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

Utilizing Peers in HIV Interdisciplinary Care Settings

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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.
What are the Resources and Supports for Self Management?

• Individualized assessment
• Patient-centered, collaborative goal setting
• Assistance in learning self-management skills, including healthy coping
• Ongoing follow-up and support
• Access to community resources that support healthy self management
• Regular safe, high-quality clinical care
Addressing These Issues…

Self management is the key to good control of diabetes

And CHWs play an important role…
Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)," outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. (HRSA)
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 of 4 DI sites, urban and rural, clinic and community settings
# Peer Roles in Providing Resources and Supports for Self Management

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<tr>
<th>What Individuals Need (RSSM)</th>
<th>Corresponding Roles for Peers</th>
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<tr>
<td>Regular safe, high-quality clinical care</td>
<td>Conduct outreach and case finding, make referrals, help patients navigate the health care system, serve as liaisons between patients and health care settings, coordinate care/services (case management), provide translation, assist with applications and paperwork for insurance or other services/programs</td>
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<tr>
<td>Individualized assessment and tailored management</td>
<td>Assess needs of patients; assess patients’ readiness to change, level of literacy, other life influences on their ability to self manage; individualize education and support; provide services in non-traditional settings, e.g., home visits</td>
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<tr>
<td>Collaborative behavioral goal-setting and problem solving</td>
<td>Help patients set and reach specific behavioral goals; help problem solve to overcome barriers</td>
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<tr>
<td>Education and skills for managing diabetes</td>
<td>Conduct outreach and recruitment for educational services, lead (or assist with) culturally appropriate and accessible self-management training and education; teach/reinforce self management skills</td>
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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

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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- Support groups
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
  - A1c: 5.4
  - Wt: 170 lbs
  - BMI: 29.18

- **4/2004**: 6-months
  - A1c: 5.5
  - Wt: 169 lbs
  - BMI: 29.01

- **10/2004**: 12-months
  - A1c: 5.3
  - Wt: 164 lbs
  - BMI: 28.15

- **8/2005**: 24-months

- **8/2006**: 36-months
  - A1c: 5.2
## Benefits of the Promotora Program

<table>
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<th>To Providers</th>
<th>To Patients</th>
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<tr>
<td>More efficient use of time</td>
<td>More time received on education</td>
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<tr>
<td>Improved diabetes control</td>
<td>Improved health outcomes</td>
</tr>
<tr>
<td>Assessment of social needs/concerns</td>
<td>Individualized care</td>
</tr>
<tr>
<td>Reinforce treatment plan</td>
<td>Greater adherence</td>
</tr>
<tr>
<td>Extension of Providers services</td>
<td>Improved access to care</td>
</tr>
<tr>
<td>Health advocate / additional clinic services and referrals</td>
<td>Specific needs met by appropriate referrals</td>
</tr>
<tr>
<td>Implement clinical protocols</td>
<td>Improved quality of care</td>
</tr>
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Comprehensive System of Care for Diabetes and Cardiovascular Disease Management

Critical Success Factors

1. Provider internalization of self-management approach to care
2. An infrastructure that supports volume yet provides some consumer choices regarding delivery
3. A system of referral, follow-up, feedback and documentation that produces integrated and consistent self-management supports
4. A system that integrates care for chronic illness management and related negative emotions.
5. A team approach to care that incorporates the promotoras.
6. Clear processes for patient care that have been developed with input from all stakeholders.
CHW Program Evaluation

• CHW logs
  – Four 2-week data collection periods
  – Quarterly beginning July 2005
  – Descriptive data collected across sites for both individual and group interventions
  • Mode of contact
  • Place of contact
  • Type of contact
  • Duration of contact
  • **Focus of contact**
Method of Individual Contact

- Phone: 78%
- Face to face: 16%
- Email: 2%
- Mail: 3%
- Unspecified: 1%
Group Contacts (198 group meetings)
Focus of CHW contacts in the Diabetes Initiative

- Teaching or practicing self management skills
- Providing assistance
  - helping to set a goal
  - giving health information (education)
  - emotional support
  - encouragement or motivation
  - personal needs (e.g. transportation, translation, filling out forms, etc.)
- Making referrals (health and/or social services)
- Recruiting participants, inviting them to participate in programs and services
- Monitoring and follow-up on participant progress
- Making client aware of rights, services available, etc. (advocacy)
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 Individual Assistance Given 
(47% of Individual Contacts)

- goal setting: 39%
- giving health information: 28%
- emotional support: 38%
- encouragement/motivation: 78%
- personal needs: 10%
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%
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.
Are CHW’s effective?

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.

Resources...

• Some of our experience captured in a Special supplement to *The Diabetes Educator*, June 2007. (Other references in bibliography).

• AADE position paper on community health workers in diabetes:
  http://www.diabeteseducator.org/About/position/position_statements.html

• APHA special primary interest group:
  http://www.apha.org/membergroups/primary/aphaspigwebsites/chw/ (check out their SPIG newsletter, winter 2009)

~Thank you~