Expanding Diabetes Prevention and Management Through Health Center Outreach

Session 2: Community Health Workers (CHWs): Strong Evidence-Based for Embracing CHWs into the Public Health and Healthcare

March 29, 2021

Housekeeping Items

- All participants muted upon entry
- Cameras on (if possible)
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email within a week after session

Access to Moodle

- Materials related to LC will be available through this platform
- Visit Moodle.nchph.org select “Expanding Diabetes Prevention and Management Through Health Center Outreach Learning Collaborative”
- Create account
- Detailed instructions on how to access materials included in our “Welcome Packet”

ABOUT US

National Center for Health in Public Housing

Training and Technical Assistance

Research and Evaluation

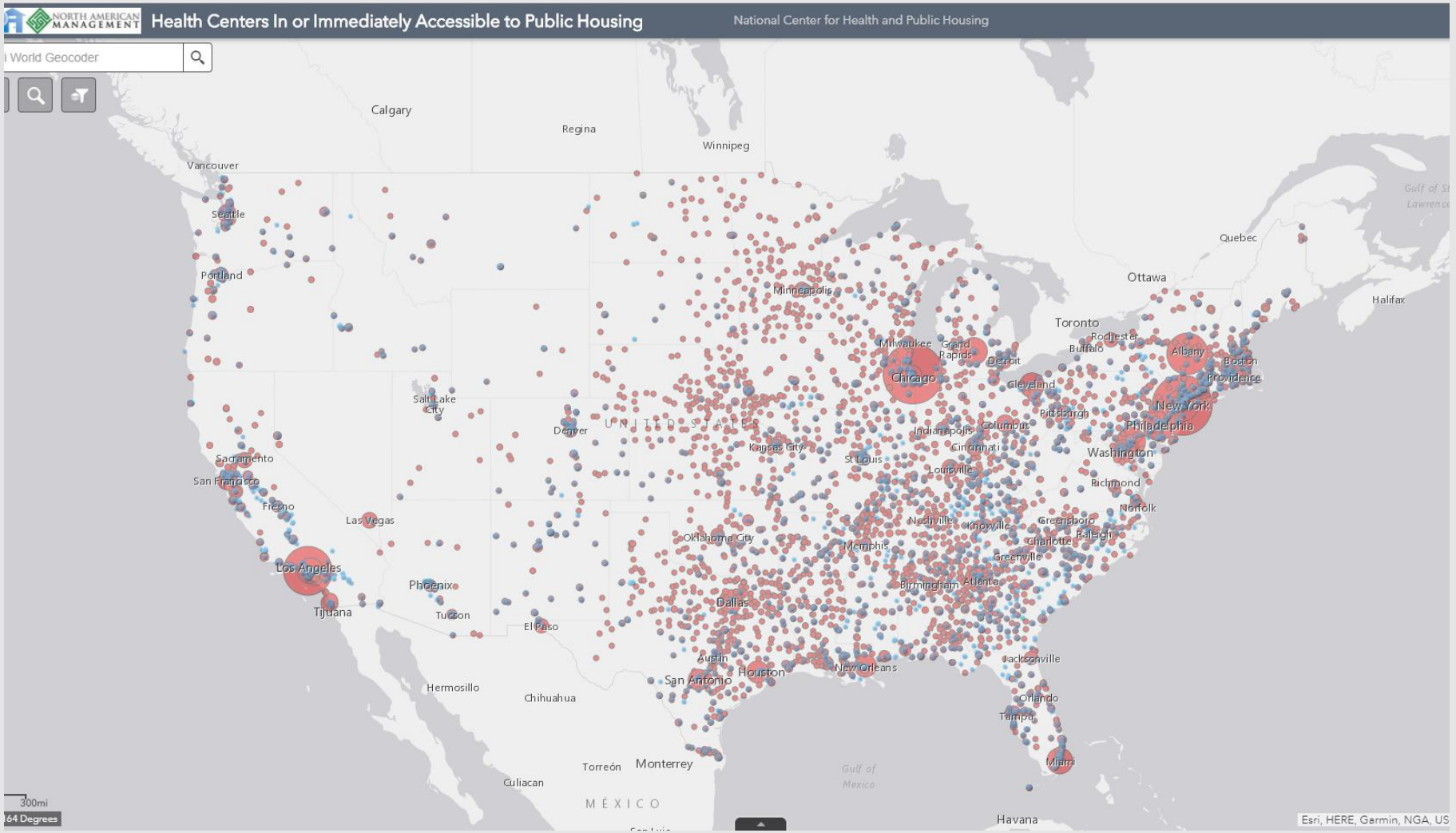
Outreach and Collaboration

Increase access, quality of health care, improve health outcomes, and improve health equity for public housing residents

