THE ROBERT WOOD JOHNSON FOUNDATION

Washington University in St. Louis
SCHOOL OF MEDICINE

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

The Role of Community Health Workers in Diabetes Self Management: Lessons Learned from the Diabetes Initiative

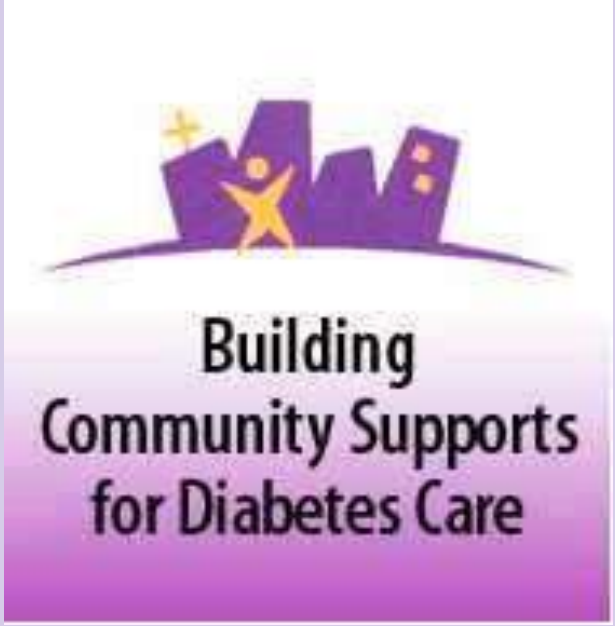
Grantmakers in Health Annual Meeting
New Orleans, March 2009

Carol Brownson
cbrownso@dom.wustl.edu

Partial support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, NJ.

Diabetes Initiative of the Robert Wood Johnson Foundation

Real world demonstration of self management as part of high quality diabetes care in 14 primary care and community settings across the US

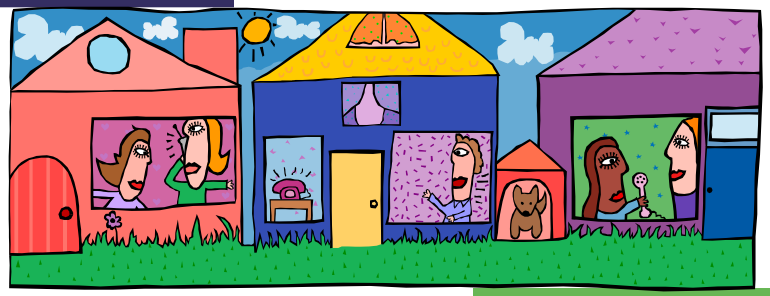


What is self-management?

- Self management is what people do to manage their chronic condition and its effects on their physical health, daily activities, social relationships and emotions.
- Self-management *support* is the systematic use of education and supportive strategies to increase people's skills and confidence to manage their health condition and problems that may arise. It also refers to the organizational structure healthcare settings can implement to facilitate improved patient self management.
- The *goal* of self-management support is to help people achieve the highest possible functioning and quality of life….no matter where along the path they start.

