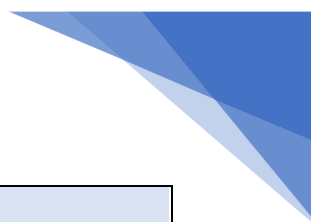
### Engage in Practice-informed Research and Research-informed Practice

Clinical social workers use quantitative and qualitative research methods, multi-disciplinary sources, and multiple ways of knowing to advance the science of social work and to inform and evaluate the efficacy of their clinical practice. Clinical social workers apply the principles of logic, scientific inquiry, and culturally informed and ethical approaches to building knowledge. Clinical social workers are knowledgeable about evidence-based interventions, best practices, and the evidence-based research process. Clinical social workers use a critical perspective in applying evidence based practice in assessment and intervention with clients, participate in the generation of new knowledge through research and practice, and use research methodology to evaluate practice.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 4.1</b>	<b>Use research methodologies from varied perspectives to identify and critically examine clinical interventions and/or outcomes for particular client systems, problems, and settings</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Evaluates strategies for conducting survey research and selects strategy that is most likely to yield best return rate.</li><li><input type="checkbox"/> Attend seminars/conferences to garner most current information from experts in a specialized area of practice.</li><li><input type="checkbox"/> Stay up to date on practices with client population served by agency/population of special interest by reviewing professional literature, attending conferences, searching web resources, etc.</li></ul>
<b>A 4.2</b>	<b>Use practice experience to critically evaluate relevant clinical knowledge and the need for additional research to address gaps in the existing knowledge base</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Stay abreast of developing trends in specialized area of clinical practice and advocate for implementation of promising, innovative practices with field instructor.</li><li><input type="checkbox"/> Present analysis of an agency policy and makes recommendations with field instructor.</li><li><input type="checkbox"/> Review literature to identify intervention(s) supported by empirical evidence.</li></ul>
<b>A 4.3</b>	<b>Evaluate the strengths and weakness of multiple theoretical perspectives and differentially apply them to client situations</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Integrate findings from multiple studies re particular problem/ diagnosis to develop most effective intervention strategy.</li><li><input type="checkbox"/> Evaluate service delivery systems to ensure that target population is being reached and make recommendations in supervision to field instructor to improve service accessibility.</li><li><input type="checkbox"/> Design culturally sensitive evaluation strategies including use of measures validated with specific population(s) served and obtaining feedback from minority clients as stakeholders.</li></ul>





**Competency #5**  
**Engage in Policy Practice**

Clinical social workers understand that both client systems and social service delivery systems are affected by policy implementation at the federal, state, and local levels. Clinical social workers help clients to understand the impact of policy on their wellbeing, including, as appropriate, the political nature of policy. Clinical social workers engage in policy analysis within their practice settings, help clients to resist internalization of self-blame for social and economic circumstances that reflect policy decisions at the mezzo and macro level, and empower clients to advocate for policy change.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 5.1</b>	<b>Understand social welfare systems and policies, the impact of policy on clients and communities, and the skills of policy analysis</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identify both formal (laws, polices, etc.) and informal structures (discrimination based on race, sexual orientation, socioeconomic status) that impact members of target population.</li> <li><input type="checkbox"/> Demonstrate knowledge of federal and state statutes and local policies that provide mandate, funding, and boundaries for agency services.</li> <li><input type="checkbox"/> Understand the policymaking process at the local, state, and federal levels and demonstrate the ways advocates can influence it.</li> </ul>
<b>A 5.2</b>	<b>Use evidence-based practice to advocate for policies that advance social and economic well-being</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identify impact of political, social, economic, and cultural forces on services delivered by agency.</li> <li><input type="checkbox"/> Assess the impact of a program design upon the interests of minorities and oppressed groups and proposes indicated changes to insure equitable service delivery.</li> <li><input type="checkbox"/> Assess and diagnose community needs and assets in ways that gather information, increase participation, and strengthen social diversity.</li> </ul>
<b>A 5.3</b>	<b>Communicate to stakeholders the implication of policies and policy change in the lives of clients</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Anticipate development of barriers to service delivery (e.g., budget cuts, negative publicity re target population) and proposes strategies to prevent disruption of services.</li> <li><input type="checkbox"/> Select appropriate strategies with field instructor in supervision for advocacy (organized protests, letters to official and legislators increasing community awareness via media, etc.).</li> <li><input type="checkbox"/> Demonstrate the capacity to plan and advocate for needed agency policy changes on behalf of a client group, community, or organizational interest.</li> </ul>
<b>A 5.4</b>	<b>Analyze policies at the agency level and advocate for agency policies that enhance client access and the delivery of effective services.</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Analyze how agency policy accommodates/fails to accommodate diversity in the community and proposes appropriate changes in policy with field instructor.</li> <li><input type="checkbox"/> Read and research agency policies related to access and service delivery paying attention to how they have evolved and discuss with field instructors' ways in which advocacy for access and delivery of services can be increased.</li> <li><input type="checkbox"/> Use knowledge gained in the classroom to assist in analyzing the policies of the agency related to access and delivery of services.</li> </ul>

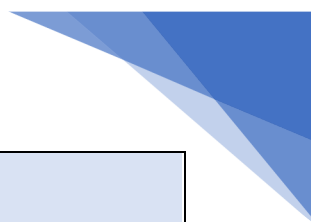
## Competency #6

### Engage with Individuals, Families, Groups, Organizations, and Communities

Clinical social workers understand that engagement is an ongoing component of the dynamic and interactive process of clinical social work practice with, and on behalf of, diverse individuals, families, groups, organizations, and communities. Clinical social workers rely on advanced clinical knowledge to build relationships with clients' systems and interprofessional partners. They possess a clinically-informed understanding of reasons why clients might be motivated or hesitant to engage in services and they demonstrate a range of clinical skills that allow them to effectively engage those they serve.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 6.1</b>	<b>Apply clinical knowledge to the process of client engagement</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Evaluate relevance of multiple theories of human behavior (psychodynamic, object relations, cognitive behavioral, family systems, person-centered, social learning, multicultural theory, etc.) in understanding a particular client or group.</li><li><input type="checkbox"/> Recognize need for and develops support or educational services for families or communities of primary clients, contributes social work's unique person in environment perspective in multidisciplinary teams.</li><li><input type="checkbox"/> Apply preparing skills prior to engagement activities at the micro, mezzo and/or macro levels and process it during a supervisory session and/or apply it to a case/example.</li></ul>
<b>A 6.2</b>	<b>Use clinical concepts and skills that reflect an understanding of the importance of the clinical relationship; the dynamics of interpersonal relationships, including the therapeutic relationship; and the need for safe, accepting spaces for implementing a full range of social work interventions</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Use a variety of interpersonal skills (e.g., active listening, clarification, verbal following, summarizing, etc.) to develop collaborative relationships with colleagues, stakeholders, board members, potential funding sources, and clients.</li><li><input type="checkbox"/> Convey respect for and appreciation of individual, family, and group diversity.</li><li><input type="checkbox"/> Demonstrate ability to engage involuntary and hostile clients.</li></ul>
<b>A 6.3</b>	<b>Effectively engage a wide range of interprofessional partners and collaterals in promoting client goals and client well-being.</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Gather information from others working with client in order to create an understanding of existing services, treatment plans and needs.</li><li><input type="checkbox"/> Review case files/records of client(s) to decrease repetition of services, increase knowledge of what needs they have already identified and/or treatment goals met.</li><li><input type="checkbox"/> Elicit feedback and input from field instructor as well as other professionals involved on client's history and presentation in preparation for working with client.</li></ul>



## Competency #7

### Assess Individuals, Families, Groups, Organizations, and Communities

Clinical social workers understand that assessment is an ongoing component of clinical relationships and apply a wide array of bio-psycho-social-spiritual theories to their understanding of diverse clients and their social environments. Clinical social workers draw upon theories, frameworks, and models of human behavior, as well as information from clients, collaterals, and other professionals, to develop a rich, strengths-based understanding of the people they serve and the challenges they experience. Clinical social workers also reflect on their own reactions to the client system and consider the effects of environmental contexts in the processes of assessment and intervention planning.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 7.1</b>	<b>Use a range of clinical perspectives and theoretical frameworks to understand client strengths and needs</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Gather appropriate information regarding symptoms, duration, and onset to apply diagnostic criteria.</li><li><input type="checkbox"/> Assist with data collection, analyses, and preparation of reports.</li><li><input type="checkbox"/> Identify gaps in information and conflicting or confusing information.</li></ul>
<b>A 7.2</b>	<b>Develop a broad understanding of client systems that integrates psychological, cultural, social and political lenses</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Evaluate relevance of multiple theories of human behavior (psychodynamic, object relations, cognitive behavioral, family systems, person-centered, social learning, multicultural theory, etc.) in understanding a particular client or group.</li><li><input type="checkbox"/> Analyze theoretical basis for treatment models utilized in practicum setting.</li><li><input type="checkbox"/> Identify emerging social problems and challenges faced by agency's clients and discuss with field instructor in supervision possible proposals of modifications in service delivery to address these concerns.</li></ul>
<b>A 7.3</b>	<b>Use assessment data to consider readiness for change and optimal interventions for client systems of different sizes</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Use empathy to respond to feelings within client's awareness and to bring to the client's attention feelings and meanings below the surface for assessment.</li><li><input type="checkbox"/> Find mutual goals to engage involuntary clients.</li><li><input type="checkbox"/> Develop and revises treatment plans based on the evolving assessment of client's needs, problems, strengths, and capabilities.</li></ul>
<b>A 7.4</b>	<b>Reflect on their own reactions to client systems and consider the effects of environmental contexts, as well as their own and the client system's preferences, in the processes of assessment and intervention planning.</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Identify and integrate evidenced-based standardized assessment instruments in the development and implementation of treatment planning.</li><li><input type="checkbox"/> Understand that problems may be defined at multiple levels (individual, family, community, society) and problem definition influences intervention.</li><li><input type="checkbox"/> Accurately perceive cues that suggest need for in-depth exploration of particular issues and be able to create clinical recommendations to client systems based on information gathered.</li></ul>

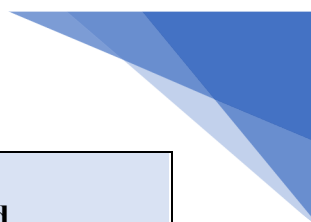
## Competency #8

### Intervene with Individuals, Families, Groups, Organizations, and Communities

Clinical social workers demonstrate that intervention is an ongoing component of the dynamic and interactive process of social work practice with, and on behalf of, diverse individuals and families. Clinical social workers apply evidence-based interventions to help achieve the goals of client systems. Clinical social workers integrate theories of human behavior and the social environment in implementing interventions with client systems. Clinical social workers use a critical perspective in identifying, analyzing and implementing evidence-based interventions to achieve client system goals. Clinical social workers engage in interprofessional teamwork, and communication in developing and implementing interventions, and demonstrate effective interdisciplinary, interprofessional, and interorganizational collaboration.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

<b>A 8.1</b>	<b>Collaborate with client systems to define therapeutic goals and treatment outcomes that address micro, mezzo and macro systems</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Develop intervention strategies that utilize client's natural support network (e.g., religious leaders, elders, healers, etc.).</li><li><input type="checkbox"/> Stay up to date on practices with client population served by agency/ population of special interest to student by reviewing professional literature, attending conferences, searching web resources, etc.</li><li><input type="checkbox"/> Identify areas of high risk (e.g., medical problems such as high blood pressure, diabetes, stroke, child maltreatment, involvement in gangs, victim of domestic or other violence) for clients served by agency and explore with field instructor appropriate interventions to be delivered in practice.</li></ul>
<b>A 8.2</b>	<b>Initiate and implement strengths-based treatment plans and contracts, based on appropriate human behavior theory, and selectively apply and integrate evidence-based practice methods to meet these goals</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Appropriately select from a variety of theoretical and/or practice models to implement intervention strategies.</li><li><input type="checkbox"/> Use a variety of intervention skills from multiple treatment models (CBT, DBT, narrative therapy, systemic family therapy, solution focused therapy).</li><li><input type="checkbox"/> Apply and articulate social work values, ethical standards, and principles unique to interpersonal interventions involving diverse populations and settings.</li></ul>
<b>A 8.3</b>	<b>Demonstrate self-awareness and differential use of self, utilizing clinical concepts such as intersubjectivity, transference, and countertransference</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> In process recordings, reflect on the emotions and thoughts that arise in working with each client (or client system) and consider similarities and differences in student and client systems.</li><li><input type="checkbox"/> In treatment plans and process recording identify interventions that involve different use of self to meet different clients' strengths, challenges and context.</li><li><input type="checkbox"/> In process recording and supervision discussions, identify issues that trigger countertransference and plan for how to use this to promote the therapeutic relationship rather than interfere with it.</li></ul>
<b>A 8.4</b>	<b>Advocate, communicate, and collaborate with other professionals to promote client well-being and achieve client system goals.</b>
	<ul style="list-style-type: none"><li><input type="checkbox"/> Apply knowledge of group process to identify stage of current functioning of an agency or community task group and identify crucial leadership skill at this stage in group development, discuss with field instructor in supervision.</li><li><input type="checkbox"/> Articulate decision process used in selecting a particular intervention for an individual client, and monitors client progress and alter interventions accordingly with guidance from field instructor.</li><li><input type="checkbox"/> Compare efficacy of various intervention strategies used with an individual, family, or group at different stages of the intervention process.</li></ul>



**Competency #9**  
**Evaluate Practice with Individuals, Families, Groups, Organizations, and Communities**

Clinical social workers demonstrate that evaluation is an ongoing component of the dynamic and interactive process of clinical practice with, and on behalf of, diverse individuals and families. Clinical social workers evaluate processes and outcomes to advance practice, policy, and service delivery effectiveness. Clinical social workers understand theories of human behavior and the social environment, and critically evaluate and apply this knowledge in evaluating outcomes. Clinical social workers utilize qualitative and quantitative methods for evaluating outcomes and practice effectiveness.

Students will demonstrate the following behaviors by the end of their advanced field practicum:

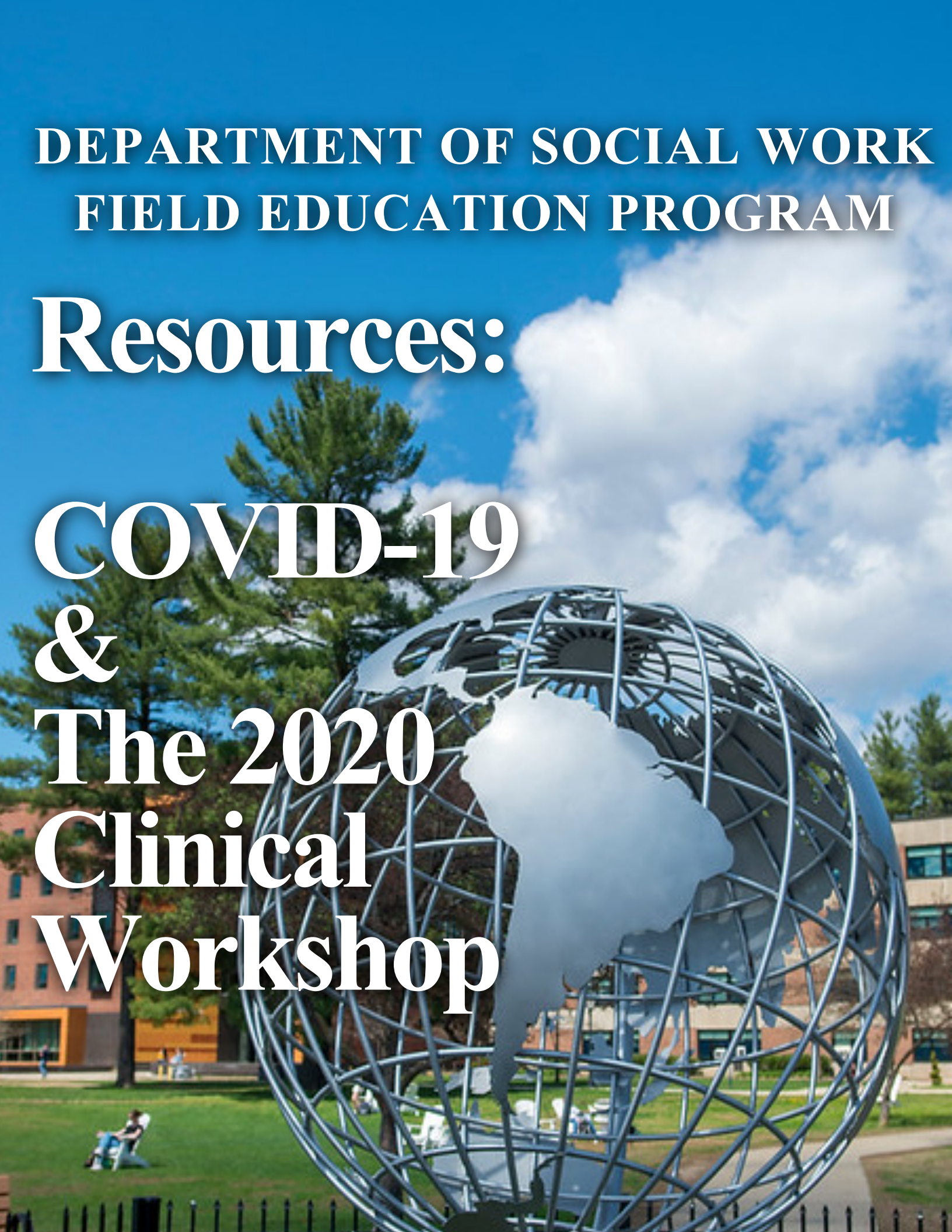
<b>A 9.1</b>	<b>Use a critical perspective and multiple methods for developing and implementing ongoing evaluation methods for clinical practice</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Demonstrate advanced knowledge in critically analyzing and monitoring, and evaluating intervention program processes and outcomes.</li> <li><input type="checkbox"/> Present rationale for selecting a particular group or single subject design to monitor progress toward treatment goals.</li> <li><input type="checkbox"/> Demonstrate the use of appropriate evaluation methods to assess and improve organizational operations and/or client systems.</li> </ul>
<b>A 9.2</b>	<b>Work collaboratively with client systems and community stakeholders to identify and apply outcome measures that reflect client and agency goals and desired outcomes</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Evaluate relevance of multiple theories of human behavior (psychodynamic, object relations, cognitive behavioral, family systems, person-centered, social learning, multicultural theory, etc.) in understanding a particular client or group.</li> <li><input type="checkbox"/> Implements a group design with a treatment group with guidance from field instructor.</li> <li><input type="checkbox"/> Apply evaluating and ending phase skills during evaluation and/or termination activities at the micro, mezzo and/or macro levels and process it during a supervisory session and/or apply it to a case/example.</li> </ul>
<b>A 9.3</b>	<b>Collaboratively utilize evaluation data to improve practitioner, agency and community practice.</b>
	<ul style="list-style-type: none"> <li><input type="checkbox"/> Continuously evaluate intervention, not only at termination, but also throughout process, and be able to evaluate results that test the efficacy of interventions used and monitor successes, failures, and progress in achieving outcomes.</li> <li><input type="checkbox"/> Develop continuous evaluation strategy that is linked to the initial assessment and intervention plan, and critically evaluates the relationship between the agency’s mission statement, agency objectives, and actual service delivery, and report results of outcome evaluations to field instructor and others as advised by field instructor.</li> <li><input type="checkbox"/> Monitor and evaluate activities using techniques that assess activities and outcomes, raise critical consciousness, motivate participation, and contribute to improvement and changes.</li> </ul>

A variety of Learning Agreements from social work programs across the country were reviewed in addition to the competencies and learning activities from our own students at WSU as part of the development of this Guide. We would like to acknowledge review of, and in some cases have adapted, documents from the publicly available websites of University of Michigan School of Social Work, Social Work Program of Ramapo College of New Jersey, Whitney M. Young School of Social Work, University of Pittsburgh, Warner Pacific College, Western Illinois University, University of Montana School of Social Work, University of Northern Iowa, Salem State University, University of New England, USC Suzanne Dworak-Peck, and Northern Central University.

**DEPARTMENT OF SOCIAL WORK  
FIELD EDUCATION PROGRAM**

**Resources:**

**COVID-19  
&  
The 2020  
Clinical  
Workshop**





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# ARTICLES & RESOURCES

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- COVID-19 Education Summary
- Telehealth Tips with Suicidal Clients
- Telehealth Clinical Considerations
- Implications of Coronavirus for America's Vulnerable and Marginalized Populations
- Responding to Healthcare Disparities and Challenges with Access to Care During COVID-19

# COVID-19 EDUCATION

## A BRIEF SUMMARY:

### Field Education and COVID-19:

All Social Work students participating in a Field Practicum will complete the videos and readings below, no later than the second week of the fall semester. Students will watch these videos as part of the integrative seminar and there will be opportunities for follow-up related discussions to occur in their integrated field seminar. Additionally, the expectation is for students to follow all policies and protocols of their individual field placement.