This webinar is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $2,004,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Chat Icebreaker:

- Name and role
- Health center name
- Health center location and number of sites

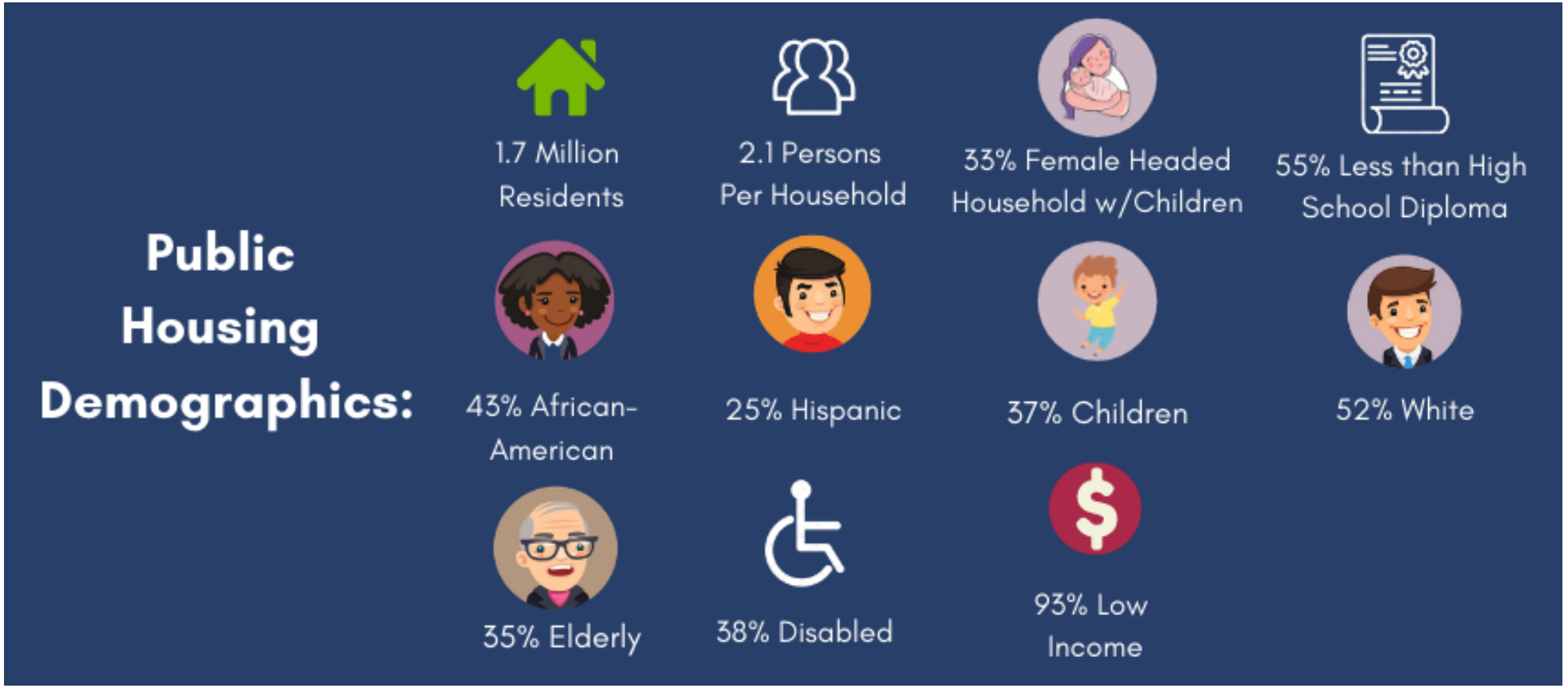


1,400 Federally Qualified Health Centers (FQHC)=30 million

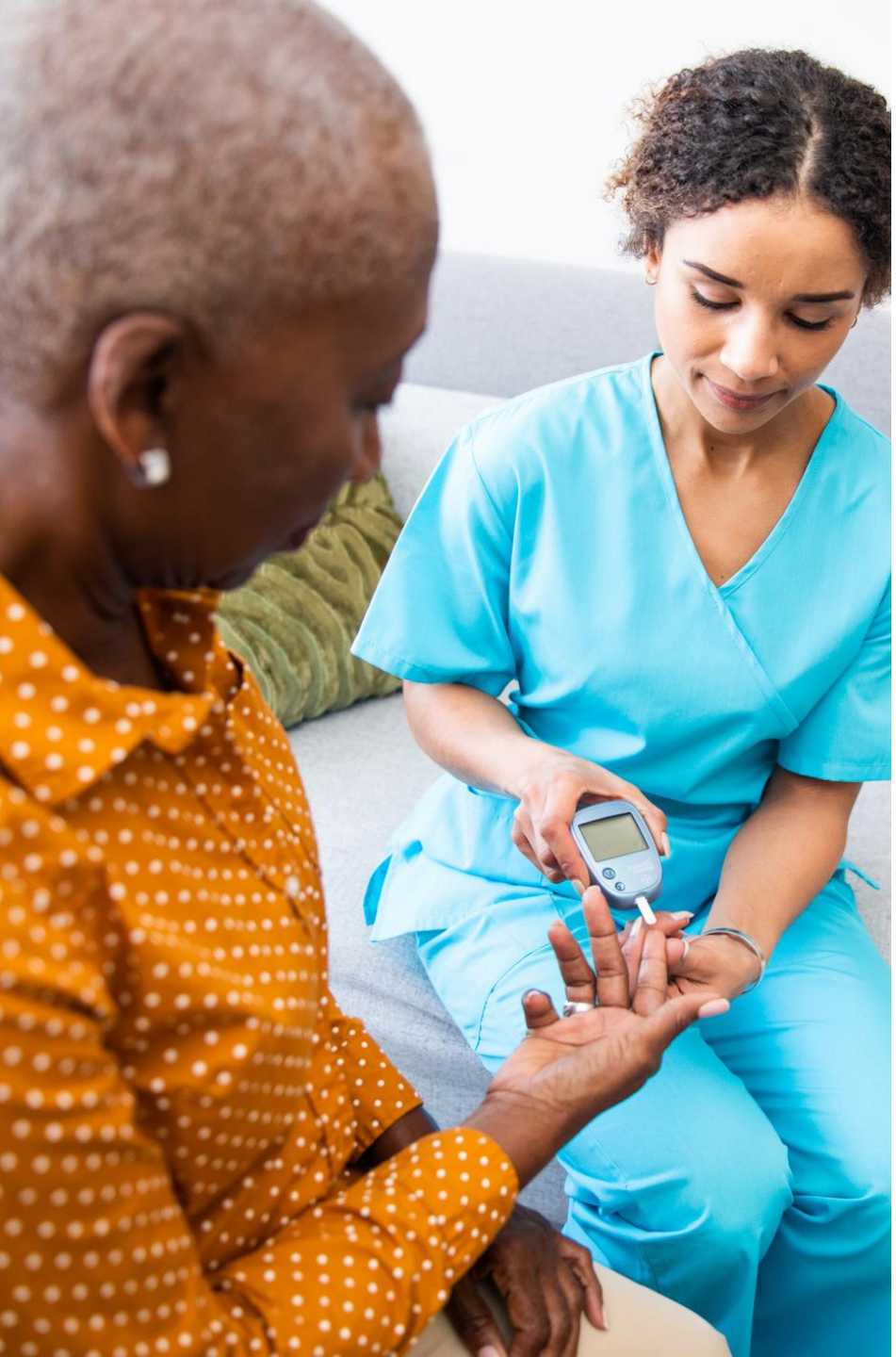
433 FQHCs near Public Housing= 5.2 million patients

108 Public Housing Primary Care (PHPC) = 856,191 patients

In 2020, there were roughly 1.7 million residents of public housing. Approximately 93% were living below poverty, 33% were headed by a single female, 37% of the households had children, and 38% had a member that was disabled. (Source: HUD)



