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

Utilizing Peers in HIV Interdisciplinary Care Settings

HRSA, Bethesda MD, February 2009

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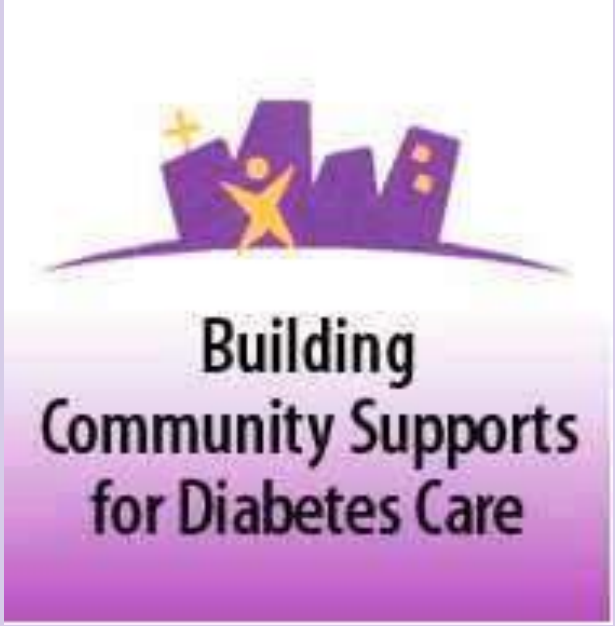
This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, NJ.

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?

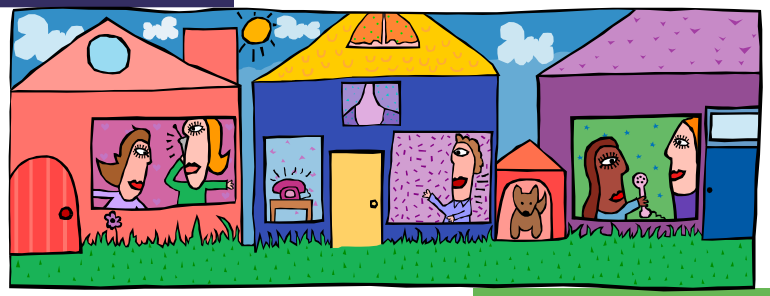
- Self management is what people do to manage their chronic condition and its effects on their physical health, daily activities, social relationships and emotions.
- Self-management *support* is the systematic use of education and supportive strategies to increase people's skills and confidence to manage 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.

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

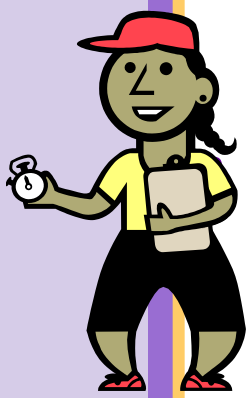


And CHWs play an important role…

CHW Definition

- 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

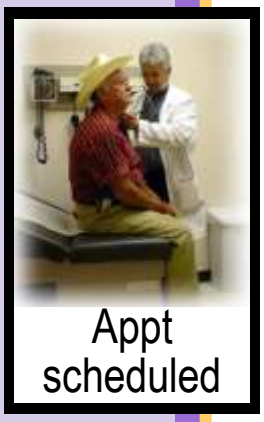
- **Elders** who form the Community Council at the Minneapolis American Indian Center guide program direction and teach self management classes to peers

- ***Promotoras*** were key to the services of 4 DI sites, urban and rural, clinicand community settings

Peer Roles in Providing Resources and Supports for Self Management

What Individuals Need (RSSM)	Corresponding Roles for Peers
Regular safe, high-quality clinical care	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
Individualized assessment and tailored management	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
Collaborative behavioral goal-setting and problem solving	Help patients set and reach specific behavioral goals; help problem solve to overcome barriers
Education and skills for management	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

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

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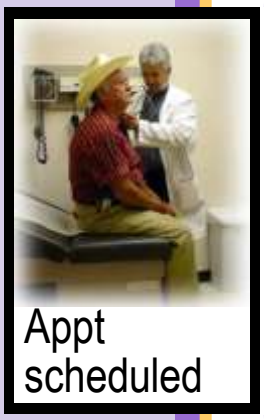
MD Follow up x 3 months, as needed