- Background/Overview of COVID-19
  - Read and Watch: “What is Coronavirus?”
  - <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus>
- Hand Hygiene
  - Read: “Clean Hands Count for Healthcare Providers”
    - <https://www.cdc.gov/handhygiene/providers/index.html>
  - Watch: <https://www.youtube.com/watch?v=seAlwbXUQTs>
- Personal Protective Equipment (PPE)
  - Watch: <https://www.health.state.mn.us/diseases/hcid/videos.html>
- What To Do If You Are Exposed
  - Read: “What to do if you are Sick”
    - <https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html>
  - Watch: <https://www.youtube.com/watch?v=6nrkthZYkzQ>

### WSU and COVID-19

- Any member of the Westfield State Social Work community who (1) is experiencing symptoms of COVID-19 and has either traveled to any affected area or been in close contact with someone ill with COVID-19 or (2) has been given a presumed diagnosis of COVID-19 by a health care provider or (3) tested positive for COVID-19, please call University Health Services at 413-572-5415 and also simultaneously notify Social Work Field Education Director, Terri Haven, [thaven@westfield.ma.edu](mailto:thaven@westfield.ma.edu) or 413-572-8405 immediately so that we are able to monitor how this is affecting our community and work with you to obtain guidance and assistance.
- Further information about WSU Health Services is available at
  - <http://www.westfield.ma.edu/student-life/health-services>
- The full WSU Safe Opening Plan is available at:
  - <https://www.westfield.ma.edu/images/uploads/president/SafeFallOpeningPlan.pdf>



# Telehealth Tips:

## *Managing Suicidal Clients During the COVID-19 Pandemic*

The current need for social distancing and isolation related to the COVID-19 pandemic has necessitated a quick expansion of the provision of mental health services via remote platforms. Here are some tips for evaluating and treating suicidal individuals remotely via telehealth.

### **Basic guidelines initiating contact when your client may be suicidal**

- Request the person's **location (address, apartment number)** at the start of the session in case you need to contact emergency services.
- Request or make sure you have **emergency contact information**.
- **Secure the client's privacy** during the telehealth session as much as possible
- **Prior to contact, develop a plan** for how to stay on the phone with the client while arranging emergency rescue, if needed

### **Adaptations for conducting comprehensive suicide risk assessment**

- Considering the current stressful circumstances, broader assessment of suicide risk is indicated. Express concern and ask directly about recent suicidal ideation and behavior using a tool like the **Columbia Suicide Severity Scale (C-SSRS)**. Consider using a risk assessment tool like SAMHSA's **SAFE-T**.
- In addition to standard risk assessment, **assess for the emotional impact of the pandemic on suicide risk**. Examples that can escalate risk: increased social isolation; social conflict for those sheltering together; increased financial concerns or worry about health or vulnerability in self, friends, and family; decreased social support; increased anxiety and fear; disruption of routines and support.
- **Identify protective factors that can be emphasized**: Reasons for living (family, hope for the future, children); deterrents (fear of injury, religious beliefs). Attend to protective factors that may have diminished recently.
- **Inquire about increased access to lethal means** (particularly stockpiles of Tylenol or medications)

### **Adaptations for clinical management for suicidal clients**

- Identify ways to increase safety short of sending client to the Emergency Department (ED)
- **Develop a safety plan** that will help clients manage their suicide risk on their own. (See below)
- Make provisions for **increased clinical contact** (even brief check-ins) until risk de-escalates
- Provide **crisis hotline (1-800-273-8255)** and **crisis text (Text "Got5 to 741741)** information
- **Identify individuals in the client's current environment** to help monitor the client's suicidal thoughts and behaviors in-person or remotely; seek permission to have direct contact with those individuals.
- If risk becomes imminent and cannot be managed remotely, arrange for the client to go to the nearest CPEP (if possible) or medical ED (if a CPEP is not available)
- **If risk is imminent, stay on the phone with the client until other care is present**

### **Adaptations to safety planning**

- Safety planning works mostly the same as when done in-person. Use the **Safety Planning Intervention** form (attached). Let the client know that you want to develop a safety plan with them to help maintain their safety and that it will take about 30 minutes to do.
- **EMPHASIZE**: Having a Safety Plan is particularly important now as a **way to stay safe without going to the ED or a medical facility**.
- **Arrange a way for the client to get a copy of the plan**. Clients can write it down as you go, or the clinician can write it down, take a picture or scan, and e-mail or text to the client.

## Steps in developing a safety plan

- **Step 1: Identify warning signs** that a suicide crisis is developing and the safety plan needs to be used
- **Step 2: Identify internal coping skills** that can distract from suicidal thoughts and de-escalate crises, taking into account limited access to resources
- **Step 3: Identify social contacts that can help distract from a suicidal crisis.** Many social distraction options have been limited by social distancing. **Focus on virtual activities** (virtual travel tours, opera, theater performances or concerts, museums or zoos; “meet-up” programs, like online painting, cooking, or karaoke; virtual hang-outs with friends via Skype/FaceTime/Zoom to watch movies or play board games; online support groups/forums or virtual AA/NA meetings) **and current social environment** (i.e., who the client is living with).
- **Step 4: Identify social supports who can help handle a suicidal crisis.** Determine who is currently available to help the client manage the suicidal crisis. If the client is currently living with others, determine together with the client who is the best source of support and who the client feels comfortable turning to. **Seek permission to contact and initiate contact** with one or two key people who will provide support to make sure they are willing to do so and have some tips on how to help the client. This takes time initially but will help the caregiver and preserve clinician time later.
- **Step 5: Identify professional emergency contacts** that are currently available. Provide the National Suicide Prevention Lifeline (**800 273-8255**; [suicidepreventionlifeline.org](http://suicidepreventionlifeline.org)) and crisis text (**text “Got5” to741741**; [crisistextline.org](http://crisistextline.org)) information
- **Step 6: Plan for reducing access to lethal means** and review/revise any existing plan that might need updating in the current situation. Discuss increased access to lethal means (particularly stockpiles of Tylenol or other medications) and if there is someone with whom the client is living who can help secure lethal means. Ensure firearms, if present, are stored safely or removed.
- **Be specific when listing adaptive options** (talking to a good friend privately vs. exposure to more general social media, which may be upsetting).
- **Virtual contact may “feel” different or mean different things to your client.** Discuss types of remote contact that best suit your client’s emotional needs. For example, some prefer phone calls or texts for disclosure of distress but video chats for distraction, etc.
- Review and revise existing safety plans to **make sure contact social contact information on steps 3-5 is electronic rather than in person.** If in person, make sure they are currently living with the client. Remember: “Contact information” can include telephone numbers, video chat, social media, game consoles, internet forums, etc.

## Ongoing follow-up and monitoring

- **Conduct a suicide screen at every contact for those at elevated risk.** Use a standardized screen such as the C-SSRS. Screening takes <2 minutes and should be done in conversational manner.
- **Review any changes in risk or protective factors** (changes in physical health in the individual or a loved one, new access to lethal means, interpersonal conflict in close quarters, social isolation and feelings of loneliness, or mistrust of the intentions of others).
- **Review and update the safety plan** as needed.
- **Get permission to continue providing follow-up phone contact.** Schedule the next contact while you are on the phone, if possible.

## Documentation and supervision/support for yourself

- **Document all interactions** and your clinical thinking/rationale. **Consult with supervisors and peers** on challenging clinical decisions and document the consultations.
- During this time when many clinicians are working remotely, it is extra important to **attend to our own isolation and mental health.** **Peer consultation groups** with other professionals using a secure platform like Zoom can help clinicians to brainstorm ideas for challenging cases and provide support.
- It is acknowledged that working with suicidal clients creates additional burden for clinicians in a time of great stress. **Periods of coverage, if possible, to allow for time off is important.**
- Clinician **self-care activities** are crucial, as is time off. Clients often respond positively and respectfully when clinicians explain that they will be unavailable for a period of time. **Informing suicidal clients in advance of when time away will occur and making alternate provisions enhances care.**

# SAFETY PLAN

## Patient Safety Plan Template

**Step 1: Warning signs (thoughts, images, feelings, behaviors) that a crisis may be developing:**

1. \*
2. \*
- 3.

**Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (distracting & calming activities):**

1. \*
2. \*
- 3.

**Step 3: People and social settings that provide distraction:**

- |            |       |          |       |
|------------|-------|----------|-------|
| 1. Name *  | _____ | Phone    | _____ |
| 2. Name    | _____ | Phone    | _____ |
| 3. Place * | _____ | 4. Place | _____ |

**Step 4: People I can ask for help with the crisis:**

- |           |       |       |       |
|-----------|-------|-------|-------|
| 1. Name * | _____ | Phone | _____ |
| 2. Name * | _____ | Phone | _____ |
| 3. Name   | _____ | Phone | _____ |

**Step 5: Professionals or agencies I can contact during a crisis**

- |   |       |        |       |
|---|-------|--------|-------|
| 1. Clinician Name *   | _____ | Phone* | _____ |
| Clinician Emergency Contact # *                             |       |        |       |
| 2. Clinician Name   | _____ | Phone  | _____ |
| Clinician Emergency Contact # _____                         |       |        |       |
| 3. Local Urgent Care or Emergency Room *                    | _____ |        |       |
| Address* _____  |       |        |       |
| Phone* _____  |       |        |       |
| 4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255) |       |        |       |

**Step 6: Making the environment safe (removing or limiting access to lethal means):**

1. \*
2. \*

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**The one thing that is most important to me and worth living for is:**



Pacific Southwest Mental Health Technology Transfer Center

## Telehealth Clinical and Technical Considerations for Mental Health Providers





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Substance Abuse and Mental Health Services Administration.

**Authors:** Heliana Ramirez, PhD, LISW, Associate Project Director, Pacific Southwest MHTTC; Amy Springmeyer, MPPA, Senior Research Associate, Center for Applied Research Solutions; Kim Weis, MA, Research Associate, Center for Applied Research Solutions; Rachelle Espiritu, PhD, Co-Project Director, Pacific Southwest MHTTC; Leora Wolf-Prusan, School Mental Health Lead for the Pacific Southwest MHTTC; Kari DeCelle, Program Manager, Pacific Southwest MHTTC; Thomasine Heitkamp, LCSW, PI and Co-Project Director, Mountain Plains MHTTC; and Brandy L. Clarke, PhD, LP, Project Director, Mid-America MHTTC.

## Telehealth Clinical and Technical Considerations for Mental Health Providers

COVID-19 is a stressful experience for most of us. We are experiencing change on a massive scale – personally, professionally, and emotionally. The mental health consequences of the COVID-19 pandemic include anxiety, grief, trauma, and depression.<sup>1, 2, 3</sup> The pandemic also affects mental health providers' work environment and practice. As behavioral health clinicians, our work may require new technological approaches and skills, some of which may be outside of our professional comfort zone.

There is unprecedented need for interventions that can be delivered safely and effectively through telehealth. Social distancing orders are causing many clinicians to work from home while their agencies close. For agencies that remain open, clinicians are often practicing social distancing by meeting with clients from separate rooms. Whether providing care remotely or from different rooms in the same building, clinicians are turning to telehealth practice (e.g., therapy over video conference, phone call, text messaging, mobile health apps, and email) to maintain continuity of care.

In the context of rapid change and emerging need, clinicians have limited time to take courses and read articles to establish telehealth practice. Further, clinicians are experiencing COVID-19-related stress themselves, which may be heightened by exposure to clients' stress. This can make it even more difficult to learn and implement new technology.

***This guide provides quick and accessible information on video conferencing telehealth basics. It is intended as a resource for licensed behavioral health providers with clinical practices. Sections include:***

- **Clinical Practices to Establish and Maintain Telehealth Care**
- **Telepresence Best Practices**
- **Telehealth Laws, Risk Management, and Billing**
- **Using Technology and Establishing Your Space**

This guide summarizes several telehealth trainings and interviews with regional telehealth clinicians, and presents telehealth webinars, resource lists, and peer-reviewed journal articles (see Appendix A). The clinical aspects of this guide were developed in consultation with Region 9 social workers Jorin Bukosky, LCSW; Giemar Fernandez, LCSW; Gabriel Lonero, LCSW; and psychiatrist Dr. James Armontrout. The logistical and technical aspects of this guide are compiled from webinars by Dr. Stan Taubman; Dr. Marlene Maheu; Dr. Barbara Stanley; Dr. David Jobes; Dr. Ursula Whiteside; Dr. Holly Robbert; Dr. William Higgins; Dr. JK Costello; Jackie Strohm, LSW; and Erika Brosig, LCSW, CTTS, DAAETS.

### Clinical Practices to Establish and Maintain Care

This section summarizes considerations for determining whether a given client is a clinical fit for telehealth services. Clients with some mental health conditions may require additional support to succeed in telehealth. The section also includes provider checklists to support the transition from in-person care to telehealth practice; guidelines for maximizing the effectiveness of telehealth sessions; and recommendations for hosting practice sessions to familiarize clients with technology prior to starting services.

#### ***Risks and Benefits of Telehealth***

Decades of research have shown that videoconference-based behavioral health produces outcomes and benefits similar to those of traditional in-person interventions.<sup>4</sup> Additionally, it promotes equal access to services for those who may have trouble accessing high-quality, in-person behavioral healthcare due to their location, physical ability, or diagnosis.

Given the benefits to clients and clinicians, telehealth services may remain long after COVID-19 social distancing orders are lifted.<sup>5</sup> For example, the familiar comforts of home can be especially helpful for people with anxiety and paranoia. Further, home is often a sanctuary for people with PTSD, and home based teletherapy enables clients to be more attuned to the session as opposed to surveilling sounds and movement in an environment they do not control.

#### **Telehealth benefits include:**

1. Accessibility for clients living with disabilities who are homebound
2. Accessibility during severe storms or other natural disasters that affect travel
3. Saves money and time for clients and clinicians who avoid commuting to a clinic
4. A point of entry for clients who are reluctant to see a therapist in person
5. Increases access to providers who can serve clients in rural areas
6. Helps clients avoid anxiety associated with commuting to the clinic



7. Avoids community-based stimuli which can overwhelm people living with neurocognitive diversity
8. Real-time transcription on video conferencing platforms can increase access to therapy for Deaf people
9. Clients who feel inhibited in face-to-face situations may experience increased comfort with self-expression due to the distance provided through video conferencing
10. Avoids disease transmission
11. Benefit for clients who prefer the comfort of their own furniture or having a pet with them
12. Provides insight into client behaviors and habits not seen in a clinical office
13. Less tardiness
14. Fewer no-shows and cancellations

While telehealth has benefits for some clients and clinicians, there are also risks and challenges for others.<sup>6</sup> These include clinical characteristic and logistical challenges, including privacy and security. *While no research has shown telehealth to be less effective than traditional modalities for specific diagnoses*, there are clinical considerations that should be part of the risk assessment process.<sup>7</sup>

#### Telehealth risks include:<sup>8,9</sup>

1. Some clients have **difficulty developing therapeutic alliance across distance**
  - For example, clients with psychosis and dementia may feel discomfort with technology and experience emotional distance from provider
2. **Difficulties managing intense client emotions** during remote sessions
  - For example, clinicians have fewer ways to provide comfort and containment from a distance when they cannot hand the client a tissue or look directly into someone's eyes
3. Patient **safety may be compromised**
  - This includes privacy issues related to technology and elevated risks of self-harm and harm to others if patients dysregulate quickly without professional staff in the vicinity who can intervene
4. **Technical challenges** can cause frustration and interfere with the therapeutic relationship
  - Technical challenges can be caused by unreliable internet service, low image resolution, audio quality and delay
5. Remote **group therapy** dynamics can be undermined by technology
  - On some platforms, the image of a person who is speaking or making noise is enlarged, which can be disruptive if people are talking over each other or making other noises like tapping their feet. This can be avoided by turning off microphones of participants who are not speaking.
6. Some clients have philosophical **objections to technology**
  - For example, some clients feel threatened by technology (e.g., if they do not have citizenship, if they have a history of abuse that involved being recorded), see it as a detriment to humanity, or simply dislike using it
7. **Inadequate space in home** to accommodate telehealth
  - Lack of privacy can be dangerous to patients with unstable or abusive living arrangements

### Client Appropriateness of Fit for Teletherapy

Telehealth clients need to be able to set up the videoconferencing system, maintain the appropriate computer/device settings, establish a private space, and participate in necessary steps for effective safety management. To assess a client's ability to complete these steps and whether telehealth services are appropriate for them, consider the client's cognitive capacity, history of cooperativeness with treatment professionals, current and past substance abuse, violence, and self-injurious behavior. If unsure whether a client will be appropriate for telehealth, consider an agreement to conduct a certain number of sessions before committing to ongoing telehealth care.

If cognitive capacity is a barrier for utilizing video conferencing, a client's chosen support person may assist. Support people must sign confidentiality agreements if they are present during the telehealth session.

As a matter of safety, some clients require face-to-face care in a controlled environment staffed by a team of clinicians. However, during COVID-19, emergency psychiatric services are often limited, and clinicians are working with clients over telehealth whom they would, under normal circumstances, refer to in-person care. Specific diagnoses should not automatically preclude clients from telehealth; their symptoms, self-help skills, support systems, and responsiveness to medications and other treatments may alter their ability to safely engage in teletherapy and should be assessed on an ongoing basis.

The process can also be adjusted to increase telehealth safety and success, including using telehealth modalities other than videoconferencing. Below are considerations for identifying whether videoconferencing is the best telehealth platform for a client.

1. Clients who are living with anxiety or paranoia may not trust the video platform and/or be concerned about who else is in the room with the therapist.
  - In such cases, a clinician can pan the room with the camera so the client can see the environment.



2. Clients experiencing mania, who have Attention Deficit Hyperactivity Disorder (ADHD), and/or are hypervigilant may be distracted by various aspects of the video platform.
  - It may be helpful to build strategies to manage distraction into the initial teletherapy sessions.
3. Clients with generalized anxiety may express concerns about telehealth communications which are the result of free-floating anxieties.
4. Clients with histories of sex trafficking may be triggered by cameras.
5. Clients living with dementia, young children, and clients with physical disabilities may need assistance using technology.
6. Dementia may result in confusion about the clinician on the screen as a television personality or hallucination as opposed to their personal therapist.
7. Clinicians may need to put in extra effort to form bonds and devise new ways to connect with young children, who are still developing interpersonal sensitivities and skills.
  - Clinicians can put a finger or hand up to the camera and invite the child to do the same, invite children to play Simon Says, and use play materials for deeper engagement.
8. Some clients may not have access to high-speed internet or necessary devices at home.
  - See “Establishing Your Telehealth Space” in this guide for information about low-cost and free internet service.
9. Clients who do not have legal citizenship, engage in behavior that is criminalized (e.g., sex work, illicit drug use), and/or are refugees from oppressive governments or gang activity may fear being recorded and have questions about media storage.
10. People experiencing domestic violence, incest, and child abuse may be overheard by the abuser if engaging in teletherapy at home or other places to which the abuser has access.
11. Clients who experience significant dysregulation – such as being severely oppositional, aggressive, or manifest behaviors that other people experience as aggressive – may not be able to safely engage in teletherapy.
12. Clients who idealize or over-value the therapist may have exaggerated expectations of the clinician and feel frustrated or disappointed with the distance created by the video platform.
13. Clients who disassociate when discussing traumatic memories may be unsafe in the telehealth environment.
  - Clients may benefit from the clinician helping to identify grounding strategies to bring them back to the here and now.
  - If another person is in the home, the therapist can text that person if the situation is unsafe for the client.
  - Having a dog or cat in the room may help pet owners regulate when in distress.

### **Clinical To-Do List**

When telehealth is appropriate for a client, there are several one-time actions to be completed during the first telehealth meeting and several actions that must be completed for each subsequent telehealth session. It is important to check with the state licensing board applicable to your practice and to know the difference between actions which are required versus those that are recommended. For example, the California Association of Marriage and Family Therapists created a helpful [Checklist](#) for providers serving clients in California. Here is a sample list of one-time and every-time actions:

**One Time Actions** to be completed upon initiation of telehealth services. Much of this information can be provided in an informed consent form.

\_\_\_\_\_ Inform the client about the use of telehealth (i.e., benefits, risks, alternatives, expectations for behavior); obtain their verbal or written consent to receive telehealth services; and document their consent in their treatment record.

- Verbal consent is appropriate and accepted current practice during the COVID-19 pandemic.