Source: HUD Resident Characteristics 2020



Diabetes in Health Centers

- 2,709,755 (9.08 %) Health Center (HC) patients with diabetes
- 82,351 (9.6%) of Public Housing Grantee patients with diabetes

Source: 2019 National Health Center Data

Community Health Workers (CHWs): Strong Evidence-Based for Embracing CHWs into the Public Health and Healthcare

Learning Objectives:

1. Summarize the Community Preventive Taskforce (CPSTF) Recommendations for Interventions Using Community Health Care Workers.
2. Explain the Roles and Competencies that CHWs can Play in Diabetes Prevention
3. Discuss Action Steps to Capture the Contribution of CHWs in Their Individual Settings

Overview of the Community Health Care Worker Field

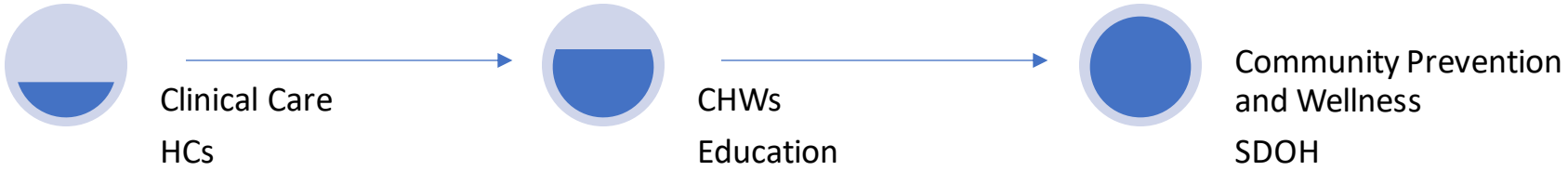
- Who are CHWs?
- What do they do?
- Where do they work?
- What are some of the Milestones in the Workforce?

Case Study

- A.B. is a retired 69-year-old man with a 5-year history of type 2 diabetes. Although he was diagnosed in 2013, he had symptoms indicating hyperglycemia for 2 years before diagnosis. He had fasting blood glucose records indicating values of 118–127 mg/dl, which were described to him as indicative of “borderline diabetes.” He also remembered past episodes of nocturia associated with large pasta meals and Italian pastries. At the time of initial diagnosis, he was advised to lose weight (“at least 10 lb.”), but no further action was taken.
- Referred by a nurse to the health center with recent weight gain, suboptimal diabetes control, and foot pain. He has been trying to lose weight and increase his exercise for the past 6 months without success.

Community Health Care Workers

- CHWs serve as our bridge to healthy communities
- CHWs help to bridge healthcare and public health



Community Health Care Workers Serve a Unique Value in Health Care and Public Health Systems

- CHWs spend more time with individuals or families in home, community, or clinical settings.

- CHWs possess the 3 C's of Community:
  - Connectedness
  - Credibility
  - Commitment

