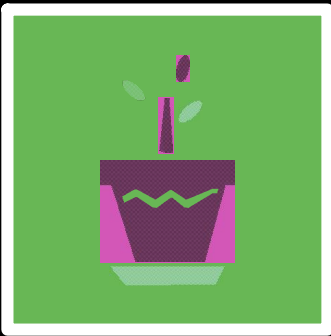


This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation in Princeton, New Jersey.



Community Health Workers in The Robert Wood Johnson Foundation *Diabetes Initiative*

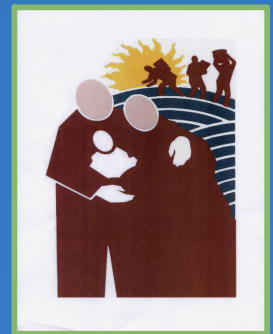


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32nd AADE Annual Meeting

August 13, 2005



The Robert Wood Johnson Foundation Diabetes Initiative

Enhancing access to
and promoting self management
as part of quality diabetes care
through primary care and community settings



**Advancing
Diabetes
Self Management**



**Building
Community Supports
for Diabetes Care**

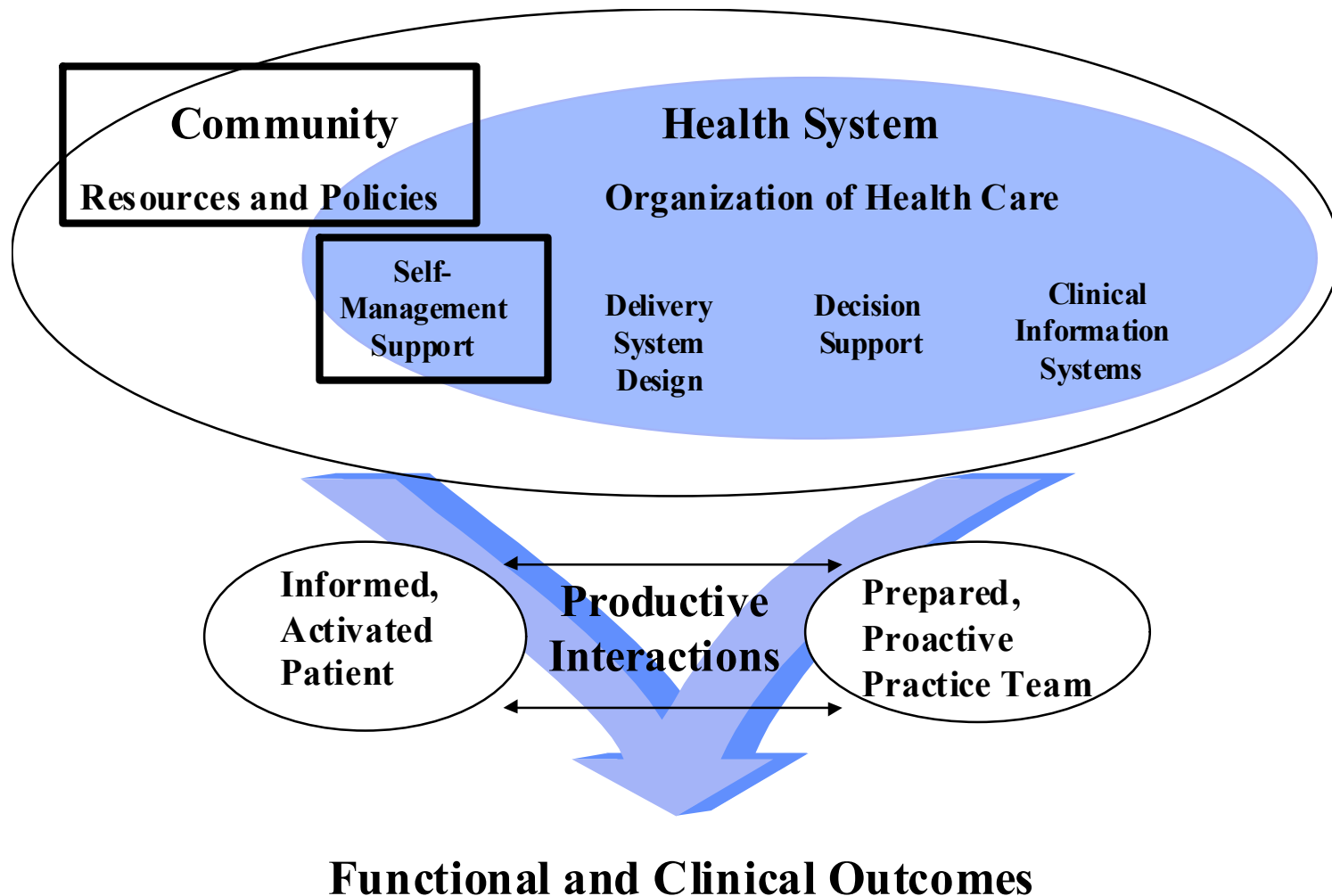


Overview of Diabetes Initiative

- Phase I: 15 month pilot projects funded Feb 2003
- Phase II: 30 month intervention projects phase began May 2004
- 14 demonstration projects
 - 6 based in primary care settings
 - 8 community supports grants (2 also in primary care settings)
- Administered by a National Program Office (NPO) located at the WU School of Medicine in SL
