CDC’s Approach to Engaging Community Health Workers (CHWs) in Diabetes Prevention and Diabetes Self-Management Education (DP 13 -1305 & DP 14-1422)

DEFINITION OF COMMUNITY HEALTH WORKER (CHW)
A 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 CHW to serve as a liaison/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy of CHW.

Intervention
Increase engagement of CHWs in the provision of self-management programs and on-going support for adults with diabetes

Performance Measure
Proportion of recognized/accredited DSME programs in targeted settings using CHWs in the delivery of education/services
States implementing CHW DSME Intervention (DP 13-1305)

Montana
Wyoming
Colorado
South Dakota
Nebraska
Oklahoma
Alabama
Georgia
Virginia
Pennsylvania
Maryland
Ohio
Delaware
New Hampshire
Massachusetts
Rhode Island
Columbia
District of

Proposed Reach of CHW-DSME Interventions (examples)

- Rhode Island has a 5 year goal of engaging CHWs in up to 40 DSME programs (up to 80% of target programs)
- Nebraska and Wisconsin have 5 year goals of engaging CHWs in up to 50% of target DSME programs

How should grantees engage CHWs in DSME?

To answer this question we collected data from the following sources:
- Grantee Work Plans
- Evidence Based Literature
- Practice Based Evidence
- Subject Matter Experts

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We considered the outcomes

- Number of recognized/accredited DSME programs using CHWs in the delivery of education/services
- Number of participants in recognized/accredited DSME programs using CHWs in the delivery of education/services

We analyzed grantee activities to engage CHWs in DSME

- Develop and implement communication plans to inform providers, payers, policy makers on role of CHW
- Work with CHW training programs to establish certification pathways
- Support Community Based Organizations, Community Health Centers to implement CHW model that focuses on referral activities, CHW driven screening, education, patient tracking and navigation
- Develop Curriculum-based training programs to increase the qualifications of CHWs to refer to diabetes management programs or provide these programs
- Participate in Community Health Worker Collaboratives to create sustainable statewide model for reimbursement including Medicaid reimbursement
- Collaborate with CHW organizations to develop and implement culturally appropriate strategies to connect patients to Clinics

We grouped activities to identify critical ‘drivers’

- Educate Providers/Health Systems
- Engage Community Organizations employing CHWs
- Engage State/Local ADA/ADE
- Develop Curriculum-based training programs
- Recruit CHWs
- Provide resources for use by CHWs
- Develop sustainable state wide model for reimbursement
- Identify state certification pathways

Stakeholder awareness
DSME program readiness
State level sustainability partners
We identified CHW-DSME roles

- Participant Outreach and Recruitment
- Health provider referral follow-up
- DSME program delivery support
- DSME program participant support

Driver Diagram for CHW-DSME Intervention in DP 13-1305

Cooperative Agreement DP14-1422

Community clinical linkage strategies to support heart disease and stroke and diabetes prevention efforts

Intervention
Increase engagement of CHWs to promote linkages between health systems and community resources for adults with high blood pressure and adults with prediabetes or at high risk for type 2 diabetes

Performance Measure
Number of health systems that engage CHWs to link patients to community resources that promote prevention of type 2 diabetes

Proposed Reach of CHW-National DPP Interventions (examples)

- Health systems engaging CHWs: FQHCs/CHCs (majority)
- Massachusetts has a 4 year goal of engaging CHWs in up to 35 health systems to increase referrals to the CDC recognized lifestyle change programs
- Maryland has a 4 year goal of engaging CHWs in up to 50% of target health systems

How should grantees engage CHWs in the CDC recognized lifestyle change programs?