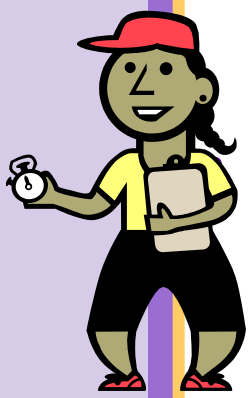
Addressing These Issues…

Self management is the key to good control of diabetes



And CHWs play an important role…

Community Health Workers in the Diabetes Initiative



- **"Coaches"** in Galveston lead DSM courses in their respective neighborhoods

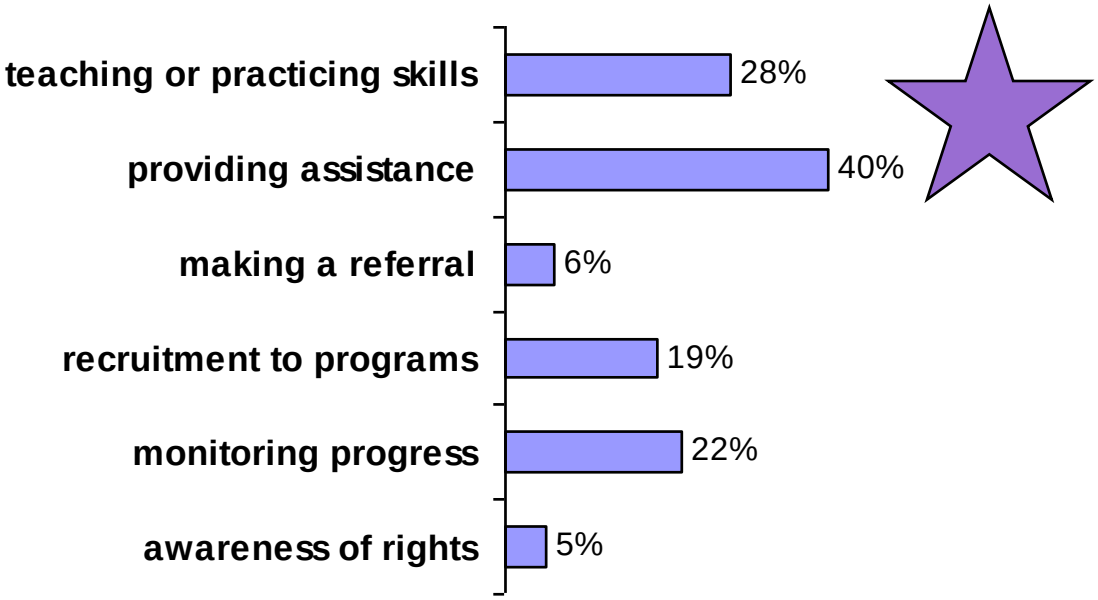
"Lay Health Educators" in Maine provide support and encouragement for physical activity to co-workers, teach self-management courses and advocate for community trails

- **"Community Health Representatives"** in MT-WY participate in self management classes and provide follow up support after classes