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

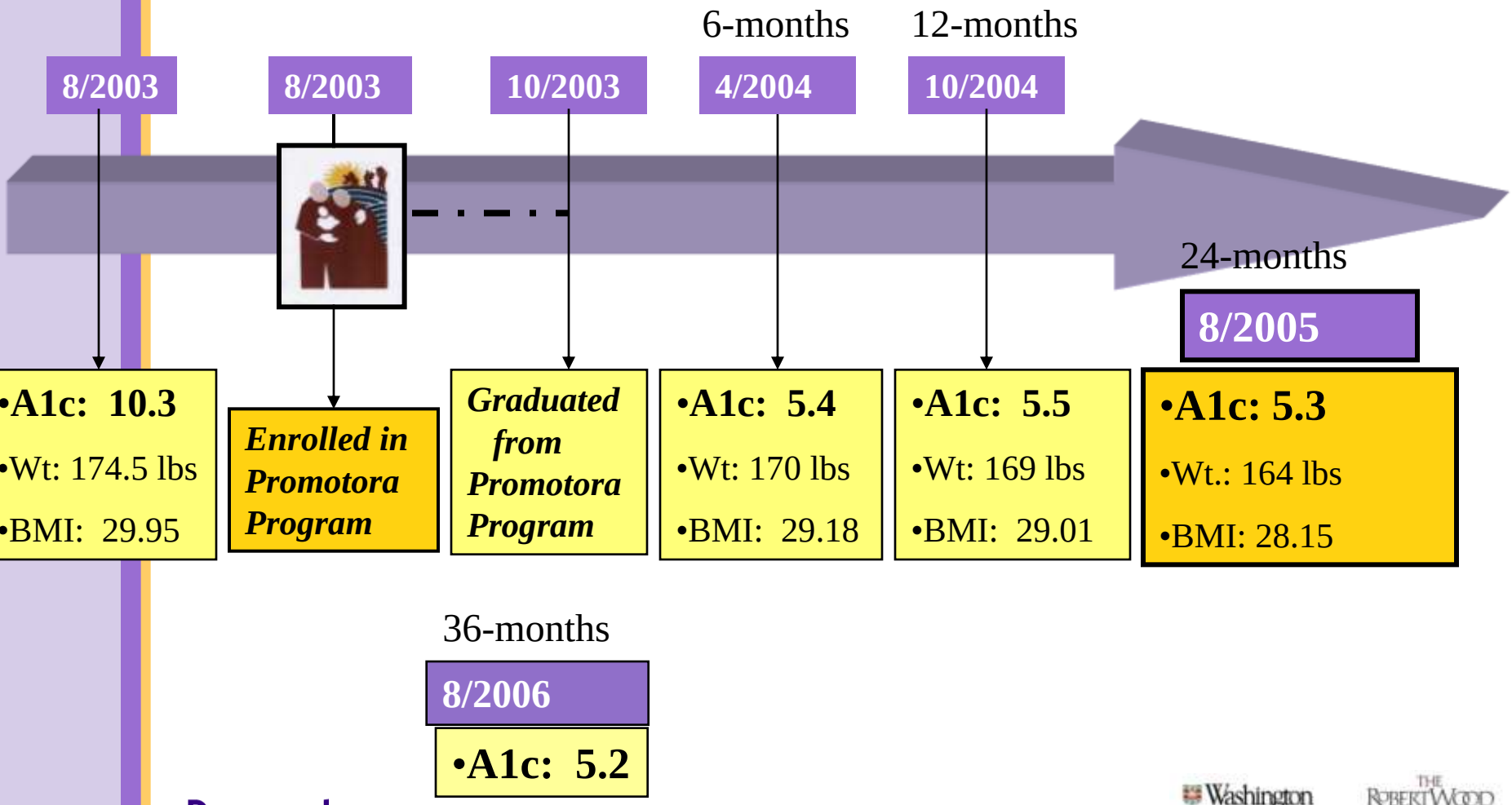
MD Follow up 1 month: Review labs & initial treatment plan