\_\_\_\_\_ Explain that in the event of a life-threatening medical emergency (including self-harming behaviors and threat to others), the clinician follows laws regarding mandated reporting. The clinician has the right to call 911 and disclose information related to the client, the emergency, and the client’s address.

\_\_\_\_\_ Explain that the clinician will continuously assess the safety of telehealth and that the clinician maintains the right to terminate teletherapy if it is not in the client’s best interest. In this event, the client will be transferred to in-person services.

\_\_\_\_\_ Explain that if the client abruptly ends the session, the clinician will call the client and if the client does not answer the phone, the clinician will call 911 to request a welfare check.

\_\_\_\_\_ Disclose common telehealth challenges, such as technical failure, unauthorized access to confidential information, and possibility of other individuals overhearing the session.

\_\_\_\_\_ Provide the clinician’s license or registration number and type.

\_\_\_\_\_ Provide contact information of resources in the client’s area, including emergency services.

\_\_\_\_\_ Explain that the clinician will contact the client if the connection is lost (to avoid a busy signal from both parties attempting to contact each other at the same time).

\_\_\_\_\_ Establish a safe word the client can use if they need to disconnect from telehealth for safety or privacy reasons without people in their immediate vicinity knowing (e.g., if they live with someone who is abusive).



\_\_\_\_\_ Provide crisis line numbers (e.g., National Crisis Line 1-800-273-8255, National Domestic Violence Hotline 1-800-799-7233) and explain that telehealth is not for emergencies but rather routine mental health care.

\_\_\_\_\_ Encourage the client to create an environment of uninterrupted privacy.

- Examples may include scheduling childcare; placing a “do not disturb” sign on the door; and, if there is no private space in their home, considering teletherapy in their car.
- If using a car, make sure to remind the client that they need a fully charged battery on their device, as well as enough gas in their car to run the heat/AC.

\_\_\_\_\_ Invite the client to a 30-40-minute practice session to help them become more comfortable with telemental health. This ensures that the next session actually begins with a focus on the therapy. **Practice session recommendations include:**

\_\_\_\_\_ Discuss what to do if technology fails.

- Examples: clinician will call client by phone if they unexpectedly log off; session will transition to phone if the sound fails in the video conferencing platform (can still stay on screen for visual connection)

\_\_\_\_\_ Help the client explore different aspects of the telehealth platform

- Examples: how to mute their microphone, how to use the chat function to upload documents.

\_\_\_\_\_ Help the client with camera angle, microphone, speaker use, lighting, and where to place the image of the clinician.

- Examples: clinician should position themselves close to the camera to facilitate approximate eye contact

\_\_\_\_\_ Discuss professional expectations that carry over from in-person sessions.

- Examples: be fully dressed; do not drink alcohol; do not allow other people in the room without notifying the clinician

\_\_\_\_\_ Ask clients, “What questions do you have about telehealth? What concerns can we address now so that you can feel comfortable with this modality when we begin therapy?”

\_\_\_\_\_ Walk through how to send assignments.

- Examples: does the client have a scanner? Can they take a photo of a piece of paper and securely email it to the clinician?

\_\_\_\_\_ Communicate confidence in the client’s ability to weather any technology challenges that may arise and normalize technology challenges as expected.

- Example: explain that differences in bandwidth can affect communication lag time

\_\_\_\_\_ Discuss ways to minimize distractions.

- Examples: mute unnecessary cell phone alerts; schedule deliveries at times outside of therapy; set children up with childcare or snacks and activities during therapy

\_\_\_\_\_ Discuss what to do if interruptions happen anyway.

- Examples: what will they do if the doorbell rings, or a child needs immediate attention?

\_\_\_\_\_ Show the client how to use background screens if they are supported by your platform.

### **Actions for Each Session:**

\_\_\_\_\_ Verbally obtain and document the client’s full name, the address of their current location, and their phone number.

- This step reduces the risk of impersonation, is useful in case of emergency, and is essential to your ability to follow local laws related to telehealth. If the client is not in their usual city or state, take a few minutes to look up emergency contact numbers in case you need to report imminent danger to self or others.

\_\_\_\_\_ Assess whether telehealth services are, or continue to be, appropriate for the client’s needs.

- Included in the consent process should be language indicating that if the clinician determines the client is no longer safe for telehealth based on psychiatric or medical symptoms, the patient will be transferred to in-person care (e.g., an emergency room or other emergency psychiatric services).

\_\_\_\_\_ Use industry best practices to maintain client confidentiality and privacy of the communication.

- State that you will not record the session and ask that the client not record the session without informing you.
- Confirm an emergency contact for the client and ask if anyone else is in the room or house/apartment with the client. These actions can help maintain their privacy as well as their safety in a crisis (e.g., if the person disassociates and needs help grounding in the present).
- Check-in at the end of sessions to see whether adjustments can be made for improved telehealth experience during the next session.

\_\_\_\_\_ Provide resources as relevant to the client’s needs. Here are videos and resources for clients regarding mental health and COVID-19:

- [Videos About Mental Health Issues during COVID-19](#) by Psych Hub
- COVID-19 [Mental Health Guides for Clients](#) by various mental health agencies
- [Mental Health and COVID-19 Resources](#)
- [Resources for Specific Audiences](#) (e.g., Native Americans, parents, construction workers, older adults, faith communities, sports communities) about coping with mental health distress and messaging about suicide during COVID-19



Ask clients the following questions at the beginning of every session:

### 1. Where are you?

- If the client is in a public space like a park or restaurant, consider canceling and rescheduling the session until they are in a secure and private environment.
- You and the client can both pan your cameras around the room to create a better sense of each other's environments.
- This can be especially helpful for clients with dementia and other cognitive challenges who might find the additional context about your environment helpful to settling into the clinical session.

### 2. Is there anyone in the room with you or who can hear you from nearby?

- Client responses may be mediated by the possibility that someone is listening, which is good to know if they become silent.
  - To decrease the chances that the conversation is overheard, encourage clients to place a towel under the door, use an app that plays white noise which can be placed next to the door, meet in their vehicle, or use headphones.
  - Never be afraid to stop and ask what is going on in the client's environment if you hear a strange noise in the background.
  - Always document if there are stressors in the environment and if the connection is lost for any reason.

## Telehealth Assessments

Clinicians in telehealth practice are expected to maintain the same standards for protecting client privacy and service provision that apply to face-to-face services. According to Dr. Marlene Maheu, Director of the Telebehavioral Health Institute, licensing boards that investigate telehealth practices usually assess what clinicians do in face-to-face practice and whether a workaround was implemented to accomplish the same task in telehealth. It is essential that clinical processes in telehealth practice do not cut corners on tasks like conducting informed consent, assessment, treatment planning, crisis management, charting, and termination.

Clinician Assessments. The assessment process must be adjusted in the telehealth context. Several of the clinician's senses that they often use in diagnosis (e.g., visual, auditory, olfactory) are limited in remote settings. Be creative with the Mental Status Exam (MSE) assessment to ensure that no aspect of an in-person assessment is omitted in the telemedicine context. Pay attention to volume, diction, and speech content. Ask a client to walk across the room in view of the camera to assess gait and appearance.

Beyond the MSE, there are many tools created for in-person assessments that require special consideration when conducted remotely. Cognitive, neuropsychological, and autism assessments are informed by the manipulation of physical materials, standardized interactions between assessor and client, and clinical observation of the person in a physical environment may or may not be appropriate for telehealth.<sup>10</sup> Additional telehealth assessment resources are on pages 19-22 of the American Psychological Association's [Guidelines for the Practice of Telepsychology](#).

Self-assessments can be completed in a virtual environment. Clinicians are encouraged to send self-assessments a week prior to the appointment and request them back over secure email. If clients have not returned the assessment, clinicians can ask clients to show them the assessment by placing it close to the camera or reading the responses out loud.

### Here are some assessment tools that are available online:

- [Beck Depression Inventory \(BDI\)](#)
- [Columbia Suicide Severity Rating Scale \(CSSRS\) and other instruments](#)
- [PTSD Checklist for DSM-V \(PCL-5\)](#)
- [Patient Health Questionnaire-9 \(PHQ-9\)](#)

## Telehealth Treatment Planning and Documentation

The Centers for Medicare & Medicaid Services (CMS) has temporarily waived requirements of the organization and staffing of the medical records department; requirements for the form and content of the medical record; and record retention requirements, **so long as the waiver is not inconsistent with a state's emergency preparedness or pandemic plan.**

As in face-to-face clinical practice, virtual treatment planning and progress must be documented in secure client medical records. Client files should never be saved in the cloud, but rather on a password-protected external hard drive that is stored within a locked cabinet behind a locked office door.

Telehealth medical records should include documentation of an evidence-based rationale for treatment decisions. At minimum, the documentation for each session should include the following:

- Details of the informed consent discussion
- A statement that the service was provided via telehealth
- A statement explaining the use of any non-HIPAA-compliant technology
- The location of both clinician and patient
- Documentation that supports coding for reimbursement



## Telehealth Crisis Management

COVID-19 is exacerbating mental health crises. Rates of domestic abuse and suicide are increasing in the U.S. and worldwide, in tandem with isolation caused by shelter-in-place orders.<sup>11,12</sup> Clinicians may find useful guidance in the [Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic](#). Other clinical resources include The International Society for Traumatic Stress Studies' [webinars and podcasts about resilience and trauma during perilous times](#) and the Suicide Prevention Resource Center's webinar [Treating Suicidal Patients During COVID-19: Best Practices and Telehealth](#).

### Safety Plans

It is essential that telehealth consent forms outline the steps the clinician will take if there are safety concerns (e.g., breaking confidentiality to engage emergency support), and that clinicians assist clients in creating safety plans adjusted to social distancing orders. Be sure that the completed safety plan is given to the client and entered in the client's chart. Patients can enter safety plans into their smartphones with a [Suicide Safety Plan App](#).

Remember that some resources ordinarily included in safety plans may not be available during the pandemic (e.g., some shelters may have closed due to social distancing orders). Referring clients to an emergency room may no longer be the first choice due to long wait times, concerns about disease transmission, and the number of psychiatric staff being diverted from ERs to ICUs. A COVID-19 Guide to suicide prevention over telehealth including assessment and safety planning can be found here: [Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic](#).

### Clinician Suicide Prevention Strategies

Assess suicide risk of all clients during every telehealth session. It is important to have a plan for how you will contact emergency services while keeping the client in teletherapy if there is imminent risk (e.g., keep client in teletherapy online portal while using your cell phone to dial 911).

Be mindful that moderate risk for suicide today could quickly turn into high risk for suicide tomorrow, outside of teletherapy. Building the client's self-help skills to engage in de-escalation or self-regulating behaviors when they are at moderate risk (e.g., sad versus despondent, frustrated versus enraged) can help prevent them from escalating to high suicide risk.

1. Clinicians should assess for COVID-19 psychological distress factors that can quickly escalate from suicidal thoughts to plans and action. [CAMS](#) (Collaborative Assessment and Management of Suicidality) is an EBP is effective over teletherapy.
2. The Recommended Standard of Care for People with Suicide Risk lists three actions, all of which can be done over telehealth:
  - a. Assess risk (including COVID-19 stress factors)
  - b. Create safety plans and means restriction to guns and medications (note that some people have unusually large amounts of medications in their home due to shelter-in-place orders)
  - c. Provide "follow-up caring contact" (0-15-minute check-ins by telephone can help the client between sessions)

[The Zero Suicide Institute](#) provides a wealth of pandemic-related suicide prevention resources on their page [Providing Suicide Care During COVID-19](#) such as a [Telehealth and Suicide Care During the COVID-19 Pandemic](#) information sheet. See Appendix B for a sample Emergency Resource Sheet.

### Client-Facing Suicide Prevention Strategies

**To help clients develop the ability to self-regulate, clinicians can direct clients between sessions to:**

- Download [Crisis Intervention Worksheets](#) from Psych Point Mental Health Center.
- Watch the Now Matters Now video [Stop, Drop, and Roll: Steps for Being on "Fire Emotionally"](#).
- Complete a Now Matters Now [Diary Card](#) and/or [DBT Skill Practice Card](#).
- Access The [Virtual Hope Box App](#) which can help clients utilize coping skills, engage in relaxation exercises and distraction, and engage in positive thinking.
- Identify protective factors accessible during shelter in place (e.g., Zoom meetings with family and friends, enjoyable activities of distraction that increase sense of wellbeing such as favorite music, meditation, or breathing exercises).

**To help clients who are in a state of suicidal crisis, clinicians can direct clients to:**

- [Watch videos](#) that have been shown to reduce suicidality among diverse groups of viewers, who reported feeling less alone and learned something useful.
- Contact crisis lines when distressed or in active crisis (e.g., National Crisis Line 1-800-273-8255, [suicidepreventionlifeline.org](#), and Crisis Text Line "HOME" to 741741).
- Visit the Now Matters Now website for crisis helpline information and [Direct advice for managing](#) intense and overwhelming suicidal urges.

### Other Mental Health Crises

In addition to suicide, clinicians need to assess for domestic violence and create associated safety plans (examples are [here](#), [here](#), and [here](#)). In regard to sexual trauma, clinicians may access a free 1.5-hour training during the pandemic [Telecounseling 101: Providing Services for Survivors](#), by Victim Services Incorporated and the Pennsylvania Coalition Against Rape (safety planning instructions begin at 50 minutes).



## Telepresence Best-Practice Tips

This section provides a quick checklist of actions, behaviors, and strategies that support both clinician and patient comfort in the telehealth environment. These tips are intended to help minimize video conferencing distractions and maximize efficacy.

### Session Tips

1. Wear an entire professional outfit, not just what is visible on camera, in case you suddenly have to get up from the table or desk during the session.
2. Video can magnify faces and movements; engage in good video etiquette.
  - Turn off the camera to wipe nose.
  - Do not eat or chew gum on camera.
  - Keep hands away from mouth and nose.
3. Develop confidence in your ability to handle whatever technical challenges might arise by having a back-up plan.
  - Keep your cell phone and the client's contact information on paper nearby in case internet service is interrupted or your computer crashes.
  - Keep earbuds or headset nearby in case the microphone on your computer fails or there is sudden ambient noise, like a neighbor mowing the lawn.
  - Ensure that the client is no longer connected to your device after the session ends and use a video conference waiting room if you have back-to-back clients.
4. Avoid wearing busy patterns and having busy images behind you, as they can slow the transmission of information.
5. Pauses in dialogue that feel natural in face-to-face therapy can be awkward in telehealth. Clinicians may find it helpful to speak more frequently to avoid pronounced silences.
6. Internet bandwidth differences may result in the client having a worse connection than the clinician, causing the clinician's speech to sound broken while the client's speech sounds normal. If this happens, use these strategies:
  - Speak more slowly than in face-to-face encounters to manage the differences in bandwidth
  - Employ non-verbal strategies, like head nodding, if saying "uh-huh" is not audible due to lag time.
7. When conducting evidence-based treatments over telehealth that include homework assignments, like Cognitive Processing Therapy, clients may experience challenges submitting assignments prior to the session.
  - If needed, clients can read their homework assignment responses to the clinician or put the assignment to the camera so the clinician can read them.
  - In these situations, clinicians may need to anticipate interventions taking longer than expected.
8. Some clients fear the therapist "being in" their living space and seeing things such as drug paraphernalia, evidence of hoarding, or indications of socio-economic disparities between client and therapist.
  - Engage in open communication about telehealth to anticipate and defuse this kind of stress.

### Ensuring Eye Contact

- Use a stationary chair so you don't rock back and forth.
- Position your eyes 2/3 of the way from the bottom of the screen.
- Test your virtual eye contact before seeing any patients.
- Find out what the patient will see when you're typing or leaning forward and back, and practice holding yourself in an inviting position.
- Practice! The simulation of eye contact through technology takes practice.
  - Rather than looking into the eyes of the image of a person on the screen, providers will need to adjust their gaze angle to look directly into the camera.
  - Moving the image of the person as close to the camera as possible can help.
- Ask client if anyone is in the room with them at the beginning of each session so that you can understand why they may look away from the camera.
- For more information on the importance of telemedicine and eye contact, [visit here](#).

## Telehealth Laws, Risk Management, and Billing

This section describes requirements that pertain to telehealth practice, and steps that clinicians can take to protect their patients and themselves. Note that these regulations may vary depending on your state or island region, and federal and state regulations may continue to change in response to the COVID-19 pandemic.



## Licensing and Privacy Protections

In most states, licensed clinicians can provide telehealth, including licensed marriage and family therapists (MFTs), educational psychologists, clinical social workers, and professional clinical counselors (check with your state's licensing board to ensure your license is permitted to practice telehealth). During COVID-19, some regulations have been relaxed to allow associate or trainee MFTs, clinical social workers, and professional clinical counselors to provide telemental health. Check with your state licensing board regarding supervision requirements for associates and trainees (e.g., The COVID-19 Interim Guidance from the California State Board of Behavioral Sciences [BBS]).

Check with state licensing boards to ensure proper laws are followed. (If conducting telehealth across state lines, the clinician is bound by the laws of the state in which the client is logging into therapy.) For information about licensing laws by state, visit [State Telehealth Laws](#) and a map of [Current State Laws and Reimbursement Policies](#).

Licensing board infractions commonly involve overstepped boundaries. Additionally, licensing board investigations often explore the extent to which clinicians ensure that teletherapy provides the same quality and processes of care as face-to-face care (i.e., that corners are not cut in adjusting practice to telehealth).

### Informed Consent

Clinicians must attain informed consent describing the risks and benefits of telehealth services. For an example of informed consent for teletherapy, [click here](#) (please note this example should be adjusted to the laws of the applicable state). Social workers may also review the article [Telemental Health](#) published by the NASW Legal Issues of the Month (March 2020). It is essential that the consent form includes discussion of appropriate boundaries around social media and other aspects of virtual contact (e.g., no client-clinician "friendships" on social media).

### Federal and State Protections

Telehealth services are regulated by federal laws, such as HIPAA and HITECH, and state laws such as the California Confidentiality of Medical Information Act. HIPAA covers transmission, security, and privacy. It is important to note that HIPAA is the foundational level of requirements, and it is superseded by state laws when the state mandates offer more client protection. To understand the distinct laws in the state where your client connects to teletherapy, it is essential to consult with that state's licensing board, especially as several federal and state laws are rapidly shifting in the context of COVID-19 (for example, some states are permitting clinicians to provide telehealth across state lines regardless of the state where they are licensed).<sup>13</sup>

## Technology Security Requirements

The platform you use should meet both your needs and the client's needs. Ask your telehealth patient if they have a preferred platform. Ideally, the platform selected and used would include all tasks related to mental health services and documentation of services, such as informed consent, intake, progress and termination notes, and referrals.

### HIPAA Compliance

There are many HIPAA-compliant video chat services clinicians can use for telehealth service (e.g., Zoom for Healthcare, Skype for Business, G Suite, and Microsoft Office). Two places to learn about various technologies are the [Telebehavioral Health Institute Telehealth Buyer's Guide](#) and the [National Telehealth Technology Assessment Resource Center's Clinician's Guide to Video Platforms](#)

#### The following software and apps are HIPAA compliant

- [Doxy.me](#)
- [Google G Suite/Hangouts Meet](#)
- [Skype for Business](#)
- [Updox](#)
- [Vsee](#)
- [Zoom Healthcare](#)

During the COVID-19 emergency, the federal government is temporarily allowing providers to use some non-HIPAA compliant video chat services that are not public-facing, such as Apple FaceTime or Skype, in good faith provision of telehealth services ([learn more](#)). Public-facing services such as TikTok or Facebook Live still may not be used.

If possible, use HIPAA-compliant software to provide telehealth. This means that video and audio are not stored or cannot be intercepted in any way. If recordings are made, they should be stored only on HIPAA-compliant devices and systems.

Note that while hardware such as an iPhone may be HIPAA-compliant, software may not be HIPAA-compliant (in fact, software that is pre-installed on devices is typically not HIPAA-compliant). While FaceTime is not HIPAA-compliant out of the box, it can be made HIPAA-compliant if both the clinician and client create a firewall.

### **Device Security**

Clinicians are encouraged to regularly update phones, computers, tablets, and other devices for current privacy protections. You do not need to become an expert in technology to start a telehealth practice, but it is a good idea to consult with experts if you have questions (e.g., [National Telehealth Resource Center](#) and [Telebehavioral Health Institute](#)).

Where possible, it is recommended that personal devices not be used for professional use. If a personal device is used (e.g., mobile phone), the most recent security update for the device should be installed. Settings that may need to be reconfigured for additional security include automated tasks that synchronize with other devices, such as email, contacts, phone/video logs.

