

COMMUNITY HEALTH WORKERS

Facilitators of Diabetes Self Management

www.diabetesinitiative.org

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COMMUNITY HEALTH WORKERS BRIDGE THE GAP

Studies have shown that people with diabetes who incorporate self management into their lives have an improved quality of life. One key component of many successful diabetes self management programs is the presence of a community health worker (CHW) as an ongoing resource for patients and physicians. CHWs assist with individualized assessment, goal setting, and teaching skills. They develop and maintain strong relationships with the populations they serve. They provide clients with social support that is critical to self management, including a flexible schedule that allows a greater ability to meet client needs. This trusting relationship lays the foundation for good self management.



The CHW reviews health education material that illustrates how self management is incorporated into daily life.

THE IMPORTANCE OF THE CHW

Because CHWs are immersed in the culture of those they serve, they are able to understand how a person's living environment and community influence their health behaviors and impact their access to and use of health resources.

CHWs provide culturally and linguistically appropriate outreach, follow-up monitoring, and social support. They extend and complement the efforts of the healthcare professional by empowering patients to acquire and apply self management skills that will improve disease management and quality of life in the settings of their daily lives.

CHWs are known by a number of titles, including promotores, coaches, lay health educators, outreach workers, etc. The range of activities and roles of CHWs are as diverse as their titles.

ROLES AND RESPONSIBILITIES OF CHWS IN THE DIABETES INITIATIVE

- Bridging cultural and language differences between community members and the health and social services systems
- Providing culturally appropriate and accessible health education and information
- Teaching and guiding practice of self management skills
- Leading classes and activities such as exercise groups
- Providing informal counseling and social support
- Promoting and recruiting participants to programs and services
- Follow up of progress and identification of needs for clinical care or self management education
- Providing assistance in accessing healthcare
- Making referrals
- Administering health-screening tests
- Making clients aware of their rights
- Advocating for individual and community needs within the health and social services systems

The **Diabetes Initiative of the Robert Wood Johnson Foundation** includes 14 projects around the United States, all demonstrating that self management of diabetes is feasible and effective in diverse, real-world settings. Specific lessons learned from the Initiative include:

- The importance of Community Health Workers in diabetes self management
- Approaches to depression, negative emotions and healthy coping in diabetes self management
- Approaches to providing ongoing follow up and support for self management, since diabetes is "for the rest of your life"
- How to develop effective partnerships between clinical and community organizations
- System and organizational factors to support self management programs in primary care settings

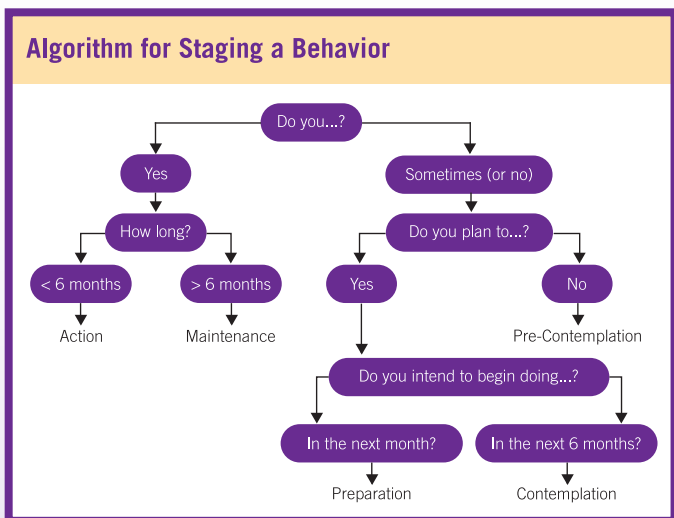
For more information, protocols, publications, and other materials, visit: www.diabetesinitiative.org

KEY LESSONS LEARNED...

USING THE STAGES OF CHANGE INTERVENTION MODEL

Health promoters (“promotoras”) at La Clinica de la Raza in Oakland, Calif., are trained peers – monolingual Spanish-speaking women who have diabetes or have a family member with diabetes. They provide individual counseling and lead or assist with group activities including diabetes education classes, Circle of Friends support group, depression group, walking club, and family home visits.

Diabetes project staff train health promoters to use the Stages of Change Model to work with patients in four key areas of diabetes self management: following a meal plan, doing physical activity, taking medications and monitoring blood sugar. They assess a patient’s readiness to make a change using this algorithm.



Materials were developed to coincide with patients’ readiness to change in the four areas. Some are publicly available at www.lumtera.com, and others will be posted soon.

The health promoters are fully accepted by providers and integrated into patient care teams, including participating in quarterly case conferences with providers. Their skills and expertise have spread beyond diabetes and are now being used in a project that targets parents of overweight children. Contact: La Clinica de La Raza Fruitvale Health Project, Inc. at 510-535-4000

INVOLVING CHWS EARLY ON

The Gateway Community Health Center, located in Laredo, Texas, incorporates community health workers into the medical practice early on so that CHWs are able to work more closely with patients.

Through group classes and individual support, the CHWs become the main point of contact for a patient after development of a treatment plan and in between doctor

follow-up visits. Another aspect of the community health worker intervention includes PHQ9 assessments that are administered near the beginning and end of a 10-week self management course. This assessment allows CHWs to incorporate depression management into the self management training, helping patients to be more informed and better equipped to successfully live with their diabetes. Contact: Gateway Community Health Center at 956-795-8140

BENEFITS OF INCORPORATING THE CHW EARLY

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 success
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

EMPLOYING COMMUNITY-BASED EDUCATION AND RESOURCES

The Galveston County Health District developed the “Take Action Galveston” program that recruits and trains community health “Coaches” to teach diabetes self management classes in their churches and communities.

A main focus of the “Take Action” classes is improving lifestyles for people with diabetes and members of their primary support systems.



A second class, “Whisking Your Way to Health,” focuses on changing diet. The series of five hands-on classes covers reducing

sugar, fat, and salt in recipes; meal- planning; adding flavor with herbs, spices, citrus, and vegetables; portion sizes; and a grocery store tour. Contact: Galveston County Health District at 409-938-2401