To answer this question we collected data from the following sources:

- Grantee Work Plans
- CHW Effectiveness Literature
- Practice Based Evidence
- Subject Matter Experts
We considered the outcomes

- Number of health systems that engage CHWs to link patients to community resources that promote prevention of type 2 diabetes
- Number of people with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program (as reported by the CDC Diabetes Prevention Recognition Program (DPRP))

We Analyzed Grantee Activities to engage CHWs in National DPP

- Align work of Diabetes Policy work group and collaborative Community of Practice efforts on CHW reimbursement
- Develop test protocols for CHWs to follow up on referrals in FQHCs that have CHWs
- Train CHWs from health systems that have initiated the CDC National DPRP process to become lifestyle coaches
- Train CHWs about National DPP and their role to encourage community members who may be at risk to be tested for prediabetes
- Conduct ongoing National DPP program utilizing CHWs as lifestyle coaches
- Coordinate creation of training grants and identify subcontract organizations to build capacity of CHWs
- Collaborate with CHW training schools to incorporate referral to National DPP into CHW training curriculum

We grouped activities to identify critical ‘drivers’

- Health system Readiness
  - Enable CHWs to follow up with screened and identified people with prediabetes
  - Collaborate with State Medical Associations to encourage the engagement of CHWs

- CDC-recognized lifestyle change program readiness
  - Train CHWs as lifestyle coaches to deliver the program and to support participants from priority populations
  - Provide access to information and resources for CHWs

- Readiness of other stakeholders
  - Local health departments to promote CHW roles
  - Community-based organizations that employ CHWs to facilitate referrals
  - CHW associations to help with recruitment of CHWs to become lifestyle coaches
  - Facilitate adoption of a core CHW training curriculum and delivery process
  - Identify certification process and mechanism
  - Promote sustainable coverage for the National DPP

We identified CHW-National DPP roles

- Participant Outreach and Recruitment
- Health provider referral follow-up
- National DPP delivery/support
- National DPP participant support

Ongoing engagement of CHWs in DSME and CDC recognized lifestyle change programs

- Lessons learned from implementation of driver diagrams
- Actual vs Proposed reach of interventions (Performance Monitoring)
- Build evidence for ongoing CHW engagement in DSME & National DPP
Discussion Questions

- Your own experience as CDEs on working with CHWs for DSME and the National DPP – strengths and challenges?
- Are the appropriate stakeholders represented in the diagram?
- Are the appropriate activities identified in the diagram?

Thanks!
Questions?
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Objectives of the presentation

Describe approaches to building capacity in community-based organizations working with CHWs to offer and sustain the National DPP.

Demonstration Project to Promote Diabetes Prevention Capacity among Hispanic/Latino Organizations

WHY FOCUS ON CAPACITY DEVELOPMENT?
Growing consensus on diabetes prevention and capacity

86 million American adults
1 out of 3 have prediabetes

There is evidence-based of a lifestyle change program for preventing type 2 diabetes.

Without sufficient capacity, development efforts will not succeed

What do we mean by capacity?

Organizational Capacity – the ability of organizations and staff to manage their affairs successfully and use resources to operate effectively
- Generic capacity – the ability (includes both skills & resources; financial and in-kind) to plan & manage organizational changes & service improvements
- Specific capacity – the ability to conduct specific activities such as recruit and retain participants

Relationship between capacity & performance

- Analogous to a motor car
- We maintain the car’s engine, chassis, brakes, tires, etc. – its capacity – because we value safe & reliable transportation – the performance – it provides
- We are interested in aspects of capacity that make it possible for organizations to have a strong performance in relation to diabetes prevention

Goal of the Demonstration Project

To test the usefulness of an intervention using the Road to Health Toolkit to build capacity among H/L CBOs interested in implementing interventions to change lifestyle behaviors.

Demonstration Project Objective

Describe approaches to building capacity in community-based organizations (CBOs) serving H/L communities and working with CHWs to offer and sustain the National DPP.

Characteristics of participating organizations

- CBOs that serve Hispanic/Latino communities - Texas, Miami, and Washington
- CBOs with experience implementing health related interventions (i.e. diabetes, obesity, physical activity, or nutrition)
- CBOs with capacity to appoint, train, and retain at least one CHW and one coordinator/supervisor
Demonstration project participants

Participants characteristics:
- Hispanic or Latino adults 18 years or older.
- At risk for developing type 2 diabetes, confirmed through the CDC Prediabetes Screening Test.
- Willing to participate in a six-week intervention to change lifestyle behaviors and 2 follow-up sessions.