•Patient educated and more informed

MD Follow up x 3 months, as needed

MD visits more focused, less follow up required

Improvements Over Time -- Gateway



Benefits of the Promotora Program

To Providers		To Patients
More efficient use of time	⟷	More time received on education
Improved diabetes control	⟷	Improved health outcomes
Assessment of social needs/concerns	⟷	Individualized care
Reinforce treatment plan	⟷	Greater adherence
Extension of Providers services	⟷	Improved access to care
Health advocate / additional clinic services and referrals	⟷	Specific needs met by appropriate referrals
Implement clinical protocols	⟷	Improved quality of care

Comprehensive System of Care for Diabetes and Cardiovascular Disease Management

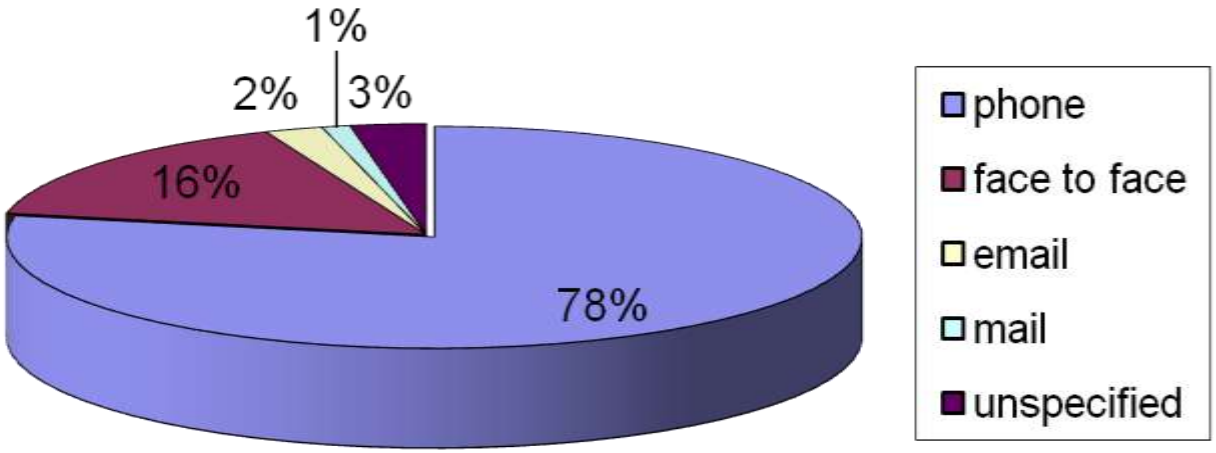
Critical Success Factors

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.

