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

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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)

- Teaching or practicing skills: 28%
- Providing assistance: 40%
- Making a referral: 6%
- Recruitment to programs: 19%
- Monitoring progress: 22%
- Awareness of rights: 5%
Types of Skills Taught or Practiced (33% of Individual Contacts)

- Healthy eating: 65%
- Physical activity: 60%
- Monitoring blood glucose: 51%
- Taking meds: 41%
- Problem solving: 30%
Types of Individual Assistance Given (47% of Individual Contacts)

- Goal setting: 39%
- Giving health information: 28%
- Emotional support: 38%
- Encouragement/motivation: 78%
- Personal needs: 10%
Usual Care – Gateway Community Health Center, Laredo, Texas

Appt scheduled

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

MD Visit → Assessment → MD Education (verbal and printed handouts)

Treatment Plan
- Labs
- Medication
- Care Plan
- Referral to Promotora program

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

Appt scheduled

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

Referral to Promotora program

10 week group classes
- Depression screening and follow up per protocol
- Individual counseling, phone follow up and support as needed
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## Benefits of the Promotora Program

### To Providers
- More efficient use of time
- Improved diabetes control
- Greater attention to social needs/concerns
- Reinforcement of treatment plan
- Extension of providers’ services
- Additional clinic services and referrals
- Better follow thru on care plans

### To Patients
- More time for education
- Improved health outcomes
- Individualized care
- More involved in care
- Improved access to care
- Specific needs met by appropriate referrals
- Improved quality of care
Improvements Over Time -- Gateway

- **8/2003**
  - Enrolled in Promotora Program
  - A1c: 10.3
  - Wt: 174.5 lbs
  - BMI: 29.95

- **10/2003**
  - Graduated from Promotora Program

- **4/2004**
  - 6-months
  - A1c: 5.4
  - Wt: 170 lbs
  - BMI: 29.18

- **10/2004**
  - 12-months
  - A1c: 5.5
  - Wt: 169 lbs
  - BMI: 29.01

- **8/2005**
  - 24-months
  - A1c: 5.3
  - Wt: 164 lbs
  - BMI: 28.15

- **36-months**
  - 8/2006
  - A1c: 5.2
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
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
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

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/](http://www.apha.org/membergroups/primary/aphaspigwebsites/chw/) (check out their SPIG newsletter, winter 2009)

~Thank you~