CHW Definition

Frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

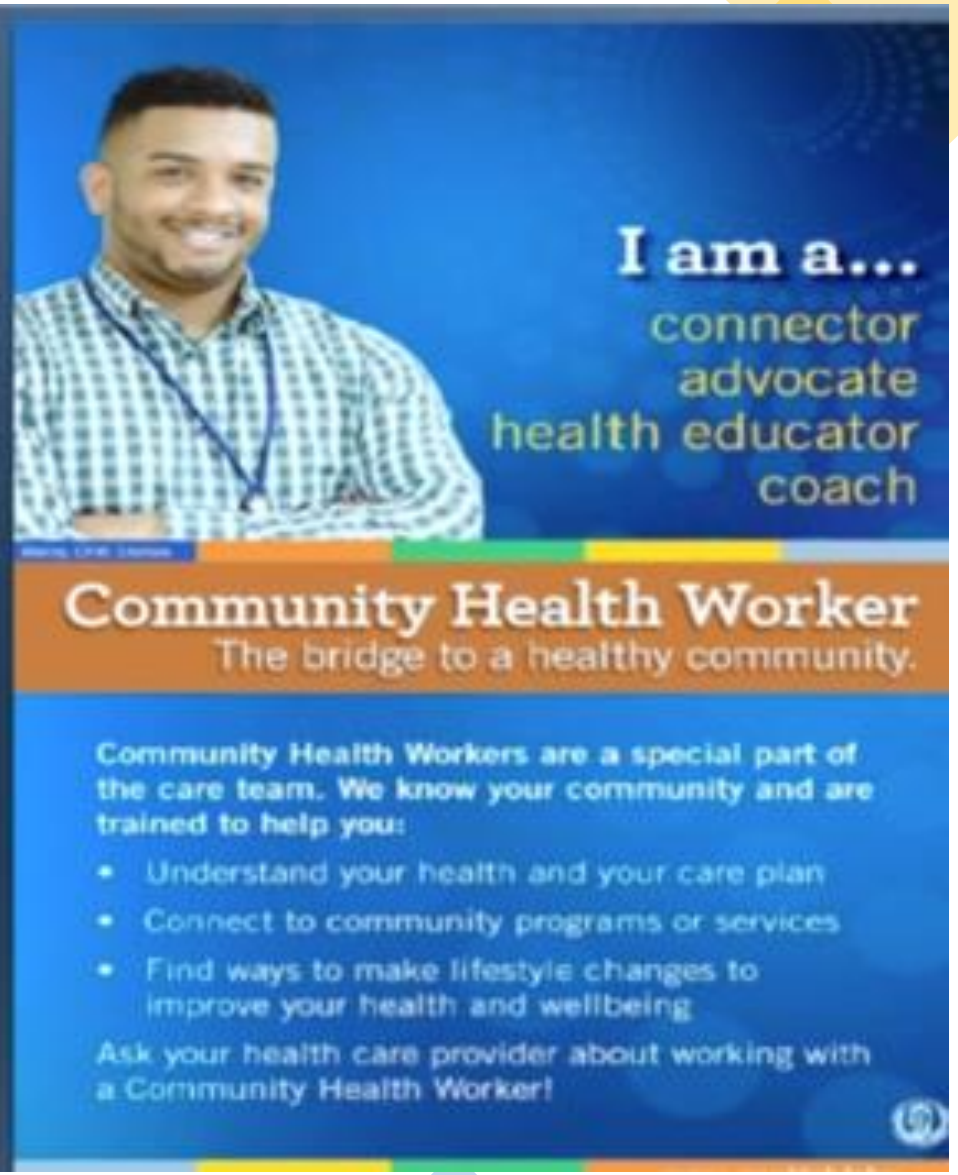
Source: American Public Health Association

Who are Community Health Workers?

- Promotor(a) de salud
- Peer leader
- Outreach educator
- Community health advisor
- Home visitor
- Street outreach worker
- Outreach advocate
- Patient navigator
- Peer advocate
- Community coordinator
- Family service coordinator
- Community health representative

CHWs are distinguishable from other health professionals because they:

- Are hired for their understanding of populations and communities they serve
- Conduct outreach as a significant portion of their time
- Have experience providing services in and across community and clinical settings



Community Resource Experts

- Navigator
- Chronic disease manager
- Benefit expert
- Health educator
- Counselor

C3 CHW Roles

- Cultural Mediation
- Providing Culturally Appropriate Health Education & Information
- Care Coordination, Case Management, & System Navigation
- Providing Coaching & Social Support
- Advocating for Individuals & Communities
- Building Individual & Community Capacity
- Providing Direct Service
- Implementing Individual & Community Assessments
- Conducting Outreach
- Participating in Evaluation & Research