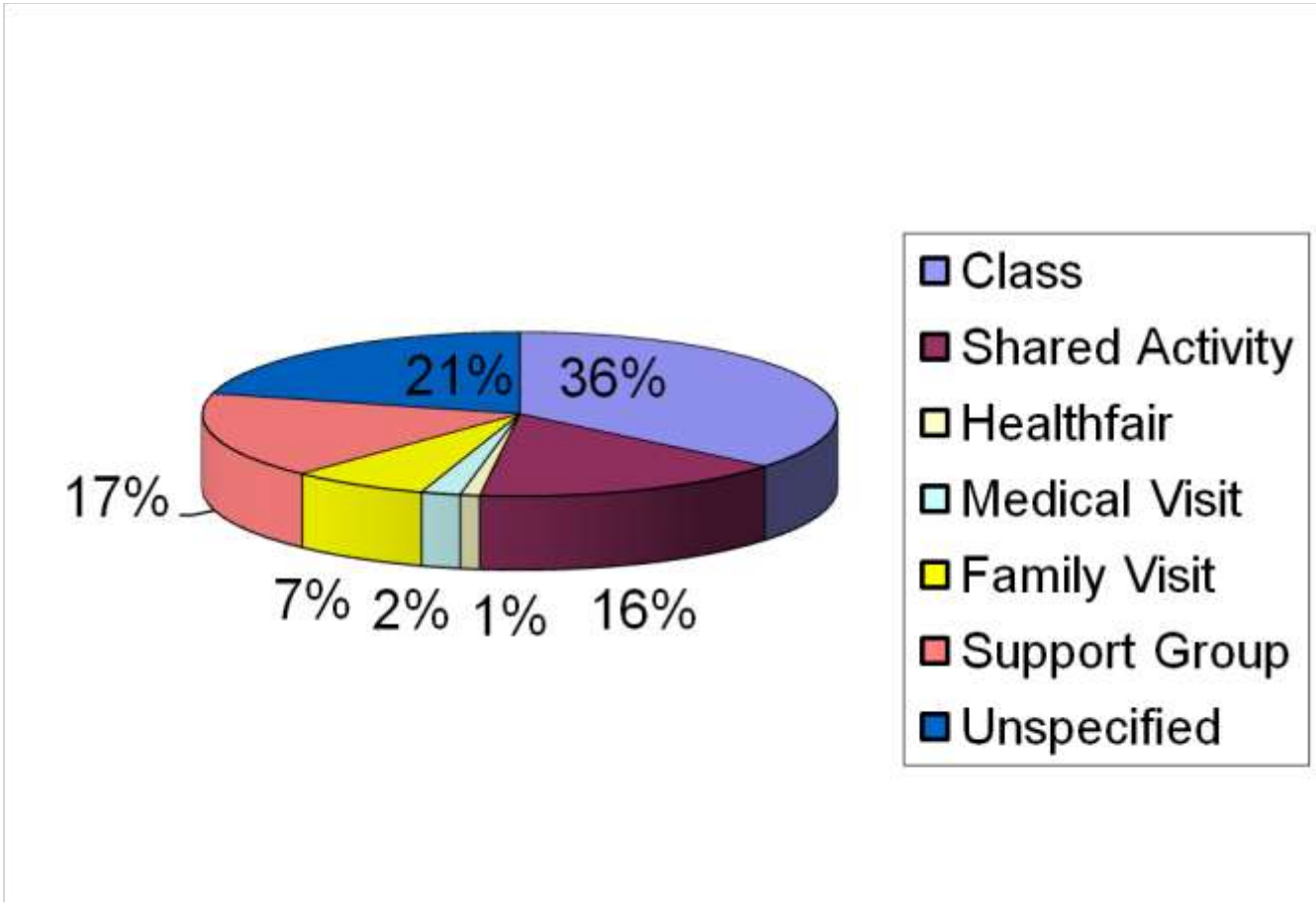
CHW Program Evaluation

- 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



Group Contacts (198 group meetings)