- External evaluator: RTI



Wagner's *Chronic Care Model*





Three Key Aspects of Chronic Disease Management that shaped the Initiative

1. Centrality of behavior
2. In every part of daily life—“24/7”
3. For the rest of your life



Self Management is the Use of Skills to:

- Deal with the health condition
- Continue normal daily activities and roles
- Manage the changing emotions brought about by dealing with a chronic condition

The goal of self-management is to achieve the highest possible functioning and quality of life....no matter where along the path a person starts.



Framework for the Diabetes Initiative: Resources and Supports for Self-Management

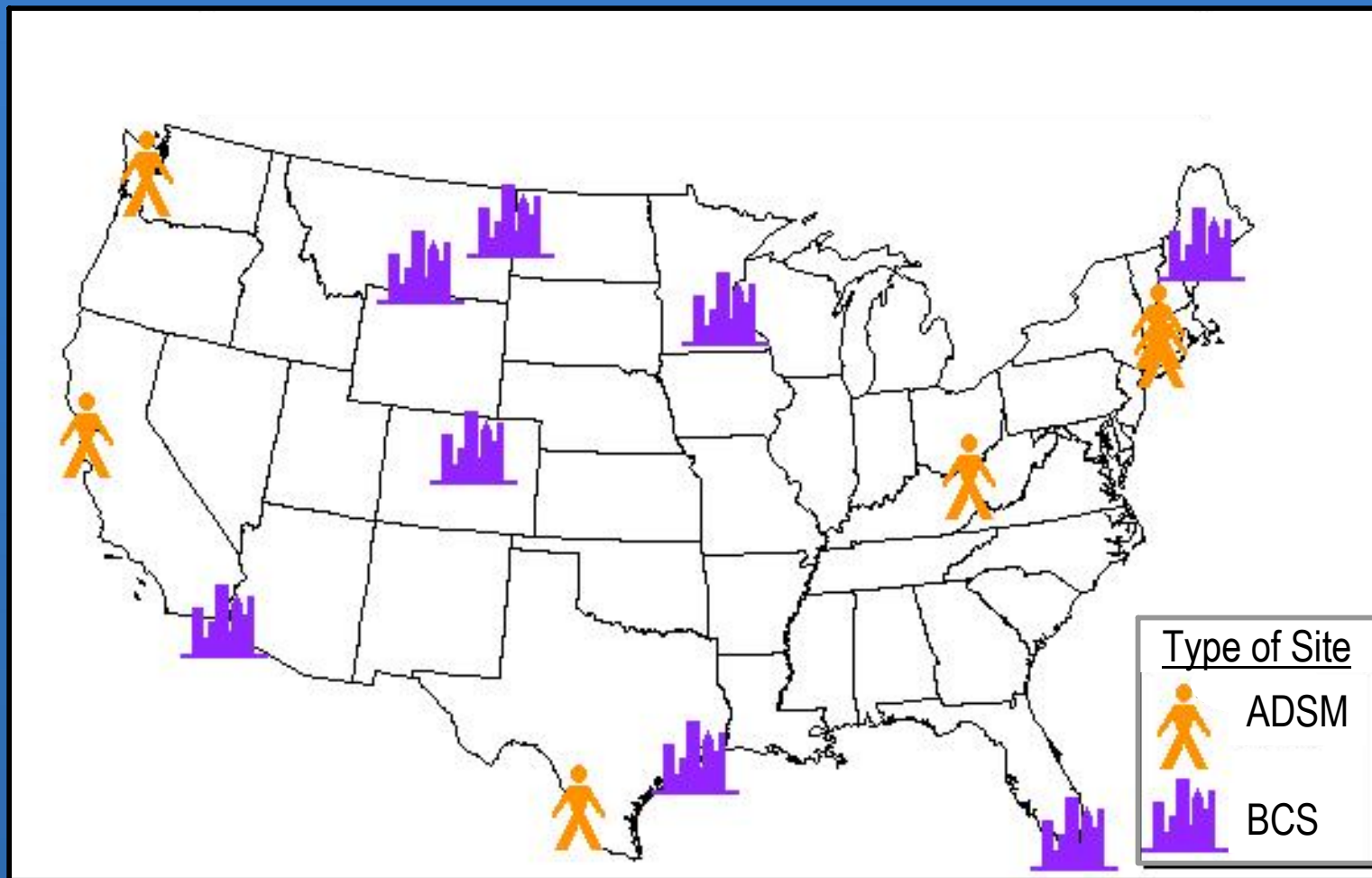
- Individualized assessment
- Collaborative goal setting
- Assistance in learning self-management skills, including healthy coping
- Follow-up and support
- Access to resources for healthy lifestyles
- Access to high quality clinical care
- Continuity of care