**For the sake of telehealth security, it is critical to have updated antivirus software and/or firewalls. The following programs are free options that can be used to determine computer security.**

- Windows 10 Defender. If you have Windows 10, Windows Defender Antivirus is already part of your operating system. [VERIFY YOU'RE UPDATED](#) ( or [click here](#) to access the verify page)
- Avast. <https://www.avast.com/free-antivirus-download>
- AVG for PC and Mac. <https://www.avg.com/en-us/free-antivirus-download>

### **Data Storage**

The Telebehavioral Health Institute (TBHI) recommends that information be stored on an external hard drive and not in the cloud to better ensure data security. TBHI also recommends hard drives, computers, and laptops be stored in a locked cabinet when not in use, and to take special care when traveling with the device.

Many devices come with preinstalled apps. For these apps, we recommend changing the settings so the information is not stored in the cloud. If a computer needs to be serviced, hire a technician to come to your house instead of dropping off and leaving the computer at a store front.

### **Other considerations for data collection and back up:**

- What types of information will be collected as part of the client record?
  - In addition to the regular charting used for in-person visits, telehealth charting must also describe strategies to ensure that clinical processes were adjusted to the telehealth platform (e.g., clients can hold completed PCL [PTSD Clinical List] screens during trauma therapy in front of the camera for the clinician to record self-reported changes in symptoms related to trauma).<sup>14</sup>
    - For a peer-reviewed article about standardized testing instruments used in telehealth to assess depression, PTSD, and anxiety, [click here](#).
- Where will this information be stored? How will it be backed up securely?
- If therapists are using apps to supplement therapy, where is the information from those applications stored? Is it secure?
  - Check with the manufacturer of the app or an IT professional to determine how to increase safety of data storage.

### **Checklist of sample risk management strategies (adapted in part from the American Professional Agency):**<sup>15</sup>

- Use HIPAA-compliant technology platforms.
- Obtain a Business Associate Agreement (BAA) for technology vendors.
- Use a secure, password-protected Internet connection (not public or unsecured Wi-Fi) with adequate connectivity.
- Ensure the client knows how to log in and use the technology. Explain the risks of using public, unsecured Wi-Fi.
- Educate your client about the use of public, unsecured Wi-Fi and how it increases the risk of being hacked.
- Ensure antivirus/anti-malware protection is up-to-date and the most recent security updates are installed.
- Check to confirm that you are compliant with the licensing requirements, prescribing laws, and privacy protections of the client's state.



- Obtain proper informed consent, including a discussion of risks, benefits, and alternatives to telehealth. Some states require written informed consent, but during the COVID-19 pandemic verbal consent is often accepted practice.
- Maintain medical record documentation in accordance with applicable laws, regulations, and guidelines.
- Create a procedure for sending, receiving, and storing documents between the clinician and client.
- As appropriate, consult with your legal staff, state licensing board, or telehealth resource center.

## Billing

The Centers for Medicare and Medicaid Services (CMS) has issued multiple blanket waivers since the COVID-19 pandemic began that should permit practitioners to be reimbursed through Medicare and Medicaid. For information about billing for telehealth services, visit the American Psychiatric Association's webpages [Telepsychiatry and COVID-19](#) and [Practice Guidance for COVID19](#) (which includes State-by-State Guidance).

The Centers for Medicare and Medicaid Services (CMS) created a COVID-19-specific [General Provider Telehealth and Telemedicine Tool Kit](#); an article [Medicare Telemedicine Health Care Provider Fact Sheet](#); [Medicare Telehealth FAQs](#); and [Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth](#).

The Centers for Disease Control has published [ICD-10-CM Official Coding Guidelines - Supplement Coding Encounters Related to COVID-19 Coronavirus Outbreak](#).

## Using Technology and Establishing Your Space

For clinicians whose transition to telehealth is supported by an employer, the agency's IT Department may have significant resources, including hardware, software, and accessories with appropriate safeguards to protect client privacy. The following information will assist clinicians transitioning to telehealth without institutional support.

### Grants for Telehealth Technology

Pursuant to the CARE ACT, the FCC has developed a [portal to accept applications](#) for a \$200 million COVID-19 Telehealth program. This program funds healthcare providers to purchase telecommunications, information services, and devices necessary to providing care during COVID-19.

- [FCC Website on COVID-19 Telehealth Opportunity](#)
- [FCC webinar on the Application Process](#)
- [FCC Public Notice on Application Contents](#)
- [Text of FCC Decision Establishing the Program](#)

### Internet Connection

The clinician's internet connection is important. Typically, you will need broadband internet with at least 20 MBPS upload/700 MBPS download speed to prevent pixelation, buffering, and video and audio inconsistency. HD will require higher speeds. Go to [www.fast.com](#) to test and monitor your connection speed for free. Open in a browser on your device for real-time monitoring.

If you are providing telehealth in a semi-public space (e.g., hotel room, private library room), be sure to connect via a hotspot on your phone instead of the public network.

### Connecting Clients

During COVID-19 stay-in-place directives, several internet providers are offering free Wi-Fi for everyone (current as of writing). These include:

- Xfinity WiFi Free For Everyone: Xfinity WiFi hotspots located in businesses and outdoor locations across the country will be available to anyone who needs them for free – including non-Xfinity Internet subscribers. For a map of Xfinity WiFi hotspots, visit [www.xfinity.com/wifi](#).





- Charter will offer free Spectrum broadband and Wi-Fi access for 60 days to households with K-12 and/or college students who do not already have a Spectrum broadband subscription and at any service level up to 100 Mbps. To enroll call 1-844-488-8395. Installation fees will be waived for new student households. Charter will open its Wi-Fi hotspots across their footprint for public use. Spectrum does not have data caps or hidden fees.

## Telehealth FAQs

Conversations with both providers and consumers of telemental health services informed the how-tos in this section. Here we answer the most frequently asked questions about the process of setting up and preparing for the delivery of telehealth services. While not exhaustive, these FAQs are a solid foundation upon which to build the transition to telehealth; where possible, we have included specific recommendations for appropriate hardware.

When transitioning to use of your personal space or home as an office, the set-up will be important. Ideally, the location will be secure; be free of noises and other people in the background; have a professional appearance; and use the right technology. The key is to avoid distractions yet also be comfortable.

- Create a space that is free from distractions.
  - Lock the door, place a “do not disturb” sign on the door as well as on the doorbell, and turn the camera away from the door.
- Choose the right microphone.
  - Considerations include quality, type of microphone, placement, speaker, and speaker location.
  - The placement is important, as many mics (such as phone earbuds) may need to be directly in front of your mouth for optimum sound quality.
- Reduce background noise.
  - Test what ambient noise the mic may pick up – doorbell, family members, traffic, neighbors, animals, etc.
  - A white noise machine outside of the office may alleviate any distracting ambient sounds.
  - Use pillows, curtains, and carpets in your workspace to help absorb sound.
- Be aware of repetitive sounds you may make without realizing it.
  - Sit in your space and pay attention to what noises you make (e.g., repeatedly tapping a pen, shuffling papers).
- Make sure all your other devices are in “silent mode” and that email/app notifications are turned off.
- Don’t forget the space in front of you.
  - Identify what might distract you during a session.
  - You may want to keep items that encourage you, keep you regulated, or keep you energized.
- Be sure to have any notes or checklists or other memory aids readily accessible.
- Have other key essentials within reach, like a glass of water, glasses, tissue, etc.

### Sample speaker and microphone options:

- Jabra Speak 510 MS Wireless Bluetooth Speaker
- Speechware USB 3-in-1 TableMike
- Plantronics Headsets
- Your personal cell phone can also be used for live, 2-way interaction



## What should I know about the camera and lighting?

- Test the camera to see what the patient will see.
  - Visually, the space should be free of clutter.
- Don't face the camera towards the door, to make sure that your patient does not see someone enter the room.
- Ensure proper lighting.
  - Providers and clients should avoid sitting in a position with a light source behind them (e.g. a window or a lamp over the shoulder) or it will cast a shadow over their face.
- If possible, go for two sources of light. Change the light source if the client is obscured by shadows.
- Consider virtual meeting backgrounds.
  - You might want to use images of your office, or similar décor.
  - Select a background image that is not distracting.
  - [Examples of office backgrounds can be found online.](#)
- Be mindful of the glare from framed glass over photographs and art.
- Dress professionally, but be comfortable.
  - Avoid busy patterns, such as stripes or polka dots.

### Sample camera options:

- [Individual telecounseling sessions](#)
- [Groups, workshop, meetings: PTZ PRO 2](#)

## How can I be sure that I'm ready to deliver telemental health services?

- Practice using the systems prior to services.
- Identify challenges and develop responses to a variety of scenarios that may occur:
  - Know what you will do in a crisis.
  - Know how to formalize the start and end of sessions.
  - Practice maintaining start and end times.
  - Create simple responses to curious comments about home or family life.
  - Create a checklist to provide structure and avoid your own distractions.
- Acknowledge that telehealth is new and challenging to both you and the patient.
  - Acknowledge your mistakes when things go wrong.
- Technology can make even the most confident person feel incompetent or frustrated.
  - Be ready to navigate these feelings in yourself and others.
- Be clear that telehealth is optional for both clinician and client.
  - Offer alternatives if either you or the client is uncomfortable.
- Additional telepresence recommendations are available in a 4-minute video entitled [Telehealth Best Practices](#).



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## Appendix A

### Free and Low-Cost Telehealth Trainings and Resources

#### Free telehealth courses:

- [Telehealth Best Practices 101 Series](#) (8 hours), American Psychological Association, CEs included
- [Telehealth: California Social Work Response to the COVID-19 Pandemic](#) (3 hours), National Association of Social Workers California Chapter, CEs included
- [How to Start a Telehealth Program](#) (36 mins), Telehealth Certification Institute
- [How to Provide Telehealth Services During the COVID-19 Crisis](#) (32 mins) by Jacqueline Thelian CPCA, CPC-I, CHCA
- [Psychiatry Unbound Podcast: Telepsychiatry and Health technologies](#) (35 mins) by Laura Roberts, M.D., Peter Yellowless, MBBS, M.D., and Jay Shore, M.D., M.P.H., American Psychiatric Association
- Several webinars and podcasts of various lengths totaling (over 4 hours for free) from the [American Telemedicine Association](#) including an [ATA COVID-19 Response Webinar Series](#)
- Two free trainings about [Suicide Prevention and Telehealth](#) by the EBP Collaborative Assessment and Management of Suicidality (CAMS)
- Two 1hr free webinars about Telehealth from the National Council for Behavioral Health (click [here](#) and [here](#))

#### Additional Courses (some free, some paid):

- [Texas Association for Marriage and Family Therapists](#)
- [Coalition for Technology in Behavioral Science](#)
- [American Telemedicine Association](#)

#### Further Resources:

- One key article to help mental health agencies assess their preparedness to conduct telehealth is the [Interprofessional Framework for Behavioral Health Competencies](#).
- National Telehealth Technology Assessment Resource Center - Clinician's Guide to Video Platforms <http://telehealthtechnology.org/toolkit/clinicians-guide-to-video-platforms/>
- Telehealth Best Practices for COVID-19 Training <https://telehealth.org/clinical>
- American Psychological Association Continuing Education Resources <https://www.apa.org/ed/ce/telehealth>
- American Psychological Association Office and Technology Checklist for Telepsychological Services <https://www.apa.org/practice/programs/dmhi/research-information/telepsychological-services-checklist>



## Appendix B

### Telehealth Emergency Contact Sheet

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

1. Family, Friend, or Neighbor who can be contacted to check on the patient:

NAME: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

NAME: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

NAME: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signed Release of Information Consent:  Yes  No

2. Local Emergency Room: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

3. Local Police Department: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

4. Emergency Psychiatric Services: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

5. Primary Care Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

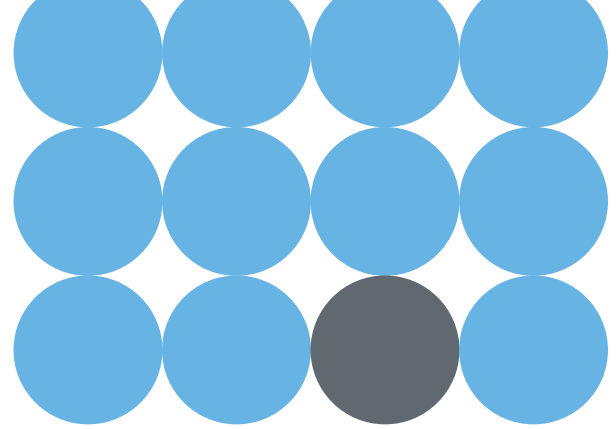
Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

<sup>1</sup> <https://www.jdsupra.com/legalnews/new-york-and-federal-lawmakers-ease-16792/>



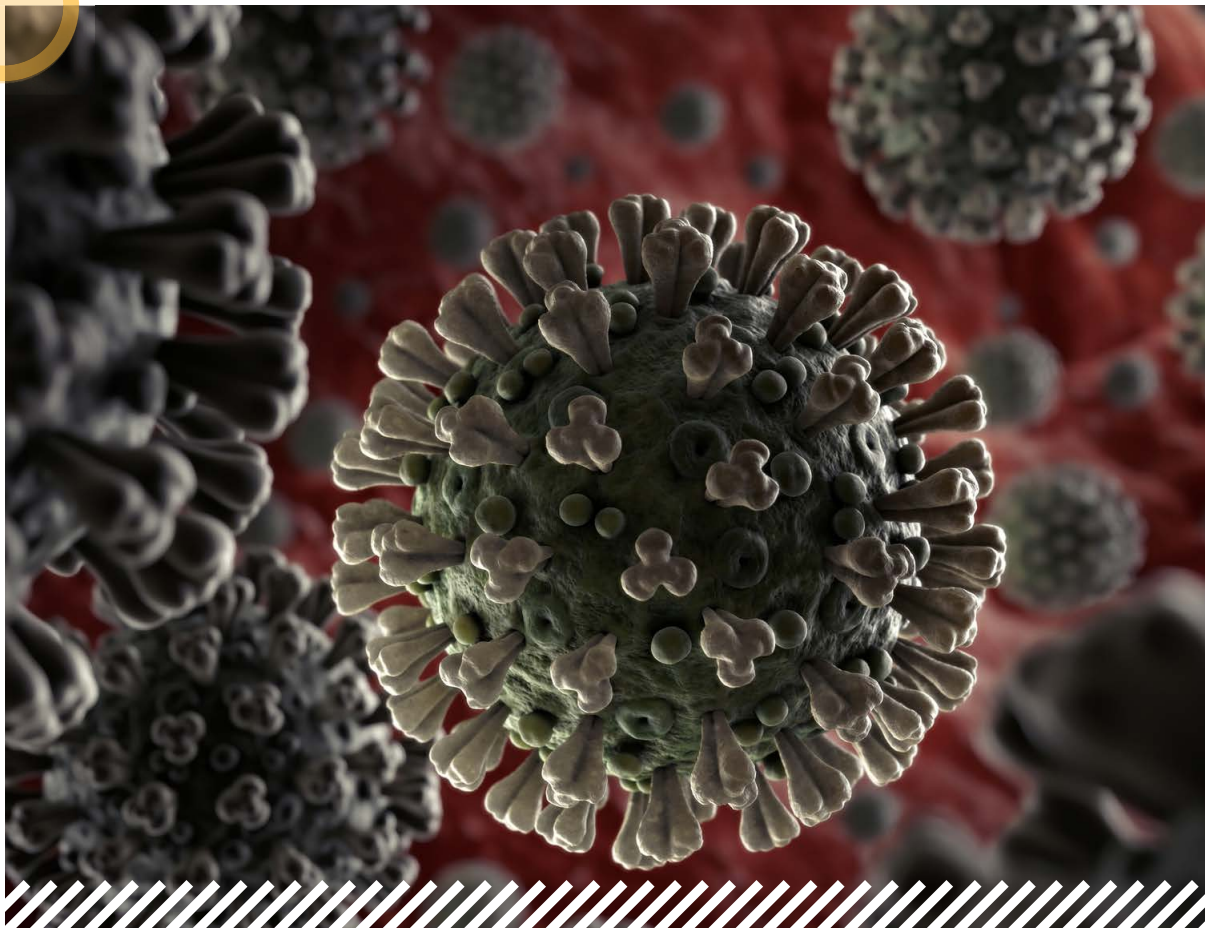
# Social Justice Brief

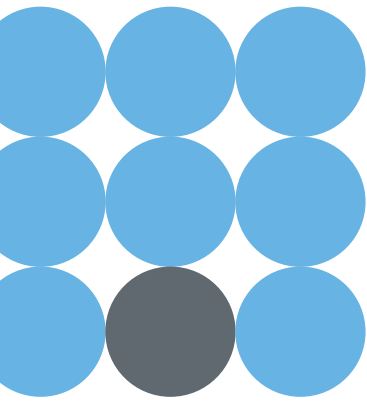
Mel Wilson, MBA, LCSW  
Senior Policy Consultant  
National Association of Social Workers



## Implications of Coronavirus (COVID-19) for America's Vulnerable and Marginalized Populations

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.





# Implications of Coronavirus (COVID-19) for America's Vulnerable & Marginalized Populations

By this time, nearly all Americans are aware that the country (and the world) is experiencing a pandemic caused by the Coronavirus (COVID-19). While pandemics are not new to the United States, COVID-19 is emerging as a public health crisis that has the potential to directly or indirectly impact nearly every household in the country. There are worst case projections that between 160 million and 214 million people in the United States could be infected over the course of the epidemic. These same projections suggest that as many as 200,000 people could die. Given possible dire results of the COVID-19 pandemic, the need for a full-scale public health mobilization to prevent the spread of the virus is an imperative at a crisis level.

It is also important to recognize that not only does an epidemic of such proportions pose a threat to the physical health of Americans, it will be disruptive to such areas as employment, education, voting, the 2020 Census, and daily patterns of socialization. All of this presents challenges to the economic and emotional well-being of children and adults alike.

For those reasons, the National Association of Social Workers (NASW) in its concern for equitable treatment of all Americans effected by natural disasters and national public health emergencies, turns its attention to America's vulnerable and marginalized populations. We know from past experiences that the impact of the COVID-19 pandemic on the general population will be exponentially increased among those who

live on the margins of our society. Therefore, it is critical that these families and individuals are not excluded from the federal and state governments' mobilization of resources to fight the spread of COVID-19—as well as protecting them from the related social and civic disruptions that will inevitably occur as the virus spreads.

The following overview succinctly discusses several major population groups who are at high risk of exposure to or contracting the novel coronavirus. It also identifies very important intersectional events (the 2020 elections and the 2020 Census) that will negatively impact marginalized families and individuals if interrupted by the COVID-19 pandemic.

## 1. ECONOMIC IMPACT ON LOW-INCOME AMERICANS

Because of the breadth of the federal and state effort to prevent the spread of COVID-19, there will, without a doubt, be a significant effect on the economic stability of low-income individuals and families. This is especially true for hourly wage earners who lack both health insurance and annual and sick leave. Given that it is not beyond possibilities that large cities or even the federal government could issue a full “sheltering in place” order, the economic blow to low-income wage-earners would be devastating.

States, businesses, and schools have, for the most part, adhered to social distancing protocols to avoid spreading the virus. But it is clear that these policies have taken their toll on the vulnerable populations. For example, if we look at the countrywide suspension and possible closure of our public schools, there is an immediate economic justice impact on low-income schools that leaves millions of low-income children at risk of missing daily nutritious meals provided by their schools through free and reduced meals programs. Nearly 30 million of all U.S. students are in subsidized meals programs. For example, in New York City close to 72 percent of the city’s public school children receive their daily breakfast and lunch at school. It is not unreasonable to suggest that long-term COVID-19-related school closures could lead to widespread food insecurity for millions of impoverished school-aged children.

It should be noted that food insecurity caused by the coronavirus crisis is not only a concern for large cities and urban areas. In Wyoming public schools, where many of the students in

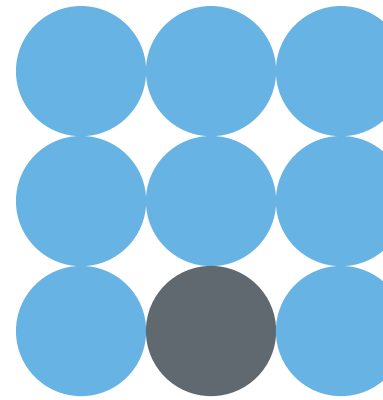
free and reduced-price meal programs live in remote, rural communities, children have to travel an hour or more on a bus to get to school, where they received daily meals. As rural public schools similar to Wyoming close, the children’s families will have to scramble financially to provide breakfasts and lunches that had been subsidized. School officials will also be asked to come up with alternatives to avoid food insecurity among these children.