Demonstration project activities design to build organizational capacity

- Recruit an adequate number of participants.
- Implement group sessions and 2 follow-up sessions.
- Retain a minimum number of participants during the program and follow-up period.
- Cover the contents with fidelity.
- Collect, track, report, and manage data.
- Participate in project’s evaluation activities.

Key programmatic activities

Implement two consecutive rounds of a six-week intervention for lifestyle change
- Two group sessions with 8-15 participants.
- Each session lasts 60-90 minutes.
- Each participant completes a minimum of 4 group sessions.
- Participant’s behavior change monitored weekly:
  - CHWs and participants record participants’ weights.
  - CHWs and participants record participants physical activity.
  - Participants record their eating habits.

Participant goals

- Goals include:
  - Lose between 5-7 percent of body weight.
  - Gradually increase physical activity to reach 150 minutes per week.
- Learn strategies aimed at:
  - Healthy eating
    - Learn how to reduce daily fat intake.
    - Discover variety, balance, and moderation in eating habits.
  - Increased physical activity
    - Examples include: walking, swimming, or mowing the lawn for at least 30 minutes, most days of the week.

Activities to assess the Demonstration Project’s implementation

- Baseline, mid-point, and final assessment consisting of:
  - In-depth interviews with program managers and supervisors to:
    - Assess changes in organizational capacity in the following areas:
      - Staff recruitment and retention
      - Participant recruitment and retention
      - Data collection/entry
      - Identify potential areas for technical assistance
      - Assess/monitor implementation adherence to the guidelines of the demonstration project (fidelity).

Activities to assess the Demonstration Project’s implementation (cont.)

- Pre- and post-training assessments
  - Surveys administered to CHWs and supervisors to measure changes in knowledge and skills.
- Assessment of behavioral change
  - CHWs measure and record the weight of the participants on a weekly basis.
  - Participants record and report physical activity and eating habits.
Implementation Fidelity was measured through...

- Use of the CDC Prediabetes Screening Test to identify eligible participants
- Recruitment of a suitable number of participants to ensure 8 to 15 members per group
- Implementation of six-week group sessions and two individual monitoring sessions after each round
- Retention of at least six participants during the six-week program and monitoring period

Implementation Fidelity Is Measured through... (cont.)

- Participant completion of at least four of the six sessions
- CHWs cover mandatory contents of the Road to Health Toolkit
- CHWs collect necessary data and record it on the spreadsheet provided

Demonstration Project Assessment Report

- Organizations' profiles highlight lessons learned and includes discussion of:
  - Organizational implementation activities
  - Challenges faced by coaches during implementation
  - Strategies to address challenges
  - Changes in organizational capacity
  - Factors contributing to changes in organizational capacity

Results thus far

- All sites have completed Round 1 and 2
- All sites have completed the baseline, midpoint, and final assessments
- Preliminary lessons learned have been identified
  i.e. Traditional approaches for recruitments of participants have not worked as well, therefore it was important to go back to the community and assess best recruitment approaches

Lessons learned

- Targeted outreach strategies that leverage existing relationships with partners and/or participants are more cost/time effective.
- Individuals and organizations conducting the outreach & recruitment efforts must be credible with the audience.
- Screening of individuals before launching recruitment efforts helps potential participants understand the need and importance of the intervention & helps recruiter better target their time and efforts.

Lessons Learned (cont.)

- Incentives that are aligned with the goals of each session are helpful for engagement and retention.
- Offering participants make-ups sessions on an individual basis facilitates retention
- Polling potential participants for a calls time slot that works for the majority helps facilitate retention.
Lessons Learned (cont.)

- Conducting the sessions in a place familiar to the participants facilitates retention.
- Taking time to clearly explain
  - Purpose
  - Goals
  - Time commitment
  - Expectations

Prior the first session facilitates retention.

Lessons Learned (cont.)

- To effectively develop organizational capacity the efforts