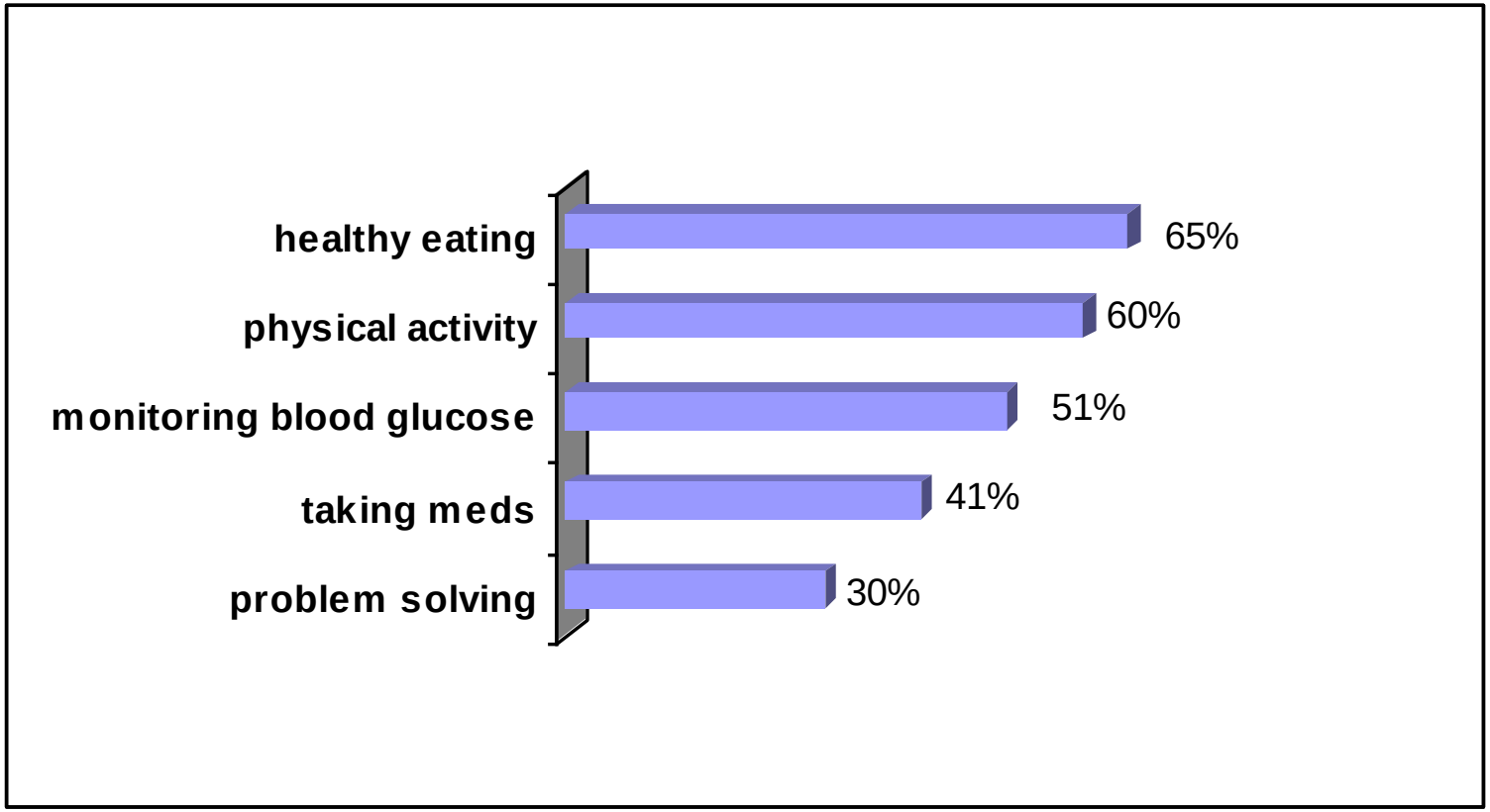
- **Elders** who form the Community Council at the Minneapolis American Indian Center guide program direction and teach self management classes to peers

- ***"Promotoras"*** were key to the services in four sites—urban, rural, clinic and community settings