### Collateral Consequences of Massive Unemployment

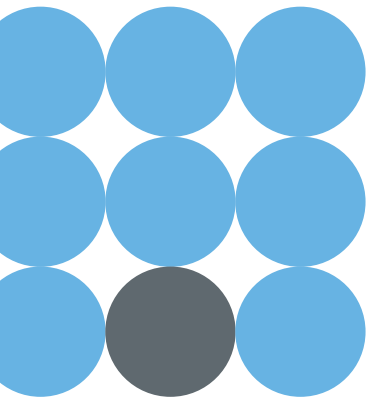
Although the President has not used his “bully pulpit” to insist that every state issues a mandatory stay at home orders, 43 states have done so on their own. There is little doubt that such orders will help contain the spread of the coronavirus pandemic, but the collateral consequence of a national lockdown is massive layoffs and shuttered businesses nationwide.

By April 16, more than 22 million American workers filed for unemployment benefits. States are being overwhelmed by unprecedented spikes in unemployment claims.

This high rate of layoffs and business closures is likely to persist for a number of months. Some economists predict that the national unemployment rate could reach levels not seen since the Great Depression. More ominously, low-wage workers are disproportionately impacted—more so than in previous recessions. This problem is exacerbated by the fact that the country’s unemployment system is less equipped to protect these workers. The COVID-19 pandemic has exposed the holes in our national safety net—in particular when







it comes to the inadequacy of state unemployment insurance systems.

### **Rise in Unemployment Leads to a Rise in the Uninsured**

In the United States, access to health insurance is closely tied to employment-based coverage. Therefore, the leap in the unemployment rate triggered by COVID-19 pandemic resulted in a corresponding rise in the number of Americans who suddenly become uninsured. It is estimated that the number of people whose medical insurance coverage from an employer could decline by 12 to 35 million. This estimate includes both workers and family members who would become uninsured. With the loss of employer-based insurance, Medicaid enrollment could increase from 71 million to between 82 and 94 million—which translates to increases in Medicaid enrollment over all states that have Medicaid expansion could increase by 11 to 23 million people.

### **Need for Consumer Protection and Relaxed Debt-Related Penalties for Low-Income People**

With the huge projected increase in the national unemployment rate caused by the coronavirus outbreak, it is without a doubt that low-income Americans will be faced with an individual and family economic crisis. There are those who call for debt management policy modifications aimed at mitigating the impending crisis in daily living for those pushed into poverty by the pandemic. Some of the debt management recommendations include the following:

**Suspend all current and pending debt collection efforts.** This would create an

immediate reduction of economic pressure on impacted individuals and families.

**Suspend paycheck garnishments.** Individuals and families need access to their full paycheck, including employer payments, as well as retirement and Social Security payments. Suspend student loan debt and accumulation of interest on that debt. This modification must remain in place until the national COVID-19 related unemployment rate returns to a level acceptable by economists.

**Increase protections against predatory lending.** Low-income people have long been targets of the predatory lending industry. During the COVID-19 crisis, it is important for federal and state governments to establish emergency guidelines that guard against loan agreements (for small businesses and individuals) that have grossly inflated interest rates. This protection is essential for individuals who seek personal loans to help survive financially during this time of shutdown.

**Institute a moratorium** on foreclosures, evictions for non-payment of rent, negative credit reporting, and utility suspension are necessary during this time of economic crisis.

### **After the CARES Act: Proposed Phase IV COVID-19 Funding**

On March 24, 2020, the U.S. Senate passed a \$2 trillion stimulus package, which the House ratified. The rationale for such payments is to offset the loss of income to working class Americans and to infuse billions of dollars into the economy to help businesses recover from losses of revenue due to the pandemic. While provisions in the CARES Act that targeted low- and moderate-income families and individuals will

provide some financial relief, there is a consensus that assistance such as short-term unemployment benefits and one-time-only direct payments to most individuals and families is inadequate for addressing the upheaval of the economic stability of impacted Americans.

Members of Congress and the White House are now discussing a [Phase 4 relief package](#). Both [President Trump and House Speaker Pelosi](#) have indicated that they would consider including funding for a large infrastructure program in Phase 4. Speaker Pelosi envisions that infrastructure spending would include building roads and bridges, but also clean water programs, broadband projects for cities and low-income urban communities, community health centers, support for state and local governments, and a “vote by mail” initiative for national elections. To be clear, Phase 4 is still in the discussion stage. Congress is expected to try to reach a bipartisan agreement after Congress returns from its break on April 20, 2020.

## Additional Resources

Center for Parent Information and Resources. Coronavirus Resources. [www.parentcenterhub.org/coronavirus-resources](http://www.parentcenterhub.org/coronavirus-resources)

Coalition for Human Needs. COVID-19 Addressing the Needs of Low-Income and Vulnerable People. [www.chn.org/articles/covid-19](http://www.chn.org/articles/covid-19)

Congress.Gov. Families First Coronavirus Response Act (H.R. 6201). [www.congress.gov/bill/116th-congress/house-bill/6201](http://www.congress.gov/bill/116th-congress/house-bill/6201)

Food Research Action Center (FRAC). COVID-19 Updates. <https://frac.org/COVID-19-updates>

National Education Association: Schools and Coronavirus: What You Should Know. [http://neatoday.org/2020/01/06/schools-and-coronavirus/?\\_ga=2.59760548.861225840.1584893195-1539643064.1584893195](http://neatoday.org/2020/01/06/schools-and-coronavirus/?_ga=2.59760548.861225840.1584893195-1539643064.1584893195)

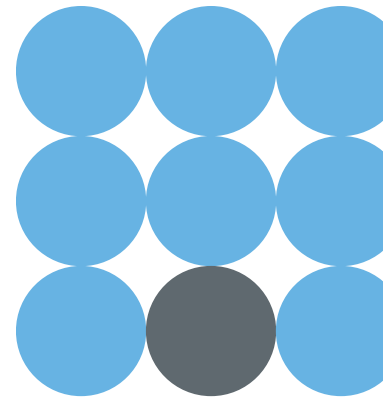
National Low-Income Housing Coalition. Responding to Coronavirus Ensuring Housing Stability during a Crisis. <https://nlihc.org/responding-coronavirus>

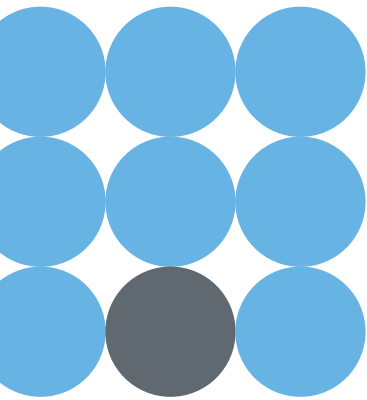
## 2. INCARCERATED, DETAINED, AND JUSTICE-INVOLVED INDIVIDUALS

As the nation struggles with the spread of COVID-19, public health officials and federal and state correctional leaders in the United States need to protect the health and safety of incarcerated individuals, including adults and youths as well as those detained because of immigration status.

The United States houses nearly a quarter of the world’s prison population. Health care in jails and prisons is adequate at best. Worse, the nation’s prisons have a large subpopulation of aging inmates. There is ample evidence, given the country’s experience with tuberculosis, HIV, and the ongoing hepatitis C epidemic in correctional facilities that congregate living institutions such as jails and prisons are incubators of infectious diseases.

The current national efforts to prevent and effectively treat COVID-19 is commendable. However, for the 2.4 million adults locked up in jails and prisons—as well as the 53,000 young people held in juvenile detention under judicial custody—there are limited guidelines and preparedness for managing COVID-19 in correctional facilities.





It is recommended that there be an immediate baseline assessment of the degree of preparedness in prisons and jails in the event of a COVID-19 outbreak. This includes infection control measures, access to appropriate protective gear, and diagnostic kits for correction staff and those incarcerated. This can be done in partnership with local academic institutions or public health departments. Furthermore, tighter regulations on sanitary practices including hand washing in correctional facilities should be enforced. In addition,

- » Medical and public health guidance is lacking. Transparent means of communication are critical between correctional facilities and state health departments for immediate reporting, testing, and coordination of care. Using the best-available evidence, guidelines tailored to prison health providers on prevention, diagnosis, and treatment of COVID-19 should be established and widely disseminated by the Centers for Disease Control and Prevention (CDC), and National Commission on Correctional Health Care.
- » Responses to reported or observed symptoms must be timely and honest, as the rate of viral transmission can lead to fatalities in an enclosed setting. Correctional employees have been implicated in litigations citing deliberate and harmful denial of medical care for incarcerated individuals. This is an opportunity to regain public trust in regard to the correctional culture of clinical passivity and deliberate indifference to the protected dignity of those under judicial custody.
- » Policing patterns should not continue to remain the same. This means that they

must make a concerted effort to increase diversions from arrest and incarceration. High levels of arrests and detentions during COVID-19 period would risk spreading infection.

- » Recidivism in the correctional system should be closely monitored during this period of prioritizing public safety. In addition, correctional facilities and community-based organizations should increase their commitment to continuity of health care during the transition of those released back to the community.
- » Policymakers should prioritize the health and safety of corrections staff. Because they work in high-risk environments, they are potential carriers of COVID-19 as they move between the community and the jails and prisons.

There is a long history of health disparities in correctional facilities, which means that unmet needs of incarcerated people have been ignored. We cannot allow such disparities to continue during the COVID-19 pandemic.

### **Prisons and Courts Receive Funding in Coronavirus Stimulus Bill**

The nation's prisons will receive funding and increased priority for protective gear and test kits for COVID-19, while federal courts would get more money and the ability to conduct video or telephone criminal proceedings. In addition, the bill will provide \$100 million to the Bureau of Prisons for salaries in the federal prison system and the Department of Justice. The funds would go for correctional officer overtime, personal protective equipment and supplies, and inmate medical care and supplies.

## Additional Resources

The Brennan Center for Justice. How Coronavirus Could Affect U.S. Jails and Prisons. [www.brennancenter.org/our-work/analysis-opinion/how-coronavirus-could-affect-us-jails-and-prisons](http://www.brennancenter.org/our-work/analysis-opinion/how-coronavirus-could-affect-us-jails-and-prisons)

Bureau of Justice Assistance. FY 2020 Coronavirus Emergency Supplemental Funding Program. <https://bja.ojp.gov/funding/opportunities/bja-20-18553>

The Justice Roundtable: Justice Roundtable Recommendations for Protecting Incarcerated Youth and Adults during the COVID-19 Pandemic. <https://justiceroundtable.org/issue/covid-19>

The Marshall Project Coronavirus. Transforming Jails Across the Country. [www.themarshallproject.org/2020/03/21/coronavirus-transforming-jails-across-the-country](http://www.themarshallproject.org/2020/03/21/coronavirus-transforming-jails-across-the-country)

National Commission for Correctional Health Care. Coronavirus COVID-19 and the Correctional Facility. [www.ncchc.org/filebin/news/COVID\\_for\\_CF\\_HC\\_W\\_3.9.20.pdf](http://www.ncchc.org/filebin/news/COVID_for_CF_HC_W_3.9.20.pdf)

## 3. DETAINED IMMIGRANTS

Nationally, there have been calls for the U.S. government to make a strong effort prevent the spread of the coronavirus in an overloaded immigration system. Those speaking out on this issue note that people in the U.S. who are incarcerated are at higher risk for disease spread and are disproportionately people of color (POC). The Prison Policy Initiative released suggestions on how the criminal justice system can slow the pandemic's spread, including by reducing the numbers of imprisoned people and improving correctional health care, among others.

The concern for exposing detained immigrants to the virus extended to Congress when, under the leadership of Sen. Kamala Harris, 12 Democratic senators sent a letter to the head of Homeland Security, U.S. Immigration and

Customs Enforcement (ICE), and U.S. Customs and Border Protection to determine if the agencies had a coronavirus response plan. The senators expressed their apprehension about the rapid spread of the virus—and that those confined to immigration detention (and staff) were particularly vulnerable to becoming infected.

At the southwest border, Border Patrol made around 593,500 apprehensions in the first eight months of fiscal year 2019. In all of fiscal year 2018, it made close to 396,600 apprehensions. Based on recent unannounced visits to border detention facilities, government investigators raised alarms about overcrowding and prolonged detentions—especially conditions that could pose an immediate risk to the health and safety. For example, detention facilities, particularly those that are overcrowded, stymie any efforts to implement social distancing specifically immigration.

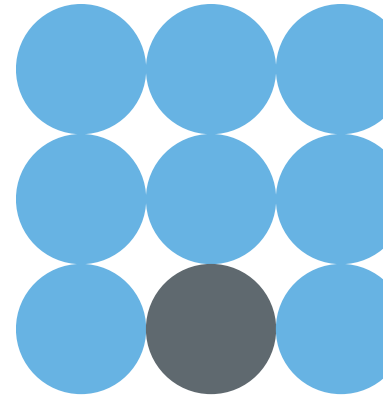
As an indication of the power of social action, ICE recently announced it was curtailing immigration arrests due to concerns for spreading coronavirus in its detention facilities. ICE stated it would now shift its focus to “public safety risks.”

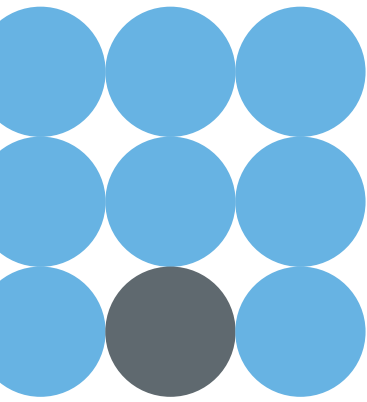
## Additional Resources

CBS News. Groups Ask Court to Order ICE to Release Sick, Elderly Immigrants at Risk of Coronavirus. [www.cbsnews.com/news/coronavirus-ice-lawsuit-actu-release-sick-elderly-immigrants-at-risk/](http://www.cbsnews.com/news/coronavirus-ice-lawsuit-actu-release-sick-elderly-immigrants-at-risk/)

CBS News. ICE Suspends Family Visits in Detention Centers amid Coronavirus Concerns. [www.cbsnews.com/news/ice-bans-family-visits-in-detention-centers-amid-coronavirus-concerns/](http://www.cbsnews.com/news/ice-bans-family-visits-in-detention-centers-amid-coronavirus-concerns/)

The Guardian. Coronavirus Inevitable in Prison-Like US Immigration Centers, Doctors Say. [www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-immigration-centers](http://www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-immigration-centers)





#### 4. IMMIGRANT FAMILIES

Beyond the plight of detained immigrant individuals, we need to pay a great deal of attention to immigrant heads of household who may be caught up in ICE raids. Advocates have called for the establishment of an “immigration enforcement-free zones” that would allow everyone, including immigrants, to seek out medical services without fear of apprehension. Over 800 public health and human rights experts urged the government to establish these zones. Their open letter reads:

The COVID-19 response should not be linked to immigration enforcement in any manner. It will undermine individual and collective health if individuals do not feel safe to utilize care and respond to inquiries from public health officials. . . . These policies should be clearly and unequivocally articulated to the public by the federal, state, and local governments.

It is clear that the Trump administration’s existing immigration policies—which are widely seen as being anti-immigrant—could make the COVID-19 health crisis that much worse for immigrant families and children. It should not be surprising that the administration’s public charge rule, which went into effect in February 2020, has made many immigrant and mixed-status families reluctant to seek health benefits that they are legally permitted to use. The reason for the reluctance is their fear that seeking medical care may jeopardize their immigration status or that of a family member’s. Under the public charge rule, officials can deny green cards to immigrants if they currently use or might use government benefits. These benefits include Medicaid and other public health programs.

With that in mind, 17 U.S. attorneys general have asked the U.S. Department of Health and Human Services (HHS) to delay the public charge rule during the coronavirus outbreak. The coalition of attorneys general take the position that the current public charge rule undermines state and city health departments’ efforts to contain the spread of COVID-19. The group drove home their concerns by reminding HHS that it had

been previously advised of the potentially devastating effects of the rule if its implementation were to coincide with the outbreak of a highly communicable disease—a scenario exactly like the one confronting our communities with the COVID-19 public health emergency. Your agency failed to consider such legitimate concerns.

The bottom line is that in the face of a pandemic, immigration status should never be a barrier for individuals and families to access potentially life-saving medical care. Such policies only serve to exacerbate the problem and put many others at risk for COVID-19 infection.

#### Additional Resources

National Immigration Law Center. Update on Access to Health Care for Immigrants and Their Families. [www.nilc.org/issues/health-care/update-on-access-to-health-care-for-immigrants-and-their-families](http://www.nilc.org/issues/health-care/update-on-access-to-health-care-for-immigrants-and-their-families)

Protecting Immigrant Families. Supreme Court Temporarily Clears “Public Charge” Regulation. <https://protectingimmigrantfamilies.org>

## 5. HOMELESS POPULATIONS

The homeless is another population that historically has been at high risk for contracting infectious diseases. Most people experiencing homelessness live in congregate living settings—including shelters, halfway houses, encampments, or abandoned buildings. In many cases, they do not have regular access to hygiene items or hot showers, leaving them at high risk for virus transmission. Consequently, the homeless is a vulnerable group that are likely to be exposed to COVID-19.

The homeless have a mortality rate from all causes that is five to 10 times higher than that of the general population. Therefore, it is reasonable to suggest that COVID-19 infection may further contribute to their mortality disparity.

During the 1980s, at the height of the HIV/AIDS crisis, the rate of HIV infection among the homeless began to skyrocket. Epidemiological studies during that period confirmed that HIV and homelessness frequently co-occurred. Relatedly, another highly communicable disease—tuberculosis—is significantly more prevalent among the homeless than in the general population. Therefore, it goes without saying that the aggressively infectious COVID-19 poses a major health threat in homeless shelters, encampments, and other congregate living environments. In California, epidemiological models project that more than 60,000 homeless people could contract COVID-19 over an eight-week period.

The National Health Care for the Homeless Council, which has over 30 years of

experience with coordinating homeless health care on a national level, has posted a comprehensive COVID-19 resource page on its website that identifies a wide range of federal and state agencies that offer information about COVID-19 risks and services for the homeless.

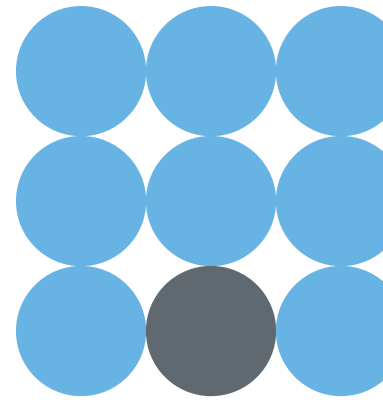
### Coronavirus Response Stimulus Package Includes Funding for Homelessness and Housing

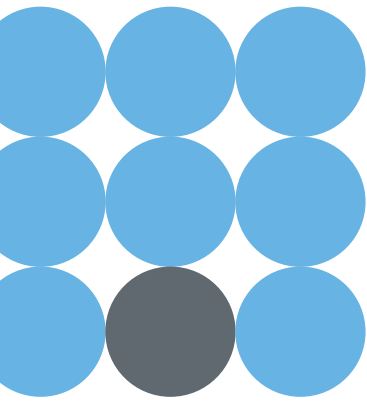
The coronavirus response stimulus package includes funding for homelessness and housing. Overall, the bill provides more than \$12 billion in funding for U.S. Department of Housing and Urban Development programs, including \$4 billion for Emergency Solutions Grants for homelessness assistance, \$5 billion in Community Development Block Grants, \$1.25 billion for the Housing Choice Voucher program, \$1 billion for project-based rental assistance, \$685 million for public housing, \$300 million for tribal nations, and so on. The bill also institutes a much-needed temporary moratorium on evictions and foreclosures for homeowners and renters in federally subsidized apartments and homes with federally backed mortgages.

### Additional Resources

National Health Care for the Homeless Council. COVID-19 Resources. <https://nhchc.org/clinical-practice/diseases-and-conditions/influenza/>

United States Interagency Council on Homelessness. Coronavirus (COVID-19) Resources. [www.usich.gov/tools-for-action/coronavirus-covid-19-resources/](http://www.usich.gov/tools-for-action/coronavirus-covid-19-resources/)





## 6. OLDER AMERICANS AND LONG-TERM CARE FACILITIES

Many older Americans, especially low-income individuals over 60 years of age, fit the description of being part of a vulnerable population. While older Americans are considered to be at high risk for coronavirus infection, those residing in long-term care facilities are at an even higher risk.

Experts suggest that the coronavirus pandemic will significantly change procedure and practices for caring for older adults. It is projected that some changes may require difficult adjustments. However, other changes may lead to improved supportive services for vulnerable seniors. For example:

The Centers for Medicare and Medicaid Services (CMS) announced that nursing homes, skilled nursing facilities, and assisted living facilities should discourage visits and screen visitors. CMS has required facilities to temporarily disallow all family and other nonmedical visits, except when a resident is dying. These changes may reduce risk of contracting COVID-19, but it will also likely lead to mental health symptoms such as depression and anxiety. It will additionally eliminate access for family members to monitor their relative's care.