Diabetes Initiative and Ecological Perspectives on Self Management



RWJF Diabetes Initiative Sites





Addressing These Issues...

Self Management is
the key to good
control of diabetes



And CHWs play an
important role...



Community Health Workers

- Known by many different names
- “Natural helpers” historically active in all cultures
- Not new to health care
- Resurgence in 90s
- Range of activities and roles as diverse as titles
- In 1998, survey documented 12,500 CHWs in the US across a number of programs
- Few studies evaluating impact/ effectiveness, particularly in chronic diseases like diabetes



Definition of a lay health worker...

- Many and varied, but generally
 - Carry out functions related to health care delivery
 - Trained in some way in the context of the intervention
 - Having no formal professional or paraprofessional certificate or degree
- In the US, the primary role of CHWs is to fill the gap in the health care system that is particularly acute among underserved communities



Key roles of lay health workers

The National Community Health Advisor Study, conducted by the University of Arizona and the Annie E. Casey Foundation reached almost 400 CHWs across the country to help identify the core roles, competencies, and qualities of CHWs. The following seven core roles were identified:

- Bridging cultural mediation between communities and the health care system;
- Providing culturally appropriate and accessible health education and information, often by using popular education methods;
- Assuring that people get the services they need;
- Providing informal counseling and social support;
- Advocating for individuals and communities within the health and social service systems;
- Providing direct services (such as basic first aid) and administering health screening tests; and
- Building individual and community capacity.



Variation Across Diabetes Initiative Sites

<u>Site</u>	<u>Audience</u>	<u>Area</u>	<u>Setting</u>	<u>CHW title</u>
AZ	H	Town/rural	Community	Promotora
WV	W/ AA	Rural Appalachia	Clinic/ Community	Community Health Outreach Worker
Galveston	W/AA/ H	County	Community	Coach
Laredo TX	H	Urban/ County	Clinic	Promotora
MA	H	Urban	Clinic	Promotora
CA	H	Urban	Clinic	Promotora
ME	W	Rural	Community/ Worksite	Lay Health Educator
CO	AA	Urban	Community	Community Health Advisor
MT	AI	Indian Country	Community	Community Health Representative
FL	H/AA/ Haitian	Town/rural	Clinic/ Community	Community Health Worker



History Of Lay Health Worker/ Promotora/ Coach Workgroup

- First conference call March 2003
- Facilitated discussion at grantee annual meeting in July to identify key topics of interest
- Between Dec and June 2004, hosted monthly conference calls on key topics of interest
- Hosted workgroup session at next grantee meeting on the relationship, and relationship building, between CHWs and CDEs (March 2004)
- Conducted survey of CHW programs in May 2004
- Current areas of focus for workgroup: role of CHWs in emotional health and evaluation of CHW interventions