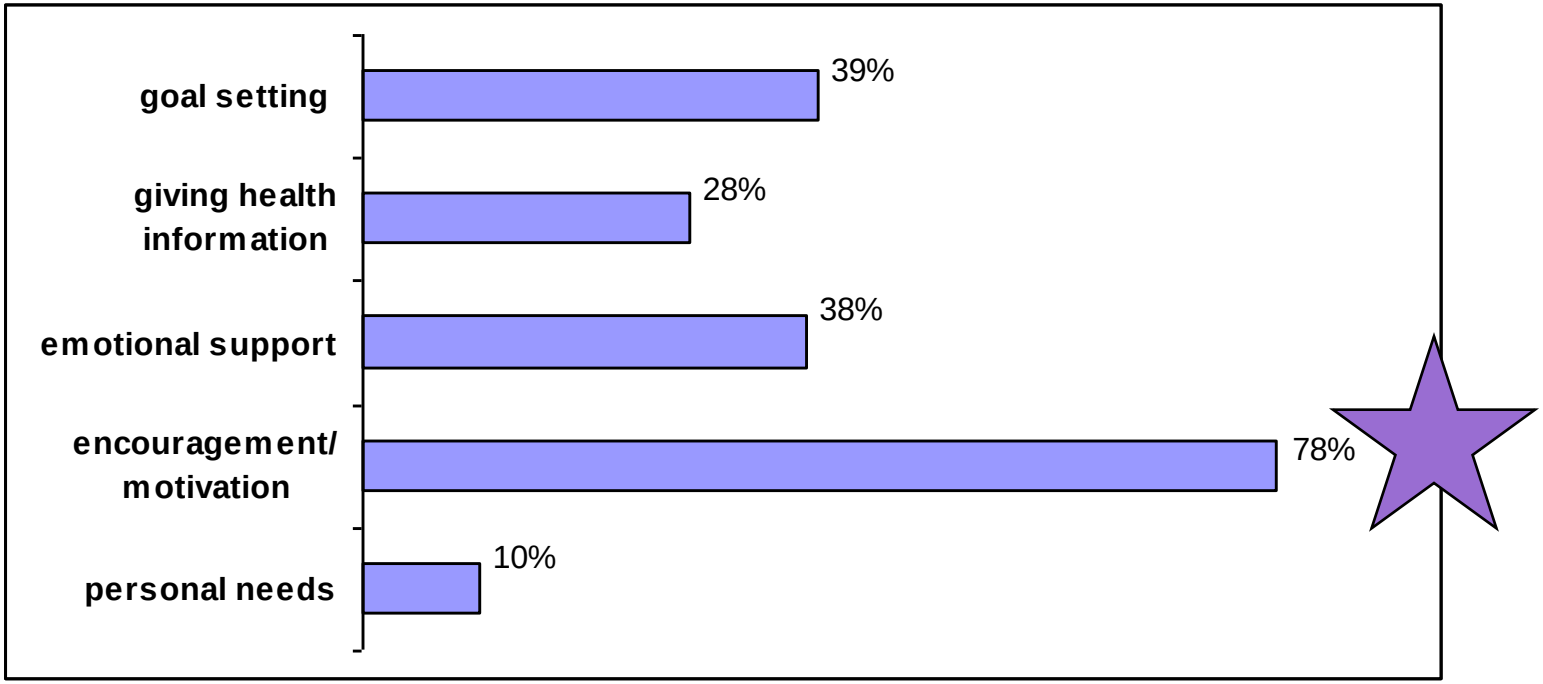
Focus of Individual Contacts
(1964 contacts)



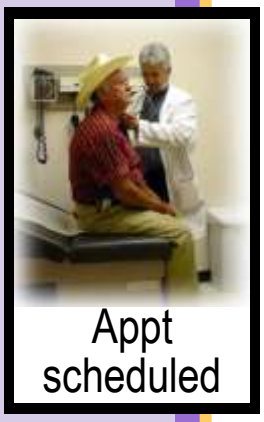
Types of Skills Taught or Practiced
(33% of Individual Contacts)



Types of Individual Assistance Given
(47% of Individual Contacts)



Usual Care – Gateway Community Health Center, Laredo, Texas



MD Visit → **Assessment** → **MD Education** (verbal and printed handouts) → **Treatment Plan** Labs Medication Care Plan

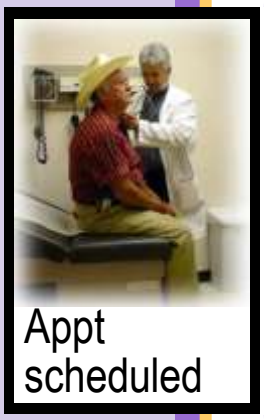
↓

MD Follow up 1 month: Review labs & initial treatment plan

↓

MD Follow up x 3 months, as needed

Promotora Intervention -- Gateway


Appt scheduled

MD Visit → **Assessment** → **MD Education** (verbal and printed handouts) → **Treatment Plan**
- Labs
- Medication
- Care Plan

Referral to Promotora program


Promotoras

- •10 week group classes
- •Depression screening and follow up per protocol
- • Individual counseling, phone follow up and support as needed
- •Case conferences with providers
- •Support groups