According to the AARP, social isolation and loneliness are serious health issues. Social isolation and related conditions are such health hazards that they have been estimated to be the equivalent of smoking 15 cigarettes a day. Therefore, a person 60 years or older with pre-existing severe chronic health conditions is already at a higher mortality risk if they contracts COVID-19. If that individual is socially isolated, their risk of succumbing to the virus is significantly greater.

## Additional Resources

AARP. How to Fight the Social Isolation of Coronavirus.

[www.aarp.org/health/conditions-treatments/info-2020/coronavirus-social-isolation-loneliness.html](http://www.aarp.org/health/conditions-treatments/info-2020/coronavirus-social-isolation-loneliness.html)

American Health Care Association. How You Can Help Prevent the Spread of Coronavirus (COVID-19) in Long Term Care Facilities.

[www.ahcancal.org/facility\\_operations/disaster\\_planning/Pages/Coronavirus.aspx](http://www.ahcancal.org/facility_operations/disaster_planning/Pages/Coronavirus.aspx)

Centers for Disease Control and Prevention. Resources for Clinics and Healthcare Facilities.

[www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html](http://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html)

## 7. CHILD WELFARE AND FOSTER CARE

As the spread of coronavirus has been challenging to all Americans—from event cancellations to school closings—through no fault of their own, caregivers for foster youths have been left ill-prepared. For example, foster families and caregivers on short notice have had to struggle to find daycare for children impacted by school closures. In addition, many caregivers are reporting that they have heard very little from child welfare agencies about supports, changes to visitation, or what to do in case of being quarantined. The foster care system, built on frequent movements of children from one home to another and regular in-person supervision, has been especially wracked with confusion and dread by the coronavirus crisis.

### Fear of Spreading COVID-19 During Placement and Investigation Contacts

Some foster care investigators looking at cases of alleged child abuse are fearful of spreading the virus from home to home. They use creative alternatives such as trying to complete the

investigation interviews at the front door—or, if available, over video chat—instead of going inside the home. Also, there is anecdotal evidence that some prospective foster parents are also refusing to accept new children due to fears of being exposed to coronavirus.

## Closure of Child and Family Courts due to COVID-19

Although abuse and neglect investigations and removal of children from the home of the primary care continue to occur, making final determinations of court-ordered foster care is currently delayed due to the coronavirus pandemic. This is because courts nationwide have suspended hearings indefinitely, leaving such decisions in limbo. The possible result is that child welfare agencies are forced to suspend removing children from their parents, even if there are indications of unsafe or abusive conditions for the child.

## COVID-19 Disruption to Foster Care Services

### Visitation and Reunification Services

Once a child has been removed from home, the main objective is family reunification. Therefore, an essential part of the services plan is to sustain continued visitation while the child is in foster care. The guidelines for containing the virus has been to curtail visitation. It is recommended that alternatives such as child welfare agencies arranging for video conferencing between foster homes, group homes, and parents. Continued visitations are such an important part of the reunification plan that agencies must become flexible in developing alternatives so that reunification services can continue.

## Court Appearances

A looming question will be whether dependency and juvenile courts continue to function at a normal pace, or if the docket will slow down tremendously. As with the previous point on visitation and reunification, it would be truly unfair to have court slowdowns delay children from being reunited with their parents.

## Protecting Youths with Preexisting Conditions

A high rate of youths in foster care have acute medical needs, some of which put them at increased risk of complications from coronavirus. These children need to be identified and targeted for increased supervision.

## Foster Parent Employment

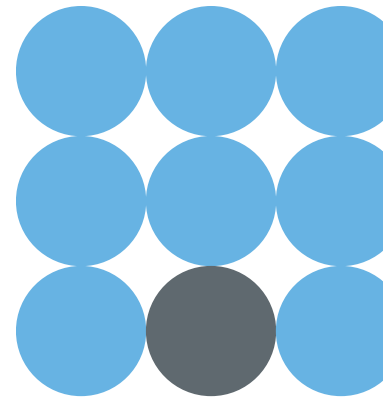
Many foster households work during the day, and most will continue to do so. Systems should expect that there will be a spike in the need for respite and child care during a prolonged period where schools are not in session.

The House “Families First” bill included an emergency paid leave benefit that would be available to foster parents who had to stay home as a result of school closure. The benefit would pay two-thirds of salary up to a maximum of \$4,000 monthly.

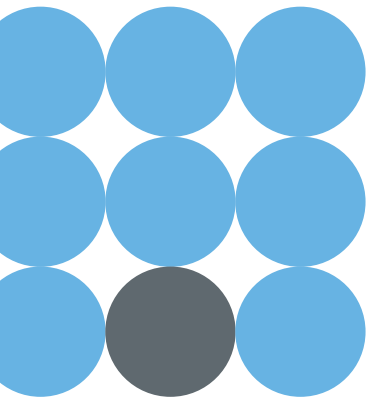
## Additional Resources

Chronicle of Social Change. As Coronavirus Shutdowns Grow, Resource Families Left with Little Guidance. <https://chronicleofsocialchange.org/coronavirus/as-coronavirus-shutdowns-grow-resource-families-left-with-little-guidance/41295>

Foster Club: The Coronavirus (Covid-19) Emergency: Information and assistance for young people in and from foster care. [www.fosterclub.com/c19](http://www.fosterclub.com/c19)







National Child Traumatic Stress Network. Parent/Caregivers Guide to Helping Families Cope with the Coronavirus Disease 2019. [www.nctsn.org/resources/parent-caregiver-guide-to-helping-families-cope-with-the-coronavirus-disease-2019](http://www.nctsn.org/resources/parent-caregiver-guide-to-helping-families-cope-with-the-coronavirus-disease-2019)

National Youth Advocate Program. COVID-19 Update. [www.nyap.org/](http://www.nyap.org/)

## 8. COVID-19 SOCIAL DETERMINANTS OF HEALTH

Early data from U.S. states shows that African Americans are more likely to die from COVID-19. This preliminary data would seem to confirm predictions of health disparities such as inequalities in access to medical care for treatment of coronavirus, [epidemiologists say](#).

[In Illinois](#), black people make up about 30 percent of the state's cases and about 40 percent of its coronavirus-related deaths, which is significant because African Americans are only 14.6 percent of the state's population.

In Michigan, black people make up [40 percent of the state's reported COVID-19 deaths](#), even though its population is just 14 percent African American. Similarly, 70 percent of the coronavirus deaths in New Orleans were among African Americans. Given these early data, minorities appear to have more difficulty getting tested for coronavirus. [A team of doctors from the Universities of Virginia and Pittsburgh](#) used data from seven states and more than 103 hospital groups and patient advocacy networks to show that thousands of minority patients were not receiving testing for the coronavirus despite showing symptoms. There is similar evidence that New York, New Orleans, and Atlanta are lagging in testing in black and Latino communities even though all three cities have black and Latino populations.

### Social Determinants of Health

Understanding and addressing [social determinants of health](#) is essential for reducing the morbidity and mortality rates in communities of color early in the coronavirus outbreak. These public health policies allow investigators to focus on identifying and removing barriers to accessing health care and related concerns—such as lack of health insurance—among populations who have historically been subjected to [health disparities](#).

Not surprisingly, the history of unequal income distribution and racial health disparities has moved the public health community to begin to look at COVID-19 prevalence data that may suggest a disproportionate biopsychosocial impact on communities of color. For instance, in [New York City and other locations](#), there are emerging data that indicate that communities of color have high COVID-19 infection rates.

As the country comes to grips with the expected [economic calamity attributed to the CPVID-19 pandemic](#), it will be clear that low-income Americans will face a daunting future. Poor people of all ethnicities and races are more likely to be minimum wage workers, under- or uninsured, and to be out of work due to COVID-19 mandatory stay-at-home orders. As in the past, communities of color are overrepresented in the low-wage workforce.

### Access to Care in Rural Areas

The social distancing protocols of COVID-19 are not as problematic for those living in rural communities, because most live miles away from other communities and even their neighbors. However, [they have to deal with several other challenges](#) mostly attributed to their distance from health and social services.

For many years, rural health care has been difficult to provide. The distance from essential services has often been insurmountable, which makes this issue a major barrier to care. The barrier has become more evident since the coronavirus outbreak, when individuals must access health providers to determine their health status and to be tested. Rural health also faces threats due to fewer health care resources and a high population of older adults who may be at higher risk for coronavirus complications due to other underlying health conditions.

Telehealth has been discussed as an important intervention for responding to the coronavirus crisis by overcoming the barrier of distance. However, a significant drawback to telehealth for those living in rural communities is the limited access to an efficient broadband connection.

The questions around the social determinants of health amid the coronavirus outbreak are expected to continue. As the economy takes a hit after businesses deemed nonessential must shutter their doors, job security becomes precarious, incomes plummet, and the social safety net could falter.

### Lack of Data Collection

It is curious that the CDC has not released disaggregated epidemiologic statistics on coronavirus testing, positivity rates, and treatment outcomes within various populations. To their credit, in Florida, five counties have revealed that black and Latino COVID-19 patients are getting hospitalized and, in some places, dying at higher rates than white patients. However, the majority of states either chose not to actively collect population-based data, or may have purposely

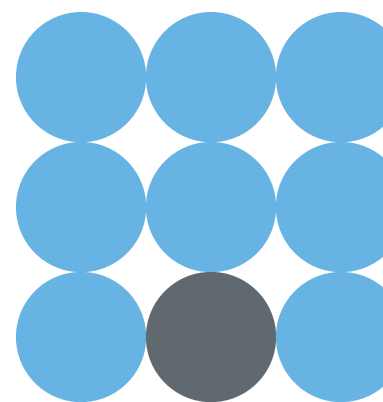
decided not to release comprehensive racial and ethnic data on those tested and treated for coronavirus. In any event, without those data, it will be difficult to target communities of color for coronavirus testing, provision of necessary medical treatment and increase the chances of recovery for those who fall ill to the virus.

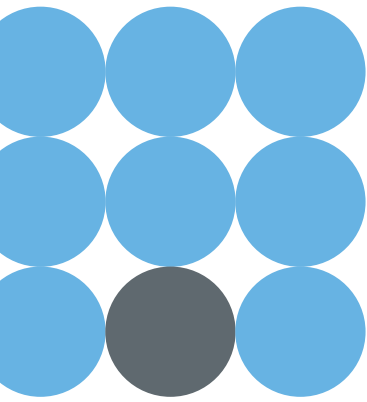
Five Democrats in Congress, including Senators Elizabeth Warren, Cory Booker, and Kamala Harris and Representatives Ayanna Pressley and Robin Kelley, are pushing for data from the federal government about racial disparities in the nation's response to the coronavirus pandemic. The members of Congress sent a letter to HHS Secretary Alex Azar stating that government is "currently failing to collect and publicly report on the racial and ethnic demographic information" for COVID-19 tests and patients.

The letter makes the point that without demographic data, policymakers and researchers will be unable to address health disparities and health inequities that could accelerate the impact of the coronavirus on communities of color. The lawmakers' letter emphasized that black and Hispanic adults often suffer from underlying health conditions such as obesity, diabetes, and asthma that can increase the risk for death from coronavirus. They also pointed out that immigrants and POC are also less likely to have health insurance.

### Additional Resources

Caravan Health. COVID-19 in Rural Areas: Addressing Social Determinants of Health. [https://caravanhealth.com/CaravanHealth/media/Resources-Page/COVID-19\\_Rural\\_CaravanHealth\\_20200319.pdf](https://caravanhealth.com/CaravanHealth/media/Resources-Page/COVID-19_Rural_CaravanHealth_20200319.pdf)





## 9. THE 2020 CENSUS

The national 2020 Census has begun. Recently, most American households began receiving invitations to respond to the census online or by phone. The coronavirus pandemic will coincide with the census's peak period of activities. The uncertainty caused by the coronavirus outbreaks will probably complicate counting every U.S. resident. As most of us can imagine, significant disruptions of the census-taking process would hinder the U.S. Census Bureau from obtaining accurate population data which is critical for determining congressional representation and the number of Electoral College votes for each state gets for the next 10 years. More important, census data are used as a determining factor for redrawing of voting districts and the share sent to states, as much as \$1.5 trillion a year, in federal funding for health care, schools, roads, and other public services to local communities. In other words, marginalized populations whose needs are often underrepresented by the White House, Congress, and some states stand to have their voices further muted if the 2020 Census is disrupted by COVID-19.

What we currently know is that because of the coronavirus pandemic, the bureau has decided to delay starting the early round of door-knocking by census workers in college towns to April 23. The Census Bureau is also delaying its full outreach effort until early April, instead of late March. That particular aspect of the enumeration effort is designed to target people in densely populated locations ranging from public transit centers to beauty shops. This is where many of the marginalized and vulnerable residents are found.

In anticipation of the potential threat that COVID-19 could pose for an accurate census, officials have set up a task force to monitor the spread of the disease. They have also stated that the Census Bureau will follow public health guidelines in training its enumeration workers.

## Additional Resources

Chicago Sun Times: Don't let coronavirus stop you from being counted in the 2020 Census. <https://chicago.suntimes.com/2020/3/20/21185131/u-s-census-bureau-2020-coronavirus-covid-19-editorial-illinois-population>

Leadership Conference for Civil and Human Rights. Coronavirus and Beyond: Emergency Response Depends on Accurate Census Data. <https://civilrights.org/edfund/2020/03/19/coronavirus-and-beyond-emergency-response-depends-on-accurate-census-data/>

U.S. Census Bureau. Census Bureau Statement on Modifying 2020 Census Operations to Make Sure College Students are Counted. [www.census.gov/newsroom/press-releases/2020/modifying-2020-operations-for-counting-college-students.html](http://www.census.gov/newsroom/press-releases/2020/modifying-2020-operations-for-counting-college-students.html)

Wired. Coronavirus Will Make the 2020 Census Even Trickier. [www.wired.com/story/coronavirus-make-2020-census-trickier/](http://www.wired.com/story/coronavirus-make-2020-census-trickier/)

## 10. VOTING RIGHTS

For the first time since the Spanish Flu pandemic of 1918, an election in the United States is jeopardized by a pandemic. As the coronavirus spreads, there are concerns about the capacity of the American electoral process and participation in the event that most states impose social distancing policies. Such policies would make campaign rallies, nominating conventions, and in-person balloting more difficult. There have been recent

situations where a political convention proved to be a public health risk for the spread of a virus. In 2016, a hotel where attendees at a Republican political meeting in Ohio quarantined in their hotel rooms after an outbreak of norovirus.

Both the Democratic and Republican National Conventions are developing contingency plans for the fate of their conventions should coronavirus continue to spread in the summer of 2020. The Democratic convention, which is scheduled for July 13–16 in Milwaukee, Wisconsin, is expected to attract more than 5,000 people. The Republican convention is slated for August 24–27 in Charlotte, North Carolina. Their conference also will have as many as 5,000 participants.

In addition to worries about the spread of COVID-19 at the national conventions of both political parties, there is apprehension about the pandemic being used as an opportunity for voter suppression proponents to compromise election integrity. The Brennan Center for Justice—one of the nation’s preeminent think tank on voting rights—discusses the complication that coronavirus will likely have on the 2020 elections. In its article How to protect the 2020 Vote from the Coronavirus, authors state,

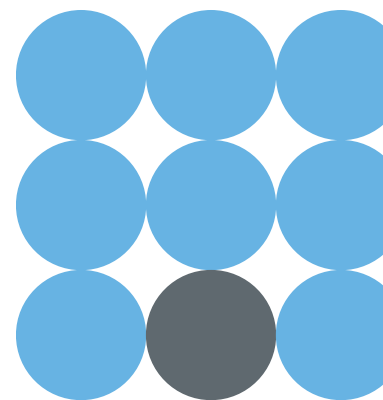
The coronavirus disease 2019 (Covid-19) presents a difficult and novel challenge to the administration of the 2020 general election. Recent election emergencies have largely been caused by catastrophic weather events, and our country has done little election planning for pandemics. Unlike a hurricane, a pandemic does not have a discrete and relatively predictable end point. And avoiding large-scale social contact is a central feature of combating

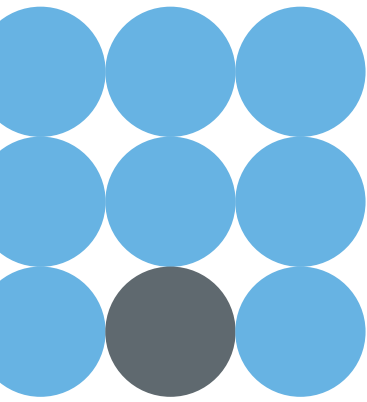
the crisis. These elements create distinct challenges for election officials on top of the significant and ongoing threats to the security of our election infrastructure.

The Brennan Center and other national voting rights organizations fundamentally call for governmental assurance that the upcoming 2020 elections are free, fair, accessible, and secure. To achieve that imperative, there is a need to modify the country’s election procedures, flexibility in adapting to unexpected disruptions in the process due the virus, and a making significant financial and material resources available for Americans to register and vote on November 3, 2020. The following are recommendations in five categories for protecting the 2020 elections in the face of COVID-19:

- (1) Polling place modification and preparation
- (2) Expanded early voting
- (3) A universal vote-by-mail option
- (4) Voter registration modification and preparation, including expanded online registration
- (5) Voter education and manipulation prevention

The Brennan Center also recommends that each state government establish an election pandemic task force to develop best practices for implementing policy voting protection commendations in a given state. It is not widely known but each state and local election officials are required to create emergency rules in the event of unanticipated threats to election processes. The coronavirus is potentially such a threat. Therefore, officials must understand the emergency rules (and





related laws) applicable to their jurisdictions in order to make appropriate adjustments to implement necessary modifications. Congress has a responsibility to establish national guidelines that ensure that every eligible American is able to vote safely, securely, and accessibly in the midst of the pandemic. In the absence of Section 5 of the Voting Rights Act, care must be taken to ensure that changes are nondiscriminatory and do not negatively impact access for communities of color.

### **Vote by Mail Options**

Senators Amy Klobuchar and Ron Wyden are pushing to make vote by mail available to every American as the coronavirus pandemic threatens to keep people at home during election season. They are proposing \$500 million of federal funding to help states prepare for possible voting disruptions caused by the coronavirus outbreak. The senators' bill also would allow Americans to vote by mail in the event of a national emergency. The bill provides that Americans could vote by mail if 25 percent of states declared an emergency related to the coronavirus outbreak.

### **Stimulus Bill Has \$400 Million in Election Help for States**

The U.S. economic stimulus package to include \$400 Million to help states grapple with 2020 voting amid the coronavirus pandemic, according to two people familiar with the bill. The funds would allow states to voluntarily increase the ability to vote by mail and expand early voting and on-line registration. However, the bill does not create a national requirement for voting by mail, which was proposed by Klobuchar and Wyden. The \$400 million is far less than the \$4 billion requested.

### **Additional Resources**

Brennan Center for Justice. How to Protect the 2020 Vote from the Coronavirus. [www.brennancenter.org/our-work/policy-solutions/how-protect-2020-vote-coronavirus](http://www.brennancenter.org/our-work/policy-solutions/how-protect-2020-vote-coronavirus)

CNBC. Senators Push to Let Every American Vote by Mail as Coronavirus Keeps People at Home. [www.cnbc.com/2020/03/17/senators-push-to-expand-vote-by-mail-as-coronavirus-keeps-people-home.html](http://www.cnbc.com/2020/03/17/senators-push-to-expand-vote-by-mail-as-coronavirus-keeps-people-home.html)

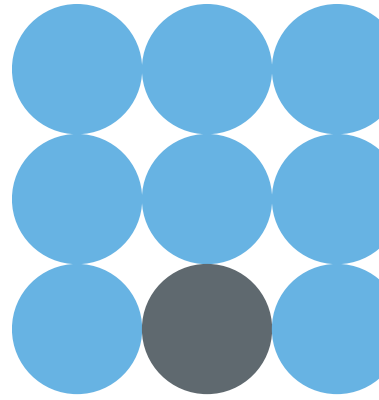
Leadership Conference for Civil and Human Rights. Congress Must Appropriate \$2 Billion To Protect Voting Rights. <https://civilrights.org/resource/congress-must-appropriate-2-billion-to-protect-voting-rights>

National Association of Secretaries of State. State Laws & Practices for the Emergency Management of Elections. [www.nass.org/sites/default/files/Election%20Cybersecurity/report-NASS-emergency-preparedness-elections-apr2017.pdf](http://www.nass.org/sites/default/files/Election%20Cybersecurity/report-NASS-emergency-preparedness-elections-apr2017.pdf)

## SUMMARY

The emerging sentiment since America has internalized the implications of the COVID-19 pandemic appears to be (1) that nearly all of us will be directly or indirectly impacted by this national public health emergency; and (2) the COVID-19 pandemic will not disappear in the near future. It is a threat to the physical well-being of Americans, but will, with certainty, disrupt the economic and social stability of many individuals and families.

