DIABETES INITIATIVE

A National Program of The Robert Wood Johnson Foundation

Moderator:

- Ann Albright, PhD, RD

Presentations:

- La Clinica de La Raza
- MaineGeneral Health
- Galveston County Health District

Community Health Worker Approaches to Implementing Self Management In Community Settings

La Clinica de La Raza
Maine General Hospital
Galveston County Health District

Discussants

- Joanne Gallivan
- Jane Kelly
- Donna Rice
- Aracely Rosales

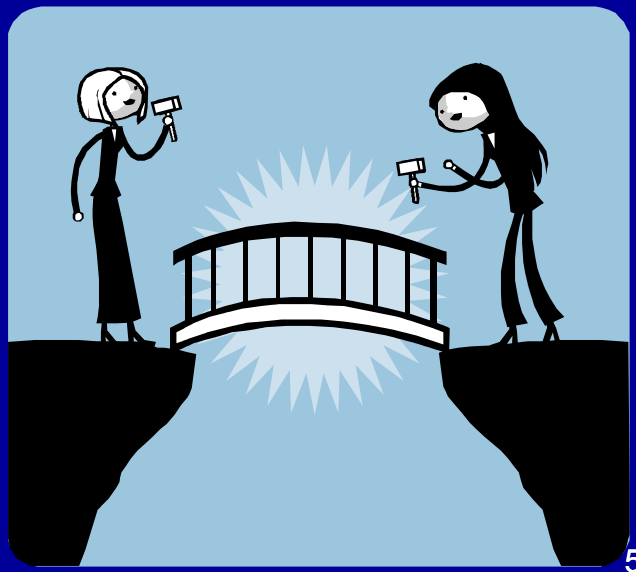
What's in a Name?

- Community Health Workers
- Community Health Advocates
- Community Health Representatives
- Peer Health Promoters
- Lay Health Workers
- Lay Health Educators
- Promotores de Salud
- Others…..

Role

- Bridges or connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care

Witmer, 1995



Core Roles

- Bridging cultural mediation between communities and health care system
- Providing culturally appropriate and accessible health education
- Assuring people get needed services
- Providing informal counseling & support
- Advocating within health systems
- Providing direct services/screening tests
- Building capacity

Wiggins and Borbon, 1998

Training

- Various curricula
- What is effective training for teaching self management in community settings?

Support for Community Health Workers

Some examples

- AADE – position statement
- APHA – position statement
- CDC – Established first national database
- Many others…

Who are we missing??

What can we do to expand involvement of community health workers in self management training?

Health Promoters use stages of change to improve diabetes in urban Mexican-Americans

RWJ Annual Meeting

Tucson, October 18-20

Claire Horton, MD

Joan Thompson, RD

La Clínica de la Raza

Oakland, CA

La Clinica de la Raza

- A community health center serving 40,000 patients a year
- 84% Latino, 8% Asian, 6% African-American, 2% other
- 85% < federal poverty level
- 7 service sites in Alameda, Contra Costa and Solano Counties (California)
- Medical, health education, mental health, nutrition services, case management, dental, optometry, x-ray, pharmacy and lab services.

Key objectives for involving promoters

- La Clinica has a long standing history of community outreach (Escuela de Promotores)
- Desire to integrate the work of Family Medicine and Preventive Medicine with Community Health Education
- Patients in our diabetes program with self management goals had the same A1c average as patients without goals.

  Missing ingredient: health promoters to translate medical management into the patient's reality

Scope of work

- Provide culturally appropriate and accessible health education information and SMS
- Teach self management skills
- Follow-up on progress of patients and identification of needs for self management education
- Advocate for patient needs
- Lead or assist in weekly groups

  (depression, walking, diabetes education, support)

Key interventions

- Diabetes education classes
- Intensive self management support groups
- Depression group
- Walking club
- One on one counseling using ttm
- In-services for providers on ttm
- Case conferences included the promoters
- Diabetes clinic every two weeks with a promoter
- Very recent: Group visits

Addressing Barriers

- Language (mono-lingual) and literacy level
  - Found ways to engage less literate CHW in other ways
  - Constant practice and on-going training
- Lack of knowledge in key areas
  - On-going training (every two weeks)
  - Constant practice
- Lack of personal transportation
  - Provided bus passes for public transportation
- Lack of documentation, therefore they cannot be employees
  - Provide incentives
- Competing priorities in their lives, such as children
  - Provided child care during promoter meetings
- Health education is often not recognized as a reimbursable service.