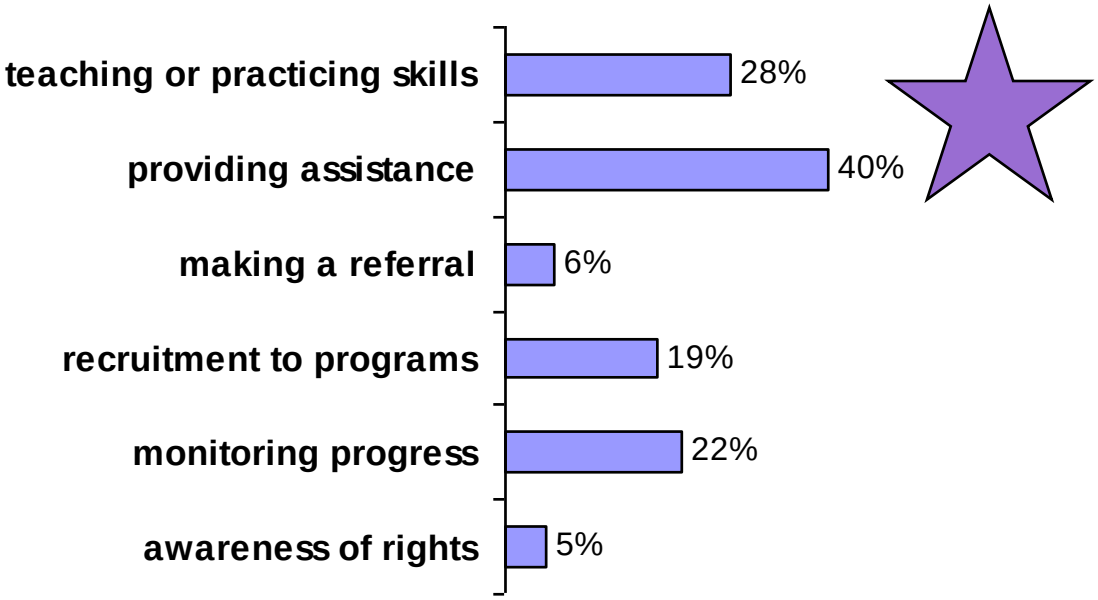


Focus of CHW contacts in the Diabetes Initiative

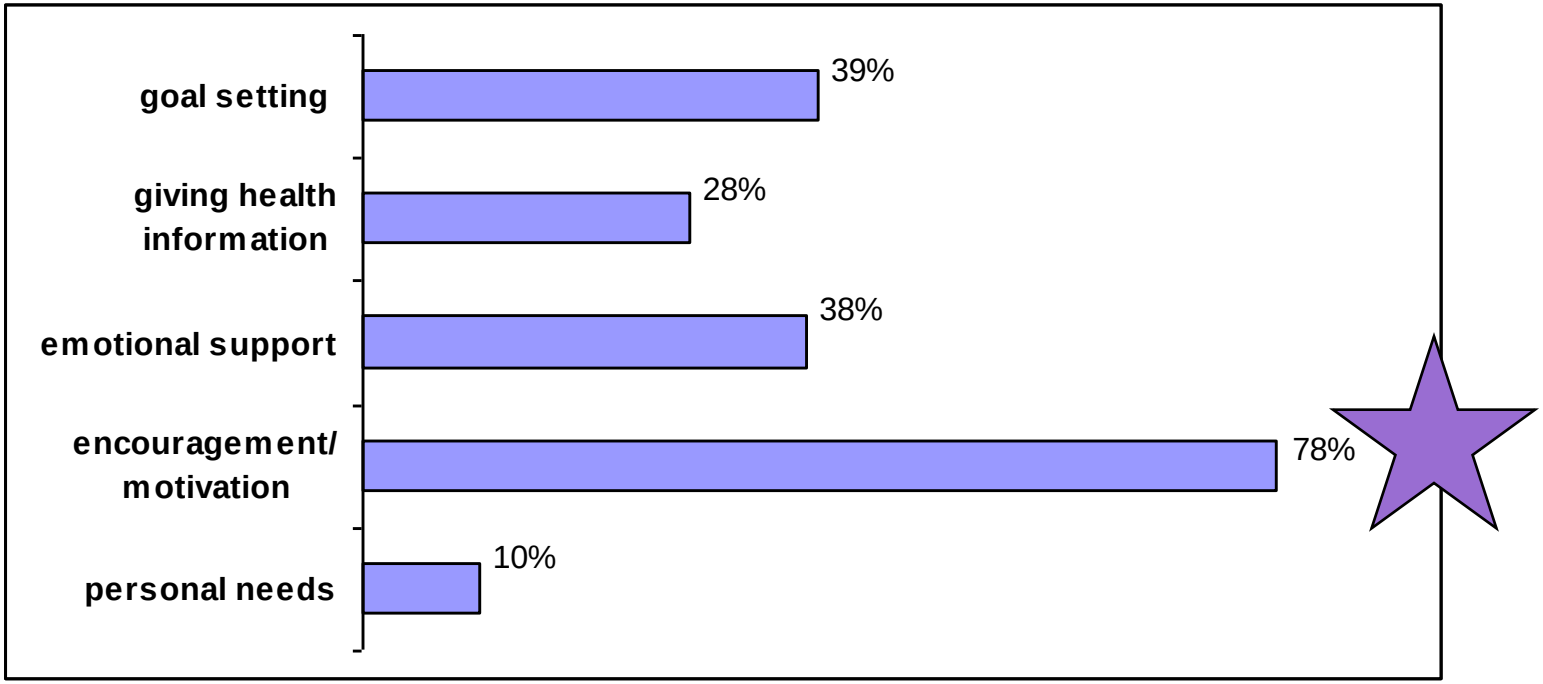
80%

- 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)