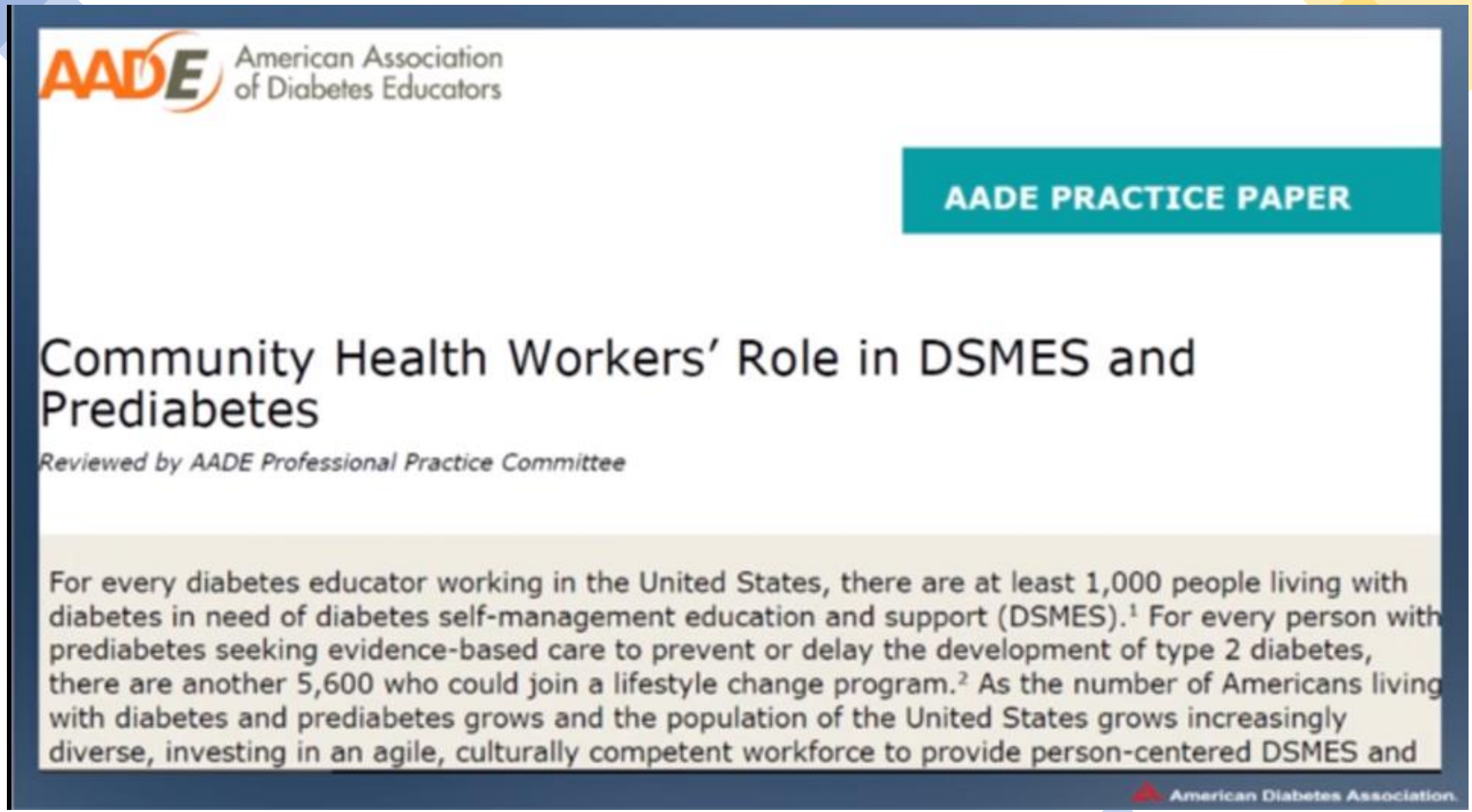
New (up form sub roles) or significant modification during C3

What CHWs Do on a Team?

- Complement existing team members
  - CHWs do not replace existing care team members
- Bridge between the community and clinic
  - Often based in one location but work in other locations
- Address social determinants of health in a unique way from other care team members
  - Convey patient/client backgrounds, constraints, and preferences in a culturally appropriate way
  - Identify client barriers including housing, transportation, education, literacy

Allen, C.G., Escoffery, C., Satsangi, A., Brownstein, J.N. (2015). Strategies to improve the integration of community health workers into health care teams: "A little fish in a big pond." *Preventing Chronic Disease*, 12(E154):1-10.

Findley, S., Matos, S., Hicks, A., Chang, J., Reich, D. (2014). Community health worker integration into the health care team accomplishes the Triple Aim in a patient-centered medical home: a Bronx tale. *J Amb Care Manage*, 37(1):82-91.