This means that vulnerable and marginalized populations are at very high risk for bearing the brunt of the pandemic. Given social work's long history of social action to help mitigate the negative impact of national public health crises on those with less resources, we are again asked to respond. With that in mind, throughout this emergency, NASW will regularly provide in-depth updates on the needs of marginalized families and individuals.





# NASW Resources

**NASW** » [SocialWorkers.org](https://www.socialworkers.org)

**NASW Foundation** » [NASWFoundation.org](https://www.naswfoundation.org)

**NASW Press** » [NASWPress.org](https://www.naswpress.org)

**NASW Assurance Services, Inc.** » [NASWAssurance.org](https://www.naswassurance.org)

**Find A Social Worker** » [HelpStartsHere.org](https://www.helpstartsHere.org)

**Social Work Blog** » [SocialWorkBlog.org](https://www.socialworkblog.org)

**NASW Research and Data** » [SocialWorkers.org/News](https://www.socialworkers.org/news)

**Social Work Advocacy** » [SocialWorkers.org/Advocacy](https://www.socialworkers.org/advocacy)



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## Responding to Healthcare Disparities and Challenges With Access to Care During COVID-19

**Moderator:** Ana Núñez, MD<sup>1,\*</sup>

**Participants:** Maria Madison, ScD,<sup>2</sup> Renata Schiavo, PhD, MA, CCL,<sup>3,4</sup> Ronit Elk, PhD,<sup>5,6</sup> and Holly G. Prigerson, PhD<sup>7,8</sup>

Viruses know no boundaries, but the impact of pandemics highlight faulty health systems and at-risk individuals. The novel coronavirus of 2019–2020 pandemic has hit certain groups of people within the United States more severely than others. Those living in underserved areas, often with financial hardship, and black and brown individuals, are more prone to experience sickness and death from the virus. This roundtable discussion brings together several experts from various fields related to health equity to address these disparities and recommend actions needed to attain equity.

**DR. ANA NÚÑEZ:** I recognize that identifying one top ranking priority is a challenge, as there are many. That said, what is your top-ranking priority during this current COVID19 pandemic? What item most needs to be realized or addressed?

**DR. RONIT ELK:** My number one priority is how culture influences and fundamentally shapes how people make meaning out of illness, suffering, dying, and death are, and how culture strongly influences people's response to getting a diagnosis to an illness, as well as treatment preferences.

And the problem is that we have a lack of appreciation in the U.S. for the cultural differences that may and in fact do compromise care for seriously ill minority—I call them patients, but people. And that is my number one priority.

**DR. MARIA MADISON:** Thank you so much, Dr. Elk, for your comments, because my number one priority is fairness. When I think of fairness, I am thinking of investing in equitable access to prevention, mitigation, and treatment for COVID. That includes looking out for the most vulnerable populations and their needs for basic things, including clean water. When we say prevention is easy, that we should wash our hands for 20 seconds, it is easy to forget that a large proportion of the population in the U.S., if not the world, does not have access to clean water, or the Internet access to learn about best practices or threats to our food supply, but even more importantly, in order to assure that we try to protect our frontline workers, personal protective equipment (PPE) supply chain, investing in vaccines, or even investing in evidence-based treatments. So for me, the number one answer has to focus on promoting equity for all the reasons Dr. Elk just described. Right now, we are seeing that a disproportionate number of people who are suffering and dying from COVID-19 are black and brown folks. We can dig deeper into why that is when we get to the other questions, but it really draws attention to the inequity in our society that allows us to continue to oppress populations that are already at risk for all aspects of inequity.

**DR. RENATA SCHIAVO:** My number one priority is to protect marginalized and vulnerable populations from this pandemic and beyond. I feel pandemics

<sup>1</sup>College of Medicine, Drexel University, Philadelphia, Pennsylvania, USA.

<sup>2</sup>Heller School for Social Policy and Management, Brandeis University, Waltham, Massachusetts, USA.

<sup>3</sup>Mailman School of Public Health, Department of Sociomedical Sciences, Columbia University, New York, New York, USA.

<sup>4</sup>Founder and Board President, Health Equity Initiative, New York, New York, USA.

<sup>5</sup>Department of Medicine, Division of Geriatrics, Gerontology and Palliative Care; <sup>6</sup>Center of the Southeast Institute for Innovation in Palliative Care, University of Alabama at Birmingham, Birmingham, Alabama, USA.

<sup>7</sup>Cornell Center for Research on End-of-Life Care; <sup>8</sup>Sociology in Medicine, Weill Cornell Medicine, New York, New York, USA.

\*Address correspondence to: Ana Núñez, MD, USA, E-mail: an33@drexel.edu





have this very strong way of showing us how widespread social and health inequalities are, and how in the day-to-day they prevent people not only from protecting themselves, but also from leading healthy and productive lives. Within the realm of vulnerable and marginalized populations, there are three main groups that come to mind as examples. First, there are children who live in poverty who may not be directly affected by the serious health consequences of COVID-19, but in many cases depend on being in school for their only meals. The pandemic has shown that in addition to school-based nutrition, we need to think of additional systems to deliver child nutrition to the 20+ million children who live in poverty in the United States, especially in communities of color that have been marginalized and discriminated against for centuries, and experience high rates of poverty. The Family First Coronavirus Act has tried to address these issues, but it is just a drop in the bucket compared to the needs we are facing.<sup>1</sup>

The second group is the homeless population. We talk about social distancing and washing hands. These are very difficult behaviors for people who live in shelters or in the street. We have seen communities coming together and trying to install temporary sinks. But again, we need more comprehensive interventions.

And third, of course, the communities of color who are more significantly impacted. We are already seeing that the highest mortality is within black and brown communities. This has to do with a history of lack of investment in communities of color, poverty, racism—please let's use that word, and a variety of other issues that have determined a higher burden of health and social inequities. I will stop it here, but again, it was very difficult to talk about one priority, so I decided to make an example of populations within the ones that we need to protect.

**DR. NÚÑEZ:** Thank you.

**DR. HOLLY PRIGERSON:** I direct the Center for Research on End-of-Life Care at Weill Cornell Medicine. Although my focus is on disparities, I have concentrated my research mostly on psychosocial influences on the poor or inadequate care at the end of life. My focus has been on mental health issues and how patients and families might feel abandoned, as well as how poor communication and lack of resources to attend to psychosocial needs are often overlooked in life-threatening illness, especially for

marginalized patient populations and families. I look more at the intersection of how psychosocial influences might be affected and impact access to care, receipt of care, feelings of injustice that some people might have gotten a ventilator whereas other people may have been denied a ventilator. We are trying to leverage the available resources that we know exist to try to remove barriers to better care for everyone, but by targeting a lot of the psychosocial issues that we think really account for who gets what.

**DR. NÚÑEZ:** Augmenting much of what you all said, the area that I see and feel that is the priority from my perspective is something that sounds sort of simple: process. There is not a coordinated, integrated, thoughtful process right now. Instead, we have this patchwork of competition where every institution and individual has to figure it out independently.

The fact that there is not a coordinated and integrated approach that oversees this pandemic speaks to the fact that we only have a public health finance structure. We do not actually have a functional, robust public health infrastructure. This void increases adverse health risk for vulnerable, marginalized populations and stresses these populations and the system. It's very difficult to ignore this impact now because we are seeing the exposure of vulnerability-risking mortality rates is just one marker—which really speaks to the pressing issues of need for integration and coordination of public health and prevention. Ultimately, it will affect everybody.

The question is, is this our opportunity to take this challenge as an opportunity to do things differently, or do we go from here and not make the needed changes that can put us all in a better position?

**DR. PRIGERSON:** By saying “process,” that sounds more macro, conceptual, zoomed-out kind of approach. And I think related to zooming out, I would say communication is important as well. By “communication,” I am referring to barriers to effective communication to decision-making, to getting care, to receiving care, to working with families at home to connecting families with work and employment. It is communications about medical decisions but also more mundane responsibilities such as going to shop for food and pick up cleaning supplies and all the sort of ways in which this COVID-19 has affected our lives.

Communication, and in particular, telecommunication appears to have become a normal part in the

way of life for many of us. Right now, this is how we are all communicating with each other, but it is important to bear in mind that access to telecommunications for certain communities might not be available. Maybe health literacy might affect communication and understanding of medical choices before making decisions. I think communication is a key aspect in how this pandemic has adversely affected different communities.

**DR. MADISON:** Yes to “process” but it must be fair process. As of the time we are having this discussion, we are seeing states like Alabama and Washington creating triages that some are calling ruthless utilitarianism, because they are singlehandedly creating hospital practices with a process that may be likely to inhibit treatment and care for certain groups, again, including our most vulnerable populations. That is why we are seeing high rates of morbidity and mortality for black and brown folks.

**DR. ELK:** So most of us have defined the problem in terms of what is happening. I would like to discuss, when we get best practices, what happens in the hospital, because this is where the physicians and nurses and ethicists and so on, have to do. I will talk about how to make advance care planning decisions and how to incorporate leaders. My expertise is with African American communities. You must incorporate pastors in your ethics committees. If you do not do that, you could be doing something morally wrong.

In the United States, they do not give sufficient respect to the pastors, who are not only leaders in terms of faith and spirituality, but in terms of everything else.

**DR. SCHIAVO:** I want to add something to what Dr. Prigerson was saying about the importance of communication in this moment. Some of the main principles of communication, and especially risk communication, are trust, transparency, and community engagement. A lot of communication has not been meeting these principles because it has been conflicting. It has not included community leaders who actually have the real understanding of the communities for which this communication is intended, who are trusted sources. Often these are the individuals who really know best about the needs, preferences, and priorities of specific communities, such as communities of color, children, and other populations. We need really to think of risk communication not as the rem-

edy when things go wrong, but something we should be prepared for in advance, during inter-pandemic times.

**DR. NÚÑEZ:** Currently we are overwhelmed by news and social media activity. An important question for me is, how do vulnerable populations identify trusted sources of communication?

**DR. PRIGERSON:** We are actually trying to develop what we call a “divine intervention” that capitalizes on the trust that we have found that healthcare chaplains and hospital chaplains have, particularly among our black patients with advanced-stage cancer. In our studies, what we have found is that for whatever reason – we do not know the mechanisms – but when very sick, dying patients seek a hospital chaplain, they are more likely to sign a do not resuscitate order. They are less likely to die in an ICU. They are more likely to enroll earlier in hospice. We have been trying to understand this, but we suspect it has to do with feelings of trust that may lead to an enhanced ability to communicate. Leveraging the power and influence that healthcare chaplains have in this crisis might be effective. We think this may be a missed opportunity, because healthcare chaplains have the ability to understand where people in their communities are coming from, as well as talk the talk to physicians.

**DR. ELK:** There are two things I think are key and that may be promising aspects. One is in terms of transparency and reaching out to the community. At the University of Alabama, Birmingham, I have been involved with the School of Public Health, where we have reached out to the black pastors, housing authority and the dean of the medical school, who himself is black, and have set up a series of webinars.

The first webinar was on Saturday, April 6, 2020.<sup>2</sup> There were 1,500 people on the webinar. Many of the people were from the housing authority, just regular people. Many others were black people from the community. The whole point was to discuss all these issues.

There were specific goals with this webinar: one was to help people in the community understand how this illness progresses and so on, and our dean did speak about that. A little bit too much jargon, but okay. And then, the other goal of the webinar was to educate participants on how to protect themselves.

I am hoping that I can partner with the housing authorities and we can create culture-based messaging,

because creating messaging that the white man and the white middle-class has developed for the large audience does not work. We know that. So I wish we would stop doing that. And so we did create culture-based messaging, and we are going to continue to do that.

What I am begging hospitals to do is to include leaders who are black, alongside other ethnic groups, on ethics board before making decisions on protocol for care allocation. Failing to do that is failing to care about the black population and can lead to lawsuits, which is discussed heavily if bottom dollar is what the institution cares about. I do not care if you have already got a policy. Change it. Revise it.

The other thing is, there is a lot of pressure in the United States for having a written advance care directive. That is not going to work in the black community, particularly in the South. If I sign something saying, “Do not resuscitate my mother, you will do nothing. As it is, you do nothing for our people. Why should I sign a piece of paper?” So do not pressure people.

And if I say that culture influences how you make decisions, in the black community in the South, it has been shown that millions of people have held belief in the concept of, “There could be a miracle. God can make a miracle happen.” I do not know why people have such difficulty with this, since so many people read the Old Testament, where the word “miracle” is everywhere. But it is very, very difficult for physicians to understand this concept. If a miracle can happen, then you have to do everything that you can for the patient until they decide.

Another thing is that nobody dies alone in the black community. There will always be a pastor or somebody who will sit with them. In this time of COVID-19, we have people sitting alone. There are a couple of practices that I have seen that could be used. One thing that can be done is to have someone sit with the patient, remembering that this is somebody’s loved one. Yes, it may take hours, and yes, there are other patients to care for. But there is always someone who can sit there and be with the person and pray with them and maybe sing a church song with them. That act can be tremendously meaningful.

The other thing is funerals. We know what happens at funerals. It is not only blacks. In Israel, they have had the ultra-Orthodox, who went to funerals where there were thousands of people. The percentage of the virus in that community is very, very high.

What can we do? One way is to have the funeral through Facebook, where singing and praying can be facilitated through a virtual platform.

I also heard from a pastor who was talking about his grandfather who passed away from COVID-19. His grandfather was a very, very senior, very respected black pastor. Thousands would have come to his funeral, but could not because of the virus. Instead, they had five people go into the church and record music. Five people somewhere else recorded the sermons. Then they put it all together and people from the church drove up and were able to see the whole video they created this way.<sup>3</sup>

**DR. MADISON:** I want to prevent the deaths. I want us to think about why 70% of COVID-19 deaths in places like Chicago are black folks. I want the country to take a public health approach, which starts with prevention.

In terms of prevention, the reason why we are seeing these rates of morbidity and mortality is because of rationing. The reason we are seeing rationing is because of the lack of planning on the national level, the lack of taking lessons not just previous pandemics and plagues, but also from other countries that have already determined and discovered. For example, cordon sanitaire does not work, so we need to do physical distancing. We need to promote social connections so we can promote sociobehavioral health and well-being.

When we do not put ourselves into a situation where we have to ration, we should see fewer deaths, and we should see much less suffering, particularly in vulnerable populations. I think the fundamental problem is that we have gotten into a situation where we have to ration.

So why are black and brown folks dying more? Is it because of rationing of ventilators? Is it because of rationing and not providing an environment where there is equitable access to treatment, equitable access to screening? We have to look at the entire chain of events that happens. It begins with prevention, and making sure we do not have to get into a situation of rationing. Rationing is one of the root causes of why we are seeing this demographic differential in morbidity and mortality. When it comes to states determining who is the most worthy, who should be the first in line to have access to screening, treatment, ventilators, it is not our black and brown folks who are already immunocompromised, who are already in high-risk groups from obesity, diabetes, and hypertension. We need to do whatever we can to reduce this pandemic of rationing. We need to promote case finding in all populations. We need to promote contact tracing. We need to promote screening. We need to learn the lessons, not using

cordón sanitaire. It reduces trust. It does not promote communication. We need to increase fact-checking and transparency in reporting on who is most infected versus affected.

There is so much we could go into related to the CARES Act and joblessness and the relationship between joblessness and comorbidities, for example.<sup>4</sup> But I saw this one data point that described how for every 1% increase in unemployment, it leads to a 3.5% increase in opioid addiction.<sup>5</sup> The pandemic's economic effects alone will exacerbate our drug and mental health problems down the road.

**DR. PRIGERSON:** We are developing a lot of psychosocial interventions that deal with the opioid epidemic and how people are responding to this pandemic psychologically, especially when they are unemployed and at home and life looks hopeless. Alcohol sales have skyrocketed.<sup>6</sup> People are going to self-soothe, and that is going to cascade to a whole bunch of problems down the road.

But that is not what I wanted to react to. What I was wondering, in terms of process and in terms of equity and thinking down the road, is what happens when people feel that there was an unfair distribution of who got saved, who got the ventilator? What could be done now to have more transparency in the ICU to support decision-making?

There was recently an editorial by Daniella Lamas in the *New York Times* about the decisions and the criteria for deciding which patients would benefit from getting a ventilator and which would not.<sup>7</sup> Ironically, or paradoxically, in end-of-life care, there are always recommendations like, "Do not put an advanced cancer patient on a ventilator anyway. It is futile. You are wasting valuable resources, and it is burdensome, and they are not going to survive." So that is not a good use of a very scarce resource.

How can those rules about who should live and who is going to be put on a ventilator be made more equitable so to address the concern down the road, so there are not lawsuits saying, "You discriminated against equally needy patients who would benefit from scarce resources but denied care for other reasons."

**DR. MADISON:** A real quick answer goes back to what Dr. Elk had said before. Your triage committees need guidance documents, and those should be written by ethics committees that are representative of the community. So you should have black ministers involved. You

should have every demographic and profession included in your ethics committees to collaborate in creating these guideposts so that it is not left up to an individual, implicitly biased practitioner.

**DR. ELK:** And having just one black person is not enough. That is insufficient.

**DR. NÚÑEZ:** At least from what I am hearing from other physicians, they are desperate for these equitable protocols. In the absence of protocols, clinicians are having to make the decision in the moment with so many things happening in terms of the trauma, lack of PPE, and so on and so forth. Healthcare providers are desperate for these equitable protocols.

And I will just remind you that we know data that say, if you have a committee, and 30% of that committee is not representative of the population, you do not have voice. So it is important when we are looking at these committees that it really is that percentage of the committee to bring that voice into the equation. But I will tell you that equitable protocols are desperately sought by healthcare providers who are in the trenches having to make these decisions, and with no time, on top of being under-resourced and potentially unsafe.

**DR. ELK:** There is a hashtag on Twitter, #pallivoid, used by the palliative care community, linking to all kinds of resources that can help. The reality is, probably only the palliative care physicians or clinicians are looking at it, but others need to as well, because this is the group that has the expertise.

Now, unfortunately, even though palliative care is the group that has this expertise, they do not and have not been trained in determining cultural aspects of care. That is why a paper on cultural aspects of care, especially at end of life, is so, so key.

*Health Equity* just published my article and in it we include a table with information about the differences in approach for how to talk to southern black and white patients.<sup>8</sup> And who determined that? The community members, both black and white. Everything that is in there is a cultural guide for clinicians. Now, this was done in the rural South. I have no idea if it works up North. Dr. Prigerson and I are going to be collaborating on another study to see to what extent that works up north. But at least, if you respect what the community has asked, then you will go a very long way in showing respect, which, in turn enhances

trust. And those additional suggestions of having somebody there with a black person, when they are ill, using FaceTime so the family can sing and pray with the patient as they are dying. How difficult is that? It is not difficult. It can easily be done. You want to build trust? Do that.

And by the way, I do not believe that it is a waste of resources, particularly for people whose culture believes God can create a miracle, and if that is what the family wants and believes, then we should respect the patient and/or family's values and act according to their established goals of care. It does not matter if medically it seems like, "Oh, this person will live and this person will die." You have to be equitable, as Dr. Nunez says.

**DR. SCHIAVO:** The issue of preparedness is of the utmost importance. We definitely need more preparedness for a variety of different issues. For example, I published with co-authors a systematic review, which perhaps is still the only review on communicating risk in epidemics in low- and middle-income countries, and also includes eligible studies on marginalized and at-risk populations here in the United States.<sup>9</sup> Some of the things we have been discussing resonate with the findings of the review, which point to the importance of communities and community engagement. As supported by several studies included in the review, when community members and families were involved, communities or patients were also more likely to adopt and embrace mitigation measures.

Another lesson that we learned from Ebola: we cannot go into communities and tell them to suspend traditions for burials and funerals during a time of crisis. We need to think about culturally sensitive rituals to substitute for existing traditions during the preparedness phase. So again, the preparedness process is really key.

I'd like to change the topic. In addition to engaging community leaders in finding solutions for issues related to the rationing of scarce resources (for example, the use of ventilators or protective equipment) so that we prioritize vulnerable and underserved populations, especially communities of color, professional associations representing the black and Latino communities should also become involved. These associations should consider issuing guidelines that physicians and nurses desperately need to treat and prioritize patients who most need these resources, especially in disparity settings.