Diabetes Initiative Survey of CHW Programs

- Lay health worker interventions are integral to ten of the 14 sites
- A written survey was administered to the sites in May 2004
- The objectives of the survey were to determine:
 1. area and population served by the CHWs
 2. roles, responsibilities and activities of CHWs
 3. mechanisms for delivery of program services
 4. recruitment and retention
 5. training and certification
 6. client recruitment methods
 7. program evaluation strategies



1. Area and Population Served

- Urbanized area (population >40,000) – 3 sites
- Rural area (population >40,000) – 2 sites
- Both urban and rural area – 2 sites
- All sites served both men and women
- All sites served adults above the age of 22
- 2 sites also served adolescents



2. Roles and Activities of CHWs



- Bridging/cultural mediation between communities and the health and social services systems – all sites
- Providing culturally appropriate health education and information – 6 sites
- Assuring that people get the services they need- all sites
- Providing informal counseling and social support – all sites
- Advocating for individuals and for community needs – 6 sites
- Building individual and community capacity – all sites
- Leading exercise groups – 2 site
- Social marketing strategy to encourage behavior change – 2 sites



3. *Delivery of Program Services*

- Client's home – 5 sites
- Community activity or health center – 5 sites
- Faith-based organization -4 sites
- Migrant camp – 1 site
- On the street/not defined- 2 sites
- Public Health Clinic – 4 sites
- Work site – 3 sites





4. *Recruiting and Retention of CHWs*

- Methods used to recruit LHWs
 - Newspaper Advertisement – 2 sites
 - Networking with other LHW programs – 2 sites
 - Referrals from providers and other professionals – 4 sites
 - Word of mouth – 4 sites
- Methods used to recognize LHWs
 - Certificate from program – 5 sites
 - Graduation ceremony – 1 site
 - Promotions – 3 sites
 - Wage increase – 2 sites
 - Recognition ceremonies – 5 sites
- Compensation varies across site (volunteer – paid with benefits)



5. Training of CHWs

- Once hired all sites require their LHWs to go through initial orientation and continuing education or training.
- LHWs are trained by either the LHW supervisor or health professional
- Examples of skills the LHWs are trained in are:
 - Ability to access resources
 - Coordination of services
 - Crisis management
 - Knowledge of medical services
 - Knowledge of social services
 - Leadership
 - Organizational skills
 - Interpersonal communication skills
 - Disease prevention and management
 - 7 of these 10 are trained in the CDSM program from Stanford (Kate Lorig)





6. *Client Recruitment Methods*

- Newspapers – 3 sites
- Referrals from other agencies or health care providers – 6 sites
- Recruitment through screening programs – 4 sites
- Recruitment through outreach activities – 4 sites
- Flyers/poster/brochures – 5 sites
- Churches and other nonprofit agencies – 4 sites
- Word of mouth – all sites





7. *CHW Program Evaluation*

- All sites currently have plans in place to evaluate their CHW intervention and most have identified some evaluation methods and tools
- Most sites were using private consultants or university personnel to conduct the evaluation
- Six sites expressed interest in working with the National Program Office on shared evaluation



A few examples....

- Gateway Community Health Center, Laredo TX*
- Holyoke Health Center*
- LaClinica de La Raza, Oakland CA*

- Open Door Health Center, Homestead FL*
- New River Health Center, WV*

- Campesinos Sin Fronteras, Somerton AZ*
- Galveston County Health District
- Maine General Health, Waterville ME*
- Metro Denver Black Church Initiative*
- MT-WY Tribal Leaders Council



Promotoras at Gateway Community Health Center in Laredo TX

- Facilitate self-management classes
- Screen patients for depression using PHQ9
- Provide individual counseling
- Lead support groups
- Conference with providers



Gateway Community Health Center Program Overview

Goal: To build a consistent infrastructure and methodology that will assist patients with diabetes to maintain their HbA1c below 7.5% over an extended period of time by implementing and integrating diabetes self-management activities in a culturally sensitive manner.

Gateway involved all components within the Center to integrate the implementation of the self management intervention into the Center's medical practice.