AADE
American Association of Diabetes Educators
AADE PRACTICE PAPER
Community Health Workers' Role in DSMES and Prediabetes
Reviewed by AADE Professional Practice Committee
For every diabetes educator working in the United States, there are at least 1,000 people living with diabetes in need of diabetes self-management education and support (DSMES).[1] For every person with prediabetes seeking evidence-based care to prevent or delay the development of type 2 diabetes, there are another 5,600 who could join a lifestyle change program.[2] As the number of Americans living with diabetes and prediabetes grows and the population of the United States grows increasingly diverse, investing in an agile, culturally competent workforce to provide person-centered DSMES and
American Diabetes Association.

Diabetes Prevention: Interventions Engaging Community Health Workers

The Community Preventive Services Task Force (CPSTF) recommends interventions that engage community health workers for diabetes prevention to improve glycemic (blood sugar) control and weight-related outcomes among people at increased risk for type 2 diabetes.

Interventions Focusing on improvements in :

- Diet
- Physical Activity
- Weight Management
- Smoking Cessation

Recommended Strategies by CPSTF

Health Education

- Diabetes Prevention
- Lifestyle Modification
- Extended Support to individuals at high-risk for diabetes

Settings:

- One-on-one interactions
  - Home visits
  - Group Sessions (Intervention teams)

Outcomes of 22 Studies

- Improve Health
- Reduce Health Disparities
- Enhance Health Equity

Research – Focus Areas

- Outcomes Related to Diabetes Control and Weight
- CVD Risk Factors
- Health Behavior Change:
  - Physical Activity
  - Nutrition

Importance of the CPSTF Recommendations

- Around 29 Million American Have Diabetes and 1/3 prediabetes
- Seventh cause of death – 20% of health care spending
- **CHWs are able to provide patients with culturally appropriate information and education on diabetes prevention, lifestyle counseling, and informal counseling and social support. They are also able to conduct home visits to ensure patients get the services they need.**

CHWs Role in Diabetes

CHW Roles	Sub-Roles	Examples/Relation to Diabetes
Cultural Mediation	➔ Navigating health and social service systems ➔ Addressing community and cultural norms ➔ Increasing health literacy and cross- cultural communication	➔ Address community perspectives and/or misconceptions on diabetes medications and management. ➔ Explain how medical processes, such as medical appointments, work in the U.S. Immigrant patients may be accustomed to walk-in medical services and may, therefore, miss their appointments.
Culturally Appropriate Education	➔ **Health promotion, disease prevention, and health condition**	➔ **Motivate and support healthy behavior change using culturally appropriate educational methods.**

	management	For example, some cultures and religious groups cannot partake in dance, such as Zumba, as a form of physical activity, while others might prefer it. ➔ Use a variety of educational methods to reach patients from various cultural backgrounds. For example, when CHWs work with patients to improve eating habits, they must be familiar with traditional cultural dishes and healthy replacements their patients will actually use.
Care Coordination, Case Management, and Systems Navigation	➔ Making health referrals and providing follow-up ➔ Helping address barriers to services	➔ **Help patients schedule appointments and check insurance coverage.** ➔ **Provide assistance with application completion and procurement of documents for services needed. For example, helping patients enroll to health insurance.** ➔ **Provide assistance care coordination. For example, planning transportation to and from appointments, etc.** ➔ **Maintain constant communication with patients with diabetes to support tracking health outcomes. For example, CHWs visiting the patient to monitor blood sugar levels regularly.**
Coaching and Social Support	➔ **Motivating people to access healthcare** ➔ **Supporting behavior change** ➔ **Facilitating support groups and informal counseling**	➔ **Help patients see their health as a priority. For example, in many cultures, women are the caregivers of others and not used to taking care of themselves.** ➔ **Help patients set culturally appropriate SMART (specific, measurable, achievable, relevant, time-bound) health goals** ➔ **Provide social support and listen to patients' concerns. For example, oftentimes immigrants, may feel socially isolated and CHWs can provide companionship and help**