Finally, I had prepared something on paid leave, because among the most promising changes that I see happening—that, again, is not sufficient to meet the actual need—is the Family First Coronavirus Response Act, as related to the provision of paid leave for at least some of the workers.<sup>10</sup>

I am not an economist, but unfortunately, this provision is really a drop in the sea, because we know that up to 19 million people will be excluded from this provision.<sup>10</sup> On the other hand, people need to stay home as a way of protecting themselves. But we know that a lot of people are excluded from the paid leave provision, and would need to choose between protecting themselves or paying rent and putting food on the table. And this happens primarily within the food service industry and other industries where the people are really on the front line of the epidemic, and/or where workers are from communities of color, or women, or from other vulnerable populations.

Although the Family First Coronavirus Response Act is a step forward, we need to engage communities to make it more of a reality for all Americans, because paid sick leave is something that is important not only during this pandemic, but it actually is a human right to be able to take care of one's health and the health of others during times of crisis and beyond. So, it is a step forward, but it is a fraction of what we need.

**DR. NÚÑEZ:** We talked about isolation, opioid use, and issues related to mental health. I think it also bears mentioning that issues of intimate partner violence go hand in hand with alcohol use and gun sales. It is also worth recognizing that both morbidity and mortality, for women, is also likely to explode during this pandemic. Many of the places that are being serviced that support victims of intimate partner violence are not-for-profits that receive federal funding, and these are going to be places with incredible need, especially in a time where there is isolation, alcohol, unemployment, et cetera. It bears mention.

The most uncertainty in terms of the future of preserved food supply, ways of moving forward to continue living, are all on the backs of populations that are predominantly the ones that have been most discriminated against, or who suffer and bear the burdens in terms of inequities. These are not necessarily the ones who have free access to be able to get on the Internet to find information. And even if they do, to other people's points, it is in such a high level of jargon, or written in English language when the

individual maybe doesn't speak English. We need much more profound translations of that content to support health literacy as a way to get messages out for everybody, from pastors to communities, because one of the challenges that I see as a physician is that suddenly everybody is interested in science.

Science is not perceived as being irrelevant anymore. Science is not a ridiculous thing. Science is not something that people do not need to know about, and suddenly people are wondering, "What do you mean by immunity?" I think this is fabulous, but I am not sure that those messages are effectively reaching the communities of need. We need to be able to make those connections and parlay into building trust. Currently, there are too many mixed messages.

**DR. ELK:** One of the things that you said about community is key. One of the research methods that is very, very appropriate, however extremely difficult to do in a very tight timeline, is community-based participatory research, where you could partner with the community. To reach the communities, we have to work in partnership with them. We can do a community-based research project where we can develop prevention guidelines in words the community will understand and according to the community's values. Even if we can only determine feasibility, the goal will be to help save some lives. But if we can determine that this is a method that we can do when the next crisis comes, we will be ready to have such studies.

And to add to what Dr. Schiavo said, I would like to stress, we have to learn from what happened in the Ebola epidemic, when whites were attempting to provide aid, they did so without paying respect to the culture. They did not listen to the people experiencing the health crisis. They did not incorporate the culture of the people into it. If you fail to incorporate the culture of the local people, you are doomed to failure, and more people will die.

It is a matter of cultural humility that people have to learn, and especially physicians, who unfortunately do not effectively receive this as part of their training. It is part of the nurses' training, but it is not part of the physician's training.

**DR. NÚÑEZ:** I agree with you. I think that with the "do to" rather than the "do with," mentality, especially with the scarcity of key equipment right now, there is a propensity to say "Let us do something." This results in, "Here is the shortcut that lets us something." And I

think that the best thing to do, even though it may take a bit more time, is actually reaching out and including community networks to create a better outcome in the end if there is a matter of trust.

**DR. SCHIAVO:** Actually there is evidence also from the Ebola crisis such as for example some interesting case studies on Sierra Leone and Liberia from UNICEF showcasing that when communities finally got involved, not only in research and intervention design, but also in the implementation and the evaluation of solutions, and in building trust in the community about the recommendations for protection, finally, the Ebola epidemic subsided.<sup>11,12</sup>

And I think this is a very important lesson, especially because in the United States, I feel we do not integrate enough community engagement in intervention design, implementation and evaluation. We have imported to a certain extent the community health worker model, but for the most part this model is being implemented in a very limited way because we primarily train people to disseminate information that experts designed. It is not really the same as the kind of community consultative process we need, especially in moments of crisis when we really need to empower communities, giving them ownership of solutions.

**DR. MADISON:** There is a long list of steps that countries such as Taiwan, Singapore, and others took that both flattened the curve faster, and reduced the prevalence of disease and mortality.<sup>13</sup> In that long, wonderful list is the item that they addressed the issue of disease stigma and compassion. I do not know where that exists in our state-by-state plans. We do not really have a national plan.

But that was listed as a policy in Taiwan and it made considerations for those affected by providing food and frequent health checks. It also included encouragement for those under quarantine. And the rapid response included hundreds of action items in their supplement. But just imagine including disease stigma and compassion as a part of the process.

**DR. ELK:** Andy Slavitt is one person who has shown unbelievable compassion and action. He was the head of President Obama's Medicare and Medicaid CMS, and helped develop the Affordable Care Act. He is very knowledgeable and very connected. He has taken it upon himself to develop an organization called the United States of Care.<sup>14</sup>

Andy Slavitt has put together so many initiatives. For example, he set up a site where ventilators can be shipped from one place to another, even before there were other initiatives. His group also set up a step-by-step guide for bringing resources to underserved communities.<sup>15</sup> (See Appendix S1; © United States of Care Campaign and reprinted with permission.)

So you can take it into your state, and all you need is the governor of that state, for example, to follow this step-by-step guide. Now, let us see how many states use this incredible model.

**DR. PRIGERSON:** In terms of resources, I do not want to plug too much of what we are doing, but we are developing online resources to aid communication between families, between families and medical professionals, particularly in the life-threatening ICU situation. But also we are developing tools to prevent people from dying alone and funerals not being able to happen in accordance with and culturally specific cremation and burial practices.

We are developing an app that actually is a virtual memorial. We have developed something called the Living Memory Home to help families in that time—it is not going to be a substitute for actually convening and having face-to-face ceremonies at some point, but the idea is, I think people are really struggling with this forced separation and lack of communication as everyone—everyone is essentially a shut-in right now. We are all shut-ins.

And when your loved one is dying in the hospital, and you are shut in, regardless of your race or ethnicity, you are upset, you are frustrated, and you need tools to help you communicate better and more effectively.

The other point I wanted to make in listening to everyone's great suggestions, is that all our suggestions are essentially top down. Community-based participatory research is great in that a lot of voices are heard. What should recommendations to actual families do? What should be some of the simple patient prompts or family caregivers' checklists for things that they should do to help them protect themselves and ensure their interests? We are always thinking about how we can help other people through being very instrumental and telling them what to do or treating people differently. What can they do themselves to have their rights and interests and values respected?

**DR. NÚÑEZ:** I certainly read that in some places patients actually got an iPad that is covered in plastic so that they are not alone, they can connect with some-

body and so on and so forth. And if we are talking about best practices, whether it is a phone or any other kind of device, to support that connection when someone is critically ill or at the end of life, that is as instrumental as having an IV.

Now, granted, I would submit to you that in terms of dying in a hospital, dying alone is a very frequent thing and very culturally devoid thing outside of that hospital. And so perhaps this is a practice we need to bring in that, just like the IV, there is this digital access to music, to a spiritual advisor, to family, to singing, whatever that is, that as a person surrounded by all the illness in a hospital, they do not necessarily feel alone.

As long as you attach it to something, it is not like you are mandating that another person necessarily be there, but if an IV is essential, then perhaps we are saying this as well, because we need to pay attention to the humanity of individuals as they go through this struggle.

**DR. MADISON:** I think that what communities also need to do, particularly my community and black communities and international communities, is to destigmatize accessing mental health services. By destigmatizing access to mental health services, society also has to provide free services, right? So let's promote access to free telehealth, promote access to paid sick time if you are fortunate to have a job, and promote access to free testing and treatment. We should promote destigmatizing access, whether it is for behavioral health or clinical health care. But right now, some of the barriers to access are both inside and outside of the community, so we should somehow support bridging that.

In Massachusetts, the Department of Public Health, through the Massachusetts Public Health Association, highlighted four action items. And I believe that the fourth one is the one we have not mentioned yet, is so important because it adds to an increase in prevalence and incidence of this pandemic, of COVID-19 pandemic, and it is to enact a moratorium on evictions, foreclosures and termination of public benefits.

What can the individual do about that? Not much. If you lost your job and you call up unemployment assistance, you are not even able to get off the waitlist on that phone. People are waiting two, three weeks to get a response in order to get unemployment insurance. I want to also stress that people finding themselves unable to get through to a representative at the unemployment office should document their every try.

And so in the process, you are getting someone telling you have to be evicted from your housing, and foreclosures, and losing your public benefits. So it is ecosocial theory. It is all around the lifespan of what is happening to our most vulnerable populations. Some of what we can do within our group, within our community is to destigmatize access and promote lobbying and advocacy. But it really is oppression working through ideological, institutional, interpersonal, and internalized mechanisms.

**DR. ELK:** One of the things that Dr. Prigerson had raised was, what about doing something for the patient? There is a tool that was developed at UAB in which the palliative care doctors said, “We will sit with your patient.<sup>15</sup> Tell us...”—they have developed a little questionnaire. The patient’s loved ones fill in the answers. “What does he love talking about? What is important to him? What is the name of...?” This is meant to help the practitioners get to know their loved one, the patient, intimately, and can help to represent the loved one in a very unique, individual way.

There is also a tool for providers on how to communicate at this time, developed specifically for COVID. All of that is both on Twitter under #pallivoid, and also on Facebook, which is much easier, and is COVID-19 Palliative Care Providers. It is open for anybody. I saw that 3,000 people are already on the Facebook group as of the time of this discussion.

It has all these tools. If the physicians and others are looking for tools, the palliative care people have the perfect tools. One of them deals with how to communicate and what to say. They use a lot of acronyms to help clinicians remember them.

**DR. SCHIAVO:** I want to highlight something that has not yet emerged from the last discussion, which is the digital divide. We all talk a lot about digital health, we talk about those apps. But these media approaches are not necessarily going to reach the vulnerable populations we need to protect, where word of mouth, community gatherings, churches, and similar channels and venues are still the preferred ways of communicating. We are already seeing that when school went online, some schools in disadvantaged neighborhoods were left scrambling to figure out how to provide online instruction.

In addition to this, we are in the middle of an infodemic, and there is a lot of information and misinformation out there. Easy and widespread access to social

media, which we did not need to care about during H1N1, really have a prominent role in disseminating this misinformation. And although some of the vulnerable populations may not use social media as their preferred media of choice, they hear from other people who have read things on social media.

So we need to be aware of these challenges and prepared to equip the public health infrastructure to react to hoaxes and misinformation. I was reading the other day that there were some hoaxes in Africa saying that blacks were not susceptible to COVID-19.<sup>16</sup> We need to be prepared to counteract misinformation, and the only way to do this is having, again, governments and public health agencies to work with community leaders, so that those leaders become our rock stars on social media and within other information settings.

Let’s give them social media accounts. Train them to use social media. Let’s do something that actually brings their trusted voices to the communities they reach, because whether these communities are on social media or not, they hear from others who are on social media. This is also another important aspect that may have an impact on training of the public health workforce and on the overall infrastructure.

**DR. NÚÑEZ:** I want to agree with you. I mean, I will share with you that in terms of our community participatory research project, Philadelphia Ujima, we brought in the radio celebrities, because the radio celebrities are important from a cultural perspective with lower-income residents in the city. Some of these radio celebrities had profound credibility, and whatever they said was viewed as true. Unfortunately it is the case that right now there is no way to certify what is actually credible information.

Dr. Prigerson raised the point that we have talked about a top-down approach, and Dr. Madison eloquently talked about how there is so much in terms of the infrastructure that does not exist, and top-down is important. But I think that some of the bottom-up is, how do we attend to the legitimate disenfranchisement of our at-risk populations, many of whom are saying, “You do not really care about me. I am expendable. I can clean. I can pick in the fields for your food, but I am not going to have time off, and if I am a casualty of this pandemic, well, then, you do not really care. Somehow I am supposed to continue to be engaged, maybe vote, and to be part of this process. How does it make sense when it seems that you all do not really care about me?”



**And so I think that there is a component that we have to reach to address that legitimate disenfranchisement as well as figure out through culturally competent sort of communication about how can they have some agency in this, how do they recruit help for when their loved one is sick, identify who were all the individuals that need to be in the loop on that conversation? Negotiating the health access process is difficult for most of us, even in better times. How can we streamline the process, provide navigation help during this global pandemic?**

**I think that disenfranchisement linked with health, health literacy, and misinformation, or “the infodemic,” is an important part of the storm, and if we do not address that, no matter what happens top down, the disenfranchisement may very well explode.**

**It is important to mention that disenfranchisement is a useful way to control the populace, because if everybody is looking at everybody else, the problem is always going to be that other person. It is us and them. The community affords strength, innovation, and cohesiveness in coming together to find and promote solutions.**

**That being said, we are hearing in the media lots of amazing examples where people are coming together to form community. This is too often drowned out by the sensational stories of hoarding and price gouging. We do not hear the common acts of checking on the elderly neighbor and sort of going grocery shopping.**

**We do not hear about that, because, again, that does not sell eyeball time for the evening news. It is important that we think about how to best use community-focused, inclusion-promoting messages as one of the antidotes to the infodemic.**

**DR. PRIGERSON:** In response to all this, and the infodemic, we are developing some tools. We call them GIST, “Giving Information Simply and Transparently,” so that when oncologists talk with advanced-stage cancer patients, you are disenfranchising patients if you talk about millimeters of tumor growth, or you talk about drugs for which they do not understand the mechanisms of action.

We are developing this intervention to both address the infodemic, to simplify and clarify main talking points, and insist that physicians have patients leave a clinic visit doing what in psychology they call cognitive interviewing, ensuring that patients have enough information to make an informed choice—they do not need

to know every single fact, but maybe the physicians or the medical community needs to decide what are the main kernels of medical information that, without which, anyone, regardless of race or ethnicity or language or education level, needs to know to make a choice that will resonate with them, that will be consistent with their values, and consistent with informed values.

So we are trying to reduce disparities, but through education and information, both on the parts of having physicians communicate to empower patients to have the information they need, to insist on the care that might be consistent with what they would want.

It is always awkward to say what patients would want. My husband and I always argue about goals of care. No one’s goal of care is to die well. You know? No one wants any of this. But as researchers, we cannot fix every problem, so what we are trying to do is at least level the playing field in terms of equity and addressing the infodemic. There are too many moving parts and complications to really have a grasp of what you need to know to get care that you deserve.

**DR. NÚÑEZ:** In summing up our conversation, what are the best words of wisdom you would put out there?

**DR. MADISON:** We must take a holistic approach, top down, bottom up, including all voices, and promoting agency to address particularly the most vulnerable. If we can address issues within the most vulnerable populations, we address the entire population.

**DR. SCHIAVO:** I would like to say that pandemics have a way of showing us how much we are interconnected. Taking care of everyone in our communities and being our brothers’ and sisters’ keeper is not only an important human rights issue but also benefits the health of everyone. I hope that this lesson is not going to be forgotten too quickly, as we have seen so many lessons be forgotten in the past. As Dr. Madison said, we really need to address all the social and political determinants of health so that we can advance health equity and racial equity in the years to come and protect people during this pandemic. In the meantime, I would like to ask for everyone to take the time to thank the people who are on the frontline. Yes, the healthcare workers, but also the food and pharmacy cashiers, the sanitation workers, the hospital housekeepers and cleaners, and everyone who puts their life at stake every day, so that so many of us can stay safe. I think it is important to say

thank you, because a lot of them are making huge sacrifices for the common good, and we need to do our share and at the minimum to thank them.

**DR. ELK:** In terms of prevention, please, work on partnering with communities to develop prevention messaging that is not as complicated as what's on the CDC or other health care sites, but is instead very simple, and not only that, takes cultural differences into consideration. Just a photograph or a picture of a Native American person or somebody in some tribal dress is absolutely insufficient.

A lot of nurses already have training in cultural competency, but sometimes physicians don't have quite as much competency in this area. It is important for all practitioners to show cultural humility and to not talk down to patients, but to ask what their cultural values and preferences are. And then once you know them, respect them. And if you do not know, there are tools and guidelines to improve cultural competency. Look at the article that we have just published in *Health Equity*.<sup>8</sup>

**DR. PRIGERSON:** One thing that struck me as a way to synthesize what we have been talking about is the huge importance of communication in making sure that families are connected, that health professionals are connected, that people get adequate information, that people's preferences and needs are heard. It all depends on facilitating and improving communication between patients, families, communities, and the medical team. There is hope, but we also know that a lot of work needs to be done to improve not just access to care, but also to strengthen communication, and improve relationships between communities and health-care institutions, between the federal government and constituents, and between practitioners and patients. Communication needs to be facilitated so that people's needs are heard and respected.

**DR. MADISON:** I have three nieces in the healthcare field. One is a black female physician, Chicago. Another black nurse in the LA area, managing 80 nurses. And the third, black female social worker. They all agreed on their answer to this question, and what they said was, "Let us work towards disease prevention and health promotion instead of a curative model for health care delivery."

**DR. NÚÑEZ:** One of my favorite acronyms is PDQ, which stands for partner-defined quality. If we can

start with the PDQ straight away, then hopefully we can take advantage of this opportunity for good.

There is an Asian proverb that says, "The best part of my house burning down is I have a good view of the moon." In crisis, there is opportunity. We are awash with opportunity. The question, as has been mentioned so eloquently by many of you, is, do we then leverage this opportunity for the better in terms of efforts of equity, relationships, communication, infrastructure, to roll it back resulting in a robust, effective prevention model? We will be able to say, "Yeah, this is not just. We've learned from the Spanish flu. COVID-19 was the tipping point where we changed things up."

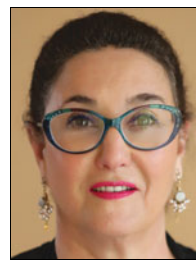
I really, really appreciate all of your time. This was a fabulous conversation. It was just really a wonderful opportunity, and thanks so much for all your insights.

#### Moderator



**Ana Núñez, MD**, is a professor of medicine and professor of obstetrics and gynecology, Dean of Diversity, Equity & Inclusion at Drexel University College of Medicine. Her expertise includes sex/gender CBR and health and workforce enhancement for underrepresented populations.

#### Participants



**Ronit Elk, PhD** is Professor, Department of Medicine, Division of Geriatrics, Gerontology and Palliative Care, at the University of Alabama, Birmingham, and Associate Director of the Center of the Southeast Institute for Innovation in Palliative Care. Her research focuses on partnering with underserved communities to develop culturally concordant palliative care interventions, based on the community's cultural values and preferences and at end of life, and in developing effective training methods for clinicians in providing the culturally concordant care. Dr. Elk has published extensively but is most proud of her work as guest Editor of a Special issue in the Journal of Palliative Medicine, focusing on Palliative and End of Life Care for African Americans. The title of her editorial:

“The first step is recognizing, acknowledging, and respecting the inequity, disrespect, and disregard our African American patients have experienced.”



**Holly G. Prigerson** is the Irving Sherwood Wright Endowed Chair of Medicine, Co-Director, Cornell Center for Research on End-of-Life Care, and Professor of Sociology in Medicine at Weill Cornell Medicine. Her research has been continuously funded for over 30

years by the National Institutes of Health to examine issues of health care disparities at the end-of-life and psychosocial influences on and outcomes of those disparities.



**Renata Schiavo, PhD, MA, CCL**, is a senior lecturer at Columbia University Mailman School of Public Health, Department of Sociomedical Sciences, and the founder and board president of Health Equity Initiative, a nonprofit membership organization. She is a passionate advocate for health equity and a committed voice on the importance of addressing and removing barriers that prevent people from leading healthy and productive lives. She has significant experience with and has written on communicating risk and promoting disease mitigation measures in epidemics and emerging disease outbreak settings.



**Dr. Maria Madison** has built her career, since 1983, around evidence-based research methods. This has included conducting and supervising significant public health projects with multicultural communities, often in resource constrained settings. She began

her career as a Peace Corps Volunteer in the Democratic Republic of the Congo, (i.e., Zaire), and continued working through the private and public sector. Dr. Madison is currently the Associate Dean for Equity,

Inclusion and Diversity at the Heller School for Social Policy and Management at Brandeis University. She teaches on subjects such as Intersectionality and Bioethics.

## Supplementary Material

### Supplementary Appendix S1

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