Components

- Patients
- Promotores
- Medical Providers
- Certified Diabetes Educator
- Medical Support Staff
- Administrators
- Board of Directors





Promotor(a) Roles and Responsibilities

- Provide informal counseling, social support and culturally sensitive health education;
 - Advocate for patient needs;
 - Assure that patients receive the health services they need and provide referral and follow-up services.
 - Assist and guide the patient in the management of their disease process.
- The promotor(a) is considered part of the medical team and plays a key role on the delivery of Diabetes Self Management.**



Gateway Diabetes Self Management Intervention Flow Chart

Medical Provider Refers Patient to Promotora

Intervention Begins

10-week Promotora-Led SM Course (2.5 hours/week)

- Baseline Behavior and Lab Assessment (knowledge, health beliefs, PHQ9)
- Advise (Diet, Nutrition, Physical Activity)
- Advise (Prevention/Management DM Complications)
- Behavioral Goal-setting (individual) every week
- Buddy Support System (Choose and Support Buddy)
- Group Problem-solving Session Weekly (Barriers)
- Goal Follow-up weekly (revision/resetting of goals)
- Telephone call weekly (remind, answer questions, problem solve, support)

10-biweekly Support Group Sessions (2.5 hours each)

- Additional advise (diet, nutrition, physical activity)
- Additional advise (Prevention/Management DM Complications)
- Group Discussion to Problem-Solve Barriers
- Buddy Support System
- Individual Goal Follow-up
- Telephone call weekly (remind, answer questions, problem solve, support)

Intervention Ends

Voluntary Biweekly Support Group

Baseline Data

HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam, Flu vaccine, Pneumovax, Hospitalizations, ER visits, Knowledge & Health Belief, PHQ9

3-month Data

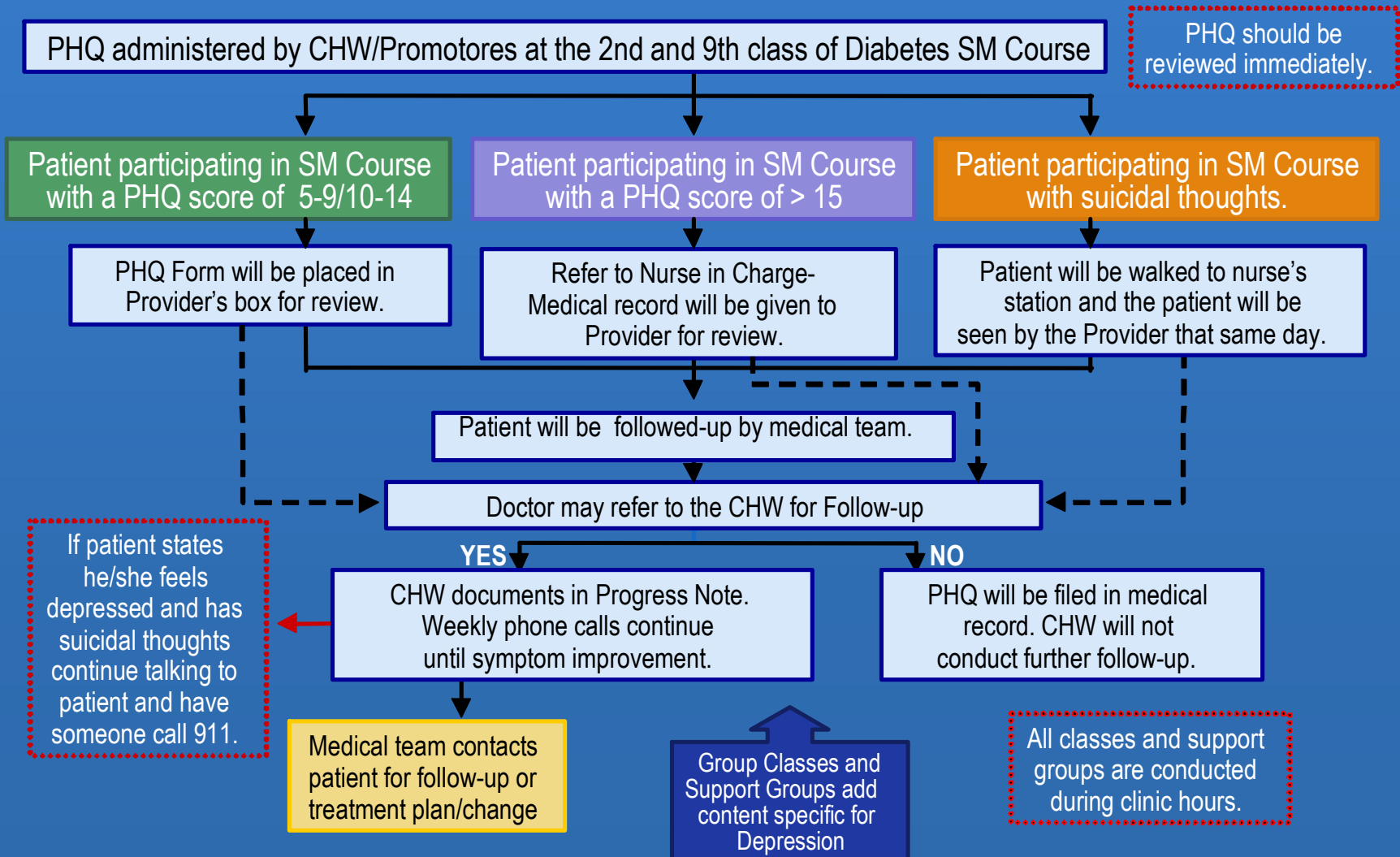
HbA1c, BP, BMI, Knowledge, Health Belief, Retention Rate, and Patient Satisfaction