MD Follow up 1 month: Review labs & initial treatment plan

•Patient educated and more informed

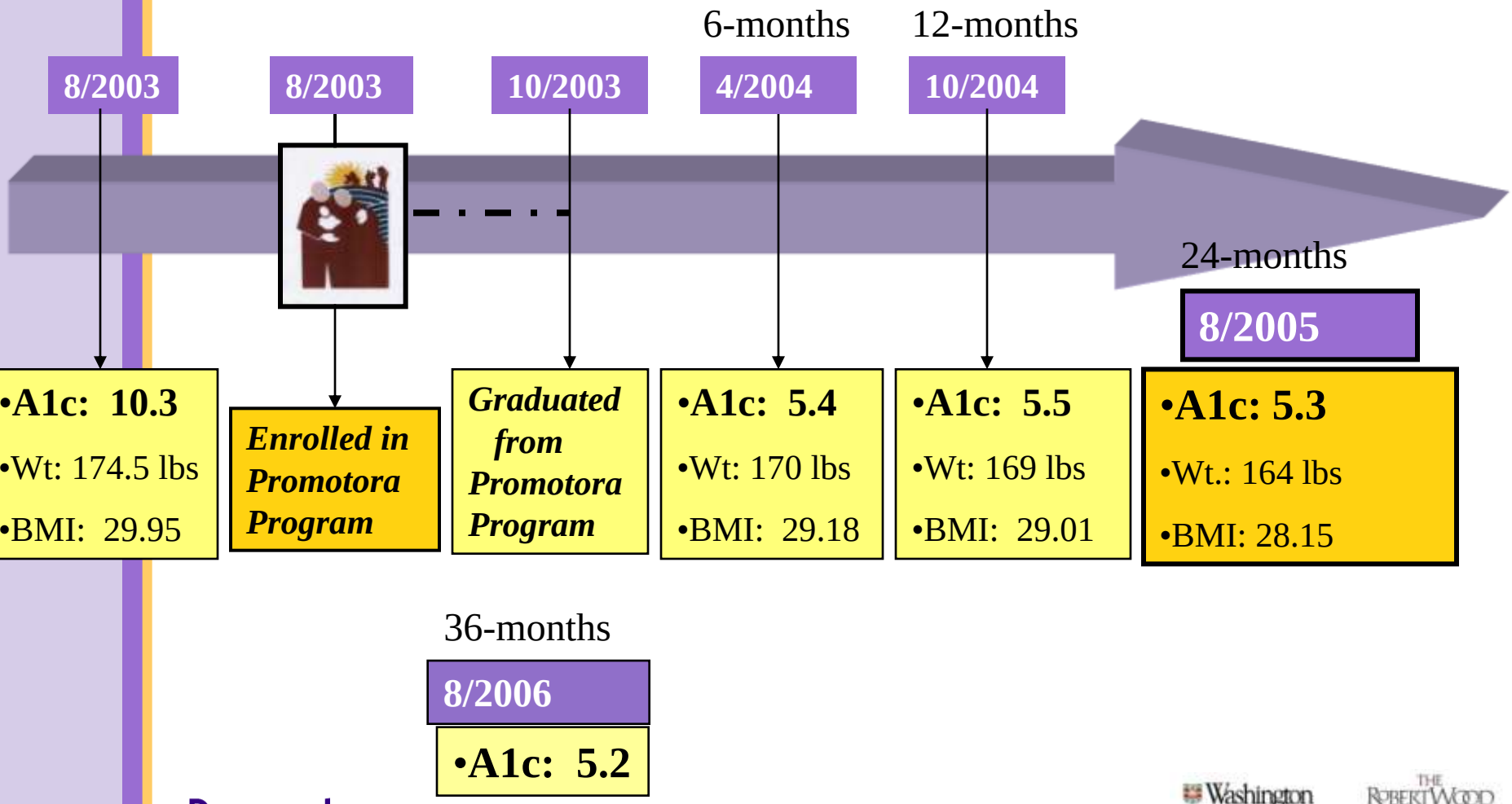
MD Follow up x 3 months, as needed

MD visits more focused, less follow up required

Benefits of the Promotora Program

To Providers		To Patients
More efficient use of time	⟷	More time for education
Improved diabetes control	⟷	Improved health outcomes
Greater attention to social needs/concerns	⟷	Individualized care
Reinforcement of treatment plan	⟷	More involved in care
Extension of providers' services	⟷	Improved access to care
Additional clinic services and referrals	⟷	Specific needs met by appropriate referrals
Better follow thru on care plans	⟷	Improved quality of care