				motivate patients to manage diabetes.
Non-Health Referrals	→	Referring individuals to community support agencies	→	**Provide domestic violence referrals. For example, if someone is in a violent relationship, they are likely unable to monitor their diabetes.** → **Provide financial assistance referrals. For example, if someone is struggling to afford rent or their mortgage, they are unlikely to be able to pay for medical services, medicine, or healthy food.** → **Refer patients to legal aid to receive assistance with legal matters. For example, if a patient is experiencing legal issues the stress caused could reflect on their health.**
Advocacy	→ →	Identifying community needs and resources Advocating for individual clients and communities	→	**Advocate for healthier options in their community. For example, petitioning for local supermarket with healthy food options or adding lighting to local park to increase security.** → **Supporting patients advocate for themselves with health care providers when they have differing ideas for their treatment.** → **Attend medical appointments with patients. For example, accompanying patients to ensure that their doctor is conducting the appropriate examinations, such as foot exams, at every visit and referring to perform eye exams annually.** → **Helping a patient advocate for themselves with health care providers if/when they disagree with a treatment recommendation.**
Building Capacity	→ →	**Building individual and community capacity** **Training with CHW peers and among networks**	→	**Encourage patients with diabetes to identify and use available resources to meet their needs and health goals. For example, showing patients how to locate and utilize information regarding local health**

			events. ➔ **Build patient's self-efficiency and self-efficacy. For example, teaching patients how to check and monitor their own blood sugar levels.**
Needs Assessments and Environmental Scans	➔ Conduct community needs assessments ➔ Conduct patient needs assessments		➔ **Conduct assessments to identify the needs of the community. For example, connecting with people living with diabetes and identifying their specific needs to develop effective programs and/or initiatives.** ➔ **Conduct environmental scans to identify and catalog the community services and resources relevant to chronic disease management and prevention**
Outreach	➔ Meet people/patients where they are by building relationships based on listening, trust, and respect ➔ Establish and maintain relationships with community organizations to provide patients with access to social resources.		➔ **Conduct community outreach. For example, establishing local gathering spaces to encourage individuals to access health and social services.** ➔ **Recruit patients for health programs or interventions. For example, recruiting potential participants to participate in diabetes management educational sessions.** ➔ **Increase the visibility of a health center or CHW service within the community. For example, participating in community health fairs and local events.**
Evaluation	➔ **Collect data** ➔ **Provide culturally appropriate insight to data interpretation** ➔ **Share results and findings with the community**		➔ **Collect pre/post-test data, conduct interviews, and other data about diabetes to demonstrate program effectiveness.** ➔ **Assist an organization or research team to better understand data trends. For example, CHWs may be aware of external factors affecting diabetes patients' participation in educational classes or programs.**

Case Study

- A.B. is a retired 69-year-old man with a 5-year history of type 2 diabetes. Although he was diagnosed in 2013, he had symptoms indicating hyperglycemia for 2 years before diagnosis. He had fasting blood glucose records indicating values of 118–127 mg/dl, which were described to him as indicative of “borderline diabetes.” He also remembered past episodes of nocturia associated with large pasta meals and Italian pastries. At the time of initial diagnosis, he was advised to lose weight (“at least 10 lb.”), but no further action was taken.
- Referred by a nurse to the health center with recent weight gain, suboptimal diabetes control, and foot pain. He has been trying to lose weight and increase his exercise for the past 6 months without success.

Assessment

Based on A.B.'s medical history, records, physical exam, and lab results, he is assessed as follows:

- Uncontrolled type 2 diabetes (A1C >7%)
- Obesity (BMI 32.4 kg/m^2)
- Hyperlipidemia (controlled with atorvastatin)
- Peripheral neuropathy (distal and symmetrical by exam)
- Hypertension (by previous chart data and exam)
- Elevated urine microalbumin level
- Self-care management/lifestyle deficits
    - Limited exercise
    - High carbohydrate intake
    - No SMBG program
- Poor understanding of diabetes

Case Study Discussion

- How would you address the patient's poor understanding of diabetes?
- How would you help your patient with his obesity and hypertension problems?
- What community and education resources would you recommend to your patient?
- What sociodemographic factor would you explore in your patient?

Next Session

- **Session 3:** What Community Health Care Workers Need to Know About Addressing Diabetes & Food Insecurity: Resources for Communities in Need
- April 5, 2021 at 1pm EDT through Zoom
- Registration link:

https://zoom.us/meeting/register/tJErcOqqrzwqG9ZQWZNmhv8UkkrkMnTxvnDp

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