6 & 12-month Data

HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam, Flu vaccine, Pneumovax, Hospitalizations, ER visits, Knowledge and Health Belief PHQ9



CHW Protocol for Depression – Gateway Community Health Center





La Clinica de La Raza: Oakland, CA

Promotoras in the ADSM Project:

- ◆ 11 Women recruited from La Clinica patient population
- ◆ All Latina with Spanish as first language
- ◆ 9 with diabetes; 2 with diabetic family members
- ◆ Five week training in diabetes basics, groups, empowerment, TTM
- ◆ Training phase included self-management goal-setting by promotoras themselves



La Clinica de La Raza: Oakland, CA

Promotora Activities:

- Enroll patients in program (10-15 patients /promotora)
- Stage patients in 4 main behavior areas at baseline and every 3 months
- Weekly 1:1 contact with patients; 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

Promotora activities:

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





New River Health Association: WV

- Community Health Outreach Worker (CHOW) Project
- Uses local people and builds on their interests and skills
- CHOWs provide education, support and resource referral to patients with diabetes and other chronic conditions
- Training and supervision are critical to success





New River Health Association: WV

CHOW activities:

- “Help Yourself” Self-management Classes
- Yoga Classes
- Link Between the Participant and Mental Health Providers
- Home Visits/ Phone Calls
- Exam Room Visits While Patient Is Waiting for the Provider
- Walking Group
- Diabetes Support Group
- Weight Loss Support Group





CHOW's lead isolated patients into groups

- Visit individually
- Offer group menu and help patients choose which is most appropriate
- Encourage them as valued participant
- Celebrate and honor success
- Develop leadership from within group
- Cultivate helping roles



Open Door Health Center: Homestead, FL

Role of Community Health Workers

Assist with:

Diabetes Support Groups & Classes

Cooking Classes & Grocery Tours

Diabetes Screening & Education

Patient Recruitment

Patient Referral for Services/Resources

Distribute Project Brochures/Flyers

Lead Walking Groups

Serve as a Liaison Between Project/Clinic Staff and Patient/ Family

Provide Peer Support via Phone Calls & Home Visits

Community Outreach





Campesinos Sin Fronteras: Somerton, AZ

Target audience: farmworkers

Promotoras are former farmworkers who provide...