Trans-theoretical model (TTM)

- Counseling methodology

  Promoters and providers were trained in ttm and used it to stage patients and customize their intervention using processes of change

- Implementation

  Patients were staged every 3 months for readiness to change

- Challenges

  Use of processes of change was difficult to determine, and highly variable depending on promoter and provider

Key Accomplishments and key lessons

Key accomplishment

- *Improved hemoglobin A1c levels for the patients
- Created a cadre of highly effective promoters who are eager to use their skills in other ways to help the Latino community
- Integration of promoters with clinical services

Key Lesson

- Promoters are passionate, empowered and dedicated people. They are effective translators of the clinical management of diabetes into the patients' reality. Once taught, they can transfer these skills to other chronic diseases.

"Move More"

Lay Health Educators: A Social Marketing Strategy Addresses the Community Resources and Policy Component of the Chronic Care Model

RWJF Diabetes Initiative Annual Meeting

October 19, 2006

Natalie Morse, Director
Prevention Center, MaineGeneral Health

"Move More"

Community-based Move More

- Build capacity (trails and walking paths, indoor walking spaces)
- Gym memberships (low cost/no cost)
- Policy/advocacy (schools, community, worksite)
- Non-directive peer support (volunteers)
- Linking patients to community resources
- Website
- Print materials (standardized distribution system)
- Chronic disease self-management classes

"Move More"

Key Objectives

- Build network of volunteers who can provide non-directive peer support (Movers and Lay Health Educators)
- Social marketing message
- Refer patients to community resources

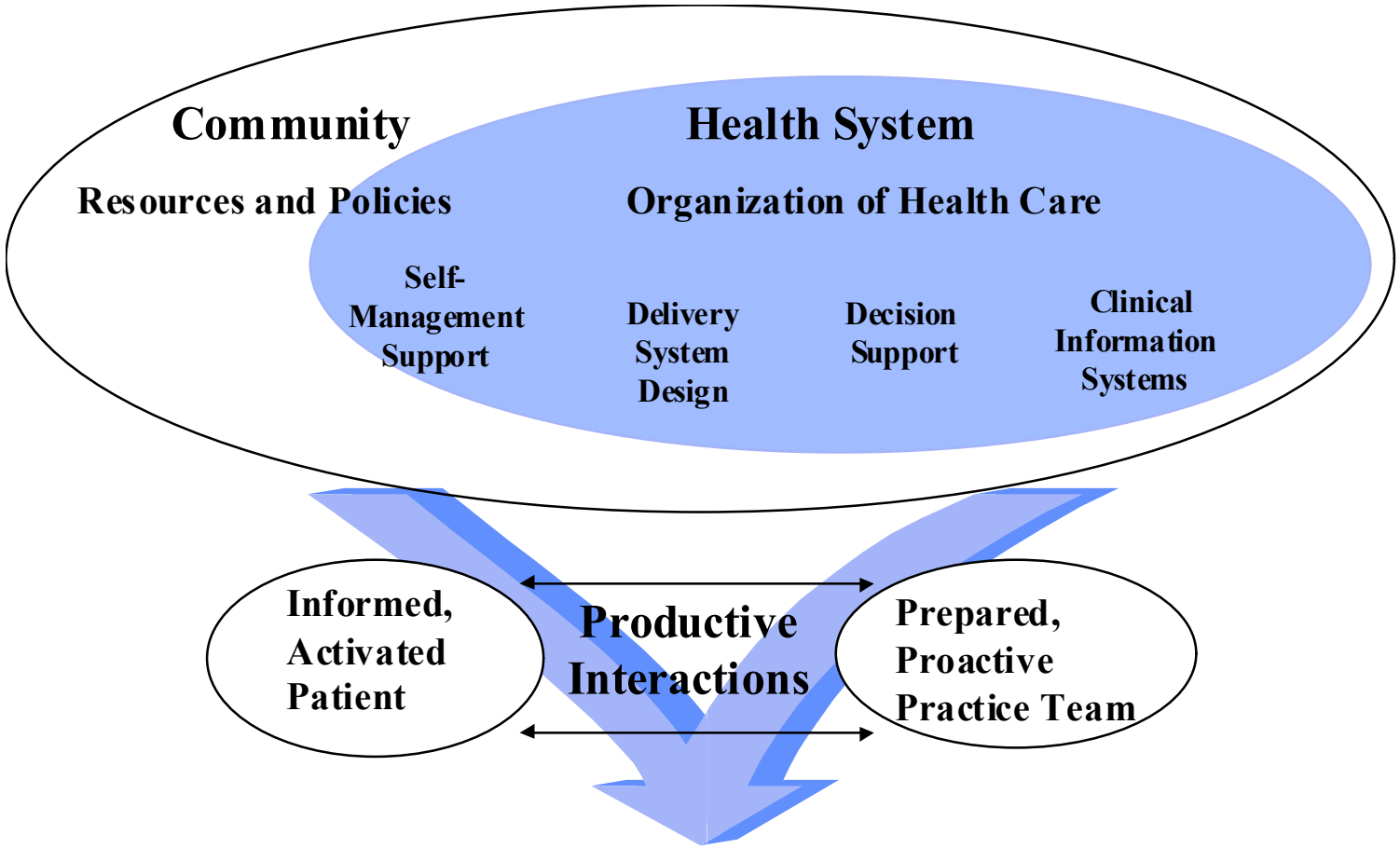
"Move More"