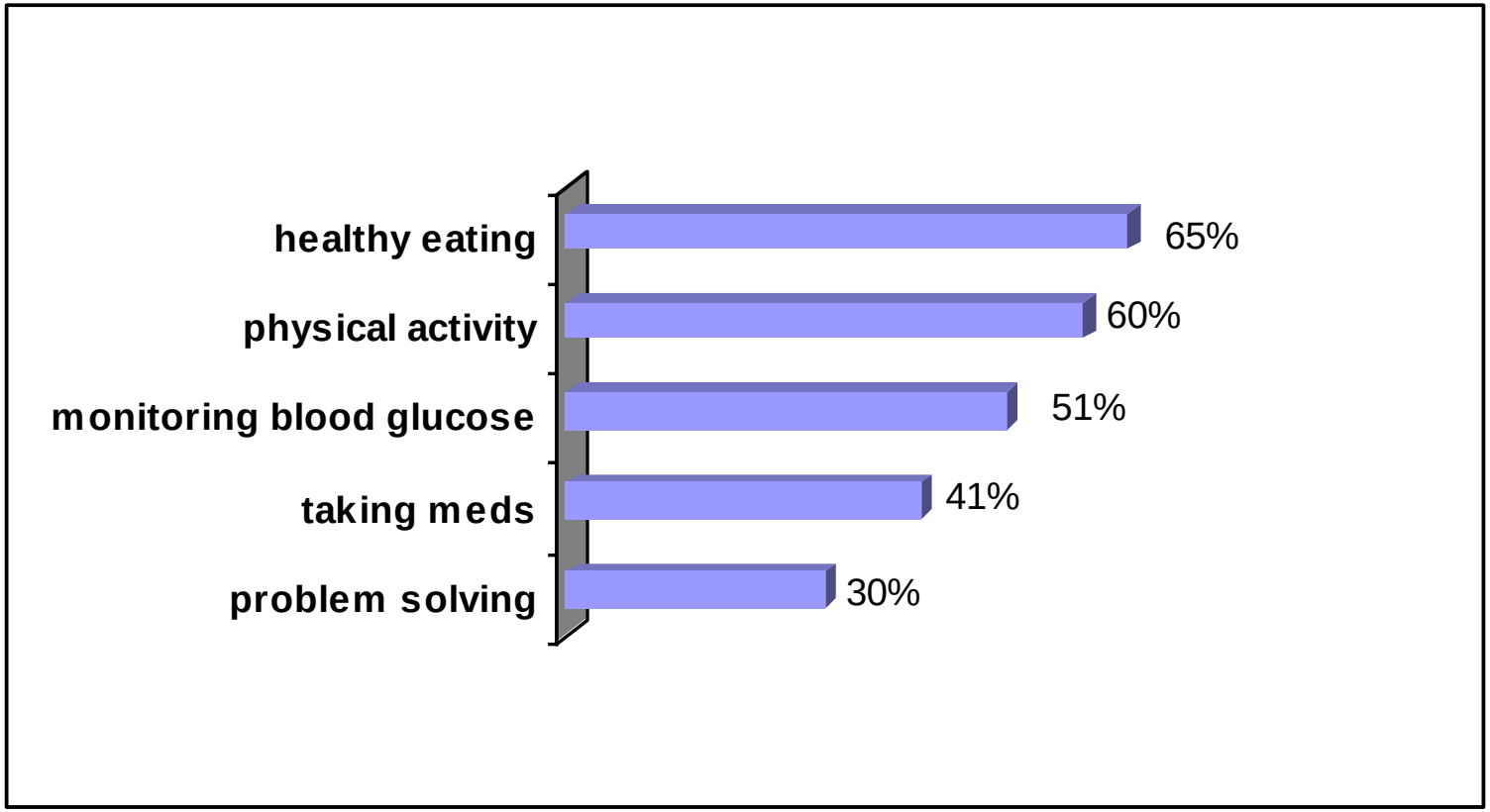
Focus of Individual Contacts
(1964 contacts)



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



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



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?

- **Babamoto** K, et al, 2009.
- **Brownstein** JN, Norris SL, Chowdhury FM, Armour T, Jack L, Zheng X, Satterfield D. Effectiveness of community health workers in the care of persons with hypertension. Am J Prev Med. 2007' 32(5)435-447.
- **Fedder** D, et al, 2003.
- **Krieger**, J. W., Collier, C., Song, L., & Martin, D. (1999). Linking community-based blood pressure measurement to clinical care: A randomized controlled trial of outreach and tracking by community health workers. American Journal of Public Health, 89(6), 856-861.
- **Krieger**, J. W., Takaro, T. K., Song, L., & Weaver, M. (2005). The Seattle-King County Healthy Homes Project: A randomized, controlled trial of a community health worker intervention to decrease exposure to indoor asthma triggers. American Journal of Public Health, 95(4), 652-659.
- **Norris** SL, et al, 2006.

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.

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~