- Education to families in their homes
- Individual counseling and problem solving
- Support groups
- Self management classes
- Outreach activities with farmworkers
- *Aminadoras*





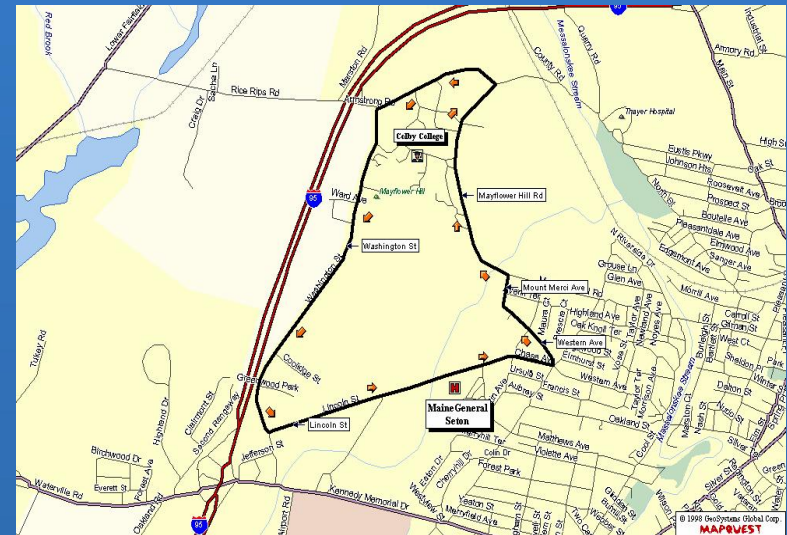
Galveston County Health District: TX

- A clinic setting conducting 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 throughout Galveston County



"Move More"

- **MaineGeneral Health's Move More Project**
- Lay Health Educators peer support
- 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
- Information about diabetes and physical activity





MaineGeneral Health: Waterville ME

What to Lay Health Educators Do?

- Give “natural” peer support to enrollees by walking with them, telling them about places to exercise, and giving them with free tools such as pedometers, weekly emails and information that helps motivate them.
- Give information to enrollees about other diabetes self-management education and support resources that are available in the Kennebec Valley Region.
- Some trained to lead self management classes





"Move More"

Where are Lay Health Educators located?

- Key clinical settings
- Worksites
- Faith Communities
- Other Community settings





Where are we now?

- Examining the role of CHWs in emotional health
- Evaluating impact of CHW interventions



CHW Program Evaluation: Phase 1

- 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



CHW Program Evaluation: Phase 2

- Structured Interviews beginning Fall 2005
 - Audiences
 - Participants/ patients
 - CHWs
 - CHW supervisors/ project coordinators
 - Outcomes of Interest
 - Satisfaction with services/ perceived benefits
 - Behavior change (participants and CHWs)
 - Health outcomes
 - Quality of life outcomes, e.g., social support



Key Roles of CHWs in Addressing Emotional Health

- Provide education and address myths and stigmas
- Teach coping skills
- Conduct assessments/ screen
- Encourage and assist with problem solving and goal setting
- Connect clients with resources/ encourage access to care
- Provide informal counseling and support
- Support treatment plan
- Monitor and follow up
- Prepare for dealing with emergencies
- Bridge cultural beliefs and language issues



Lessons Learned.....

- Involving the health care team in developing protocols/ roles for CHWs is key to program success (e.g., only clinicians can diagnose mental disorders)
- It is essential to establish clear roles and procedures for handling emergencies (e.g., suicidality)
- Educational materials and activities should be culturally and linguistically appropriate
- The unique relationship between the CHW and the client lends itself to addressing emotional health
- CHWs can serve as role models for healthy coping by taking care of themselves



Next steps

- Convene a workgroup! 😊
- Develop resource materials/ guidelines for CHW's role in emotional health



At the end of the day....

- We've learned some things so far, including....
 - All sites have grown from their opportunities to learn from each other. We all need to share our stories, network, and document our successes.
 - Their work is effective for those they serve and health enhancing for the CHW (Campesinos example)
 - CHWs have a unique role in health and health care that only they can do
- We still have much to learn, much to do, and much to report
- There are challenges!
- We are still having fun!



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Thank you!



CHW resources

- <http://www.famhealth.org/CHWResources/index.htm>
- <http://www.usm.edu/csho/>
- http://www.usm.edu/csho/program_links.html
- <http://www.chwnetwork.org/page5.html>
- <http://www.cdc.gov/diabetes/projects/comm.htm>
- <http://www.apha.org/legislative/policy/policysearch/index.cfm?fuseaction=view&id=254>
- <http://wahec.com/>