Key Strategies

- CDC Best Practices for increasing physical activity* (Creation of or enhanced access to places for physical activity combined with informational outreach activities, and social support interventions in community settings)
- Social Marketing (The Mover is the messenger)

**The Guide to Community Preventive Services: What works to promote health?* Task Force on Community Preventive Services. Oxford University Press, 2005

Wagner's *Chronic Care Model*



www.improvingchroniccare.org

"Move More"

Barriers

- Stigma in the community of having diabetes
- Explaining to community members and professionals that social marketing is about much more than a mass media campaign.
- Helping health care professionals understand the importance of peer support, and that non-professionals are important in referring patients to community resources and delivering the physical activity message.

"Move More"

Lay Health Educator Intervention

- Provide non-directive peer support in community and worksite settings…"gentle encouragement"
- Refer patients to self-management resources in the community
- Promote physical activity opportunities
- Lead chronic disease self-management classes
- Enroll patients in Move More

"Move More"

Most important outcome

RWJF funding provided time and resources to conduct formative research, develop strategies and establish a network of volunteers. Move More is now a low cost program that can be sustained in a rural setting through the use of volunteers.

"Move More"

Lessons learned

- Lay the groundwork (trails, indoor walking places, website, relationships with partners, etc.)
- Slow and steady work with volunteers, health care professionals and community members are key to sustainability.

Take Action

Galveston

D. Darlene Cass, RN

Community Health Workers Facilitate Self-Management

Key objectives for using Community Health Coaches

- Provide diabetes self-management education in non-traditional setting
- Remove barriers to class attendance
- Community Health Coaches would be trained and supported by Galveston County Health District

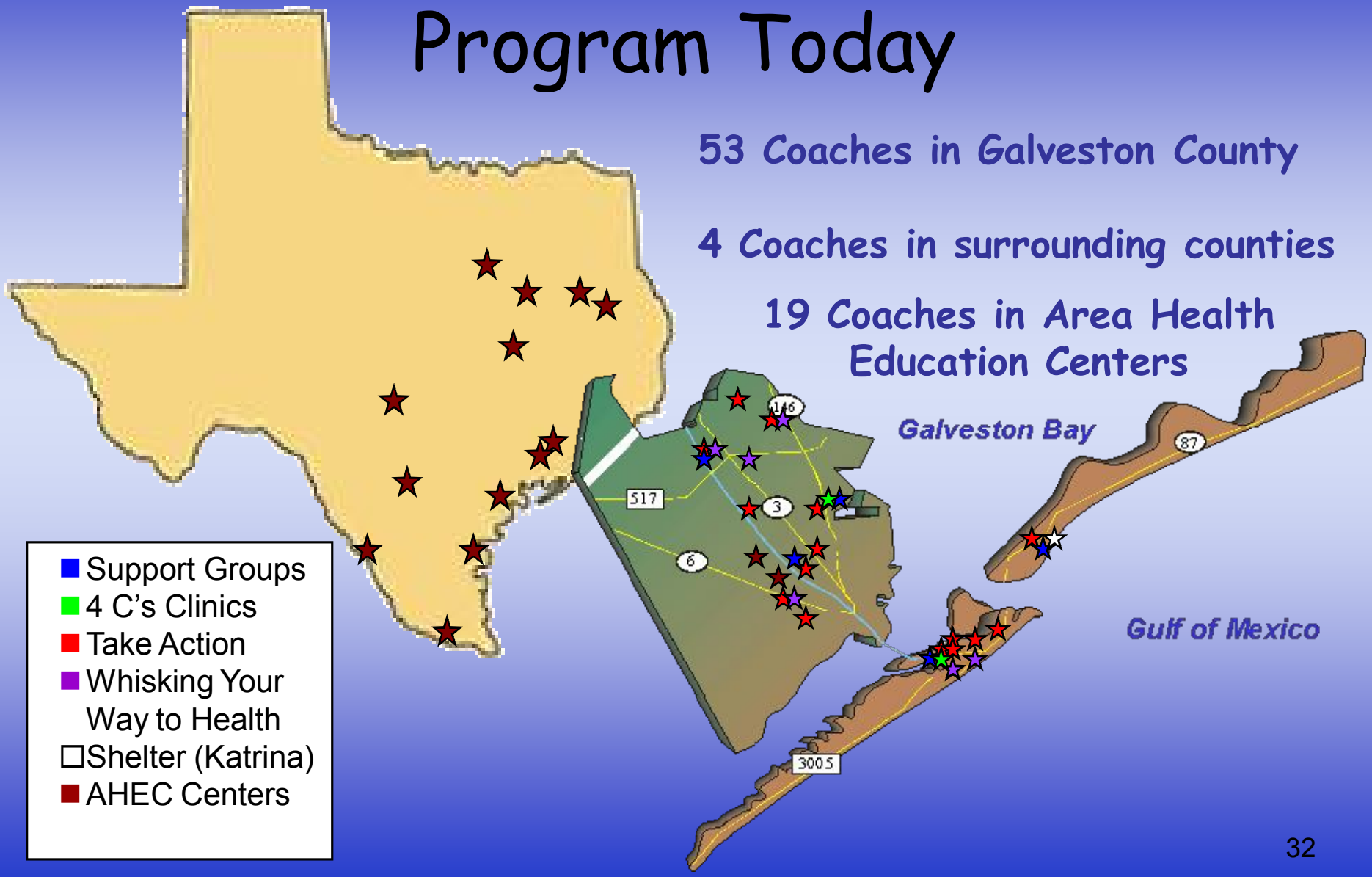
Key strategies of the intervention

- Use Take Action, A Diabetes Self-Management Program curriculum
- Focus - to empower participants to take control of their diabetes through knowledge
- Participants would use Action Plans to assist in behavior change
- Coach Support
  - Coach recruitment
  - Coach training
  - Coach support
    - Supplies for classes
    - Ongoing support

Barriers

- Easier to find coaches then participants
- Coach health
- Pace of working with volunteers
- Schedules
- Organizations wanting programs but one of many priorities, low level of support

Our Community Health Coach Program Today



What Successful Community Health Coaches Look Like

- Enthusiastic
- Dedicated
- Over come personal barriers
- Want to share knowledge and experience with others

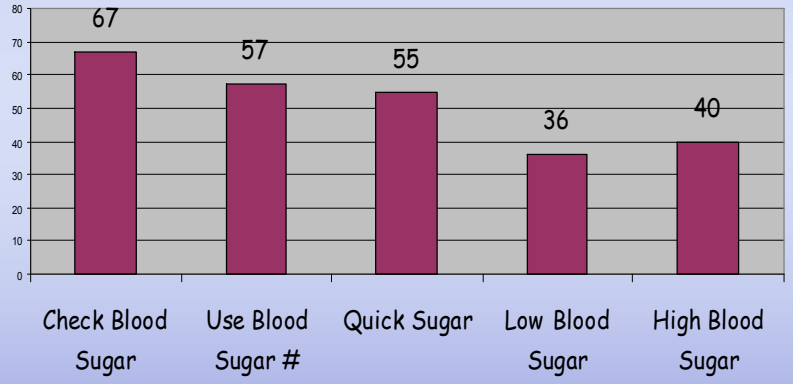
Important Outcomes from the Intervention

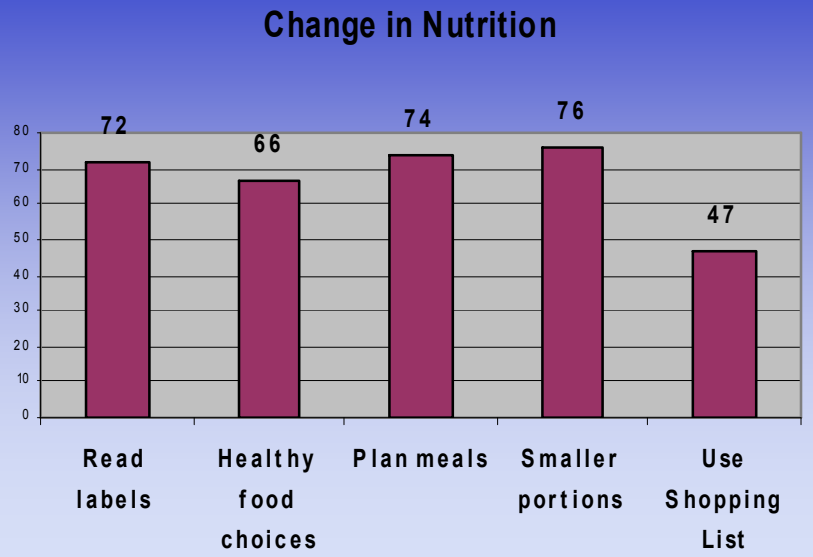
- Training and Teaching Material
  - 100% of coaches reported the materials were clear and tool box was helpful
  - 100% of coaches felt there was adequate information to teach the class
  - 63% were very confident and 31% confident they would be able to teach the Take Action Program after the training
- Location of classes in Galveston County
  - 17 locations (churches, social service agencies, senior centers, families, pharmacies)
  - One time series and ongoing classes
  - Support groups
- 704 participants

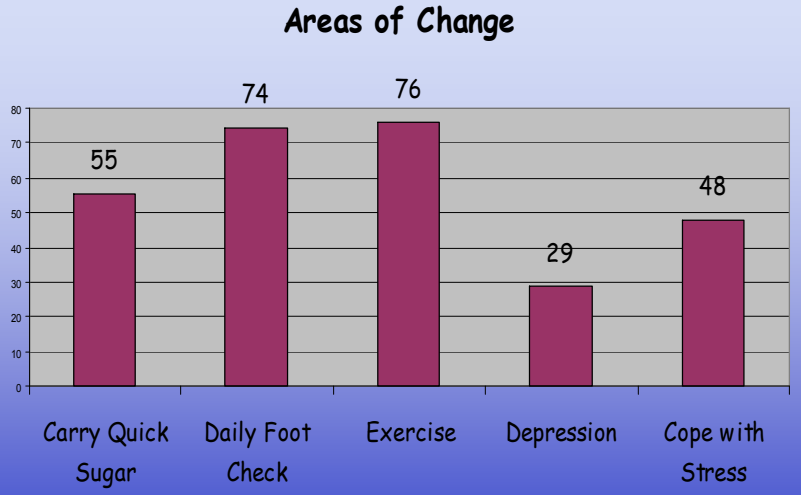
Important Outcomes from the Intervention

- 97% of participants completing an evaluation indicated they were making changes in the management of their diabetes
- 88% indicated there was a lot of new information provided
- 100% indicated Action Plans helped with behavior change
- 58% never attended diabetes education classes
- 98% indicated they would use the Diabetic Record

Changing Behavior







Lessons Learned

- A Lay Person can successfully teach Take Action, A Diabetes Self-Management Program

  (98% of participants indicated coaches were well prepared)
- Work at the pace of the volunteers with gentle nudging
- Continuing support is essential