Improvements Over Time -- Gateway



La Clinica de La Raza: Oakland, CA (clinic-based)

Promotora Roles and Responsibilities:

- Enroll patients in program (10-15 per promotora)
- Stage patients in 4 main behavior areas at baseline and every 3 months (using TTM tools)
- Follow-up weekly with patients; provide stage appropriate counseling
- Identify patients with depression
- Lead classes, support group, walking club
- Communicate as needed with clinic providers, nutritionists, and mental health staff via case conferences

Holyoke Health Center: MA (clinic-based)

Promotora activities:

- Facilitate drop-in breakfast clubs and snack clubs
- Facilitate self-management classes (Spanish and English)
- Coordinate walking groups and culturally appropriate exercise classes
- Conduct outreach to patients who have missed appointments

Campesinos Sin Fronteras: Somerton, AZ (community based)

Promotoras are former farmworkers who serve that population by providing:

- Education to families in their homes
- Individual counseling and problem solving
- Support groups
- Self-management classes
- Outreach activities with farmworkers
- Referral/ coordination with clinic

Galveston County Health District: TX (community based)

A clinic setting trained volunteers to conduct community-based education

- "Coaches" coordinate and facilitate *Take Action* self-management classes using a curriculum developed by project staff
- Staff support volunteer coaches, who are reaching diverse populations in their neighborhoods throughout Galveston County

MaineGeneral Health's Move More Project (community based)

Lay Health Educators trained by health center staff to provide support to their peers in natural settings:

- Tools (e.g., maps of outdoor walking trails and indoor walking spaces, pedometers, physical activity logs)
- Walking groups and walking partners
- Incentives and awards
- Motivational and informational weekly emails
- Self management workshops (some)

What makes CHWs effective?

- CHWs have access to the population they serve
- They are personally invested (passion, commitment)
- The unique relationship they have with clients provides critical social support
- This trusting relationship lays the foundation for good self management
- CHW's have greater flexibility to meet clients needs, e.g., time, place, scope
- They have the training and support to fulfill their various roles

Davis KL, O'Toole ML, Brownson CA, Llanos P and Fisher EB. "Teaching How, Not What: The Contributions of Community Health Workers to Diabetes Self Management." *The Diabetes Educator*, 33(Suppl 6): 208S-215S, 2007.

Some Lessons Learned

- Involving the health care team and CHWs in developing protocols/ roles for CHWs is key to program success
- It is essential to establish clear roles and procedures for how CHWs will handle emergencies (e.g., suicidality)
- CHWs can help ensure that educational materials and program activities are culturally and linguistically appropriate
- The unique relationship between the CHW and the client lends itself to addressing emotional health and well as physical health
- CHWs are the best role models when they also take care of themselves
- Their work is effective for those they serve and health enhancing for the CHW
- CHWs have a unique role in health and health care that only they can do

Questions for further exploration…

- Best ways to identify and recruit peers for different types of programs
- Most effective ways to provide ongoing oversight and support for community health workers
- Stable mechanisms to reimburse costs of and provide appropriate compensation for peer workers and/or how to develop appropriate staff development
- How best to integrate and sustain peer support interventions in ongoing health or other social services delivery systems.

Resources…

- Selected Readings Handout
- Additional Diabetes Initiative articles in a special supplement to *The Diabetes Educator,* June 2007.
- APHA special primary interest group: http://www.apha.org/membergroups/primary/aphaspigwebsites/chw/ (check out their SPIG newsletter, winter 2009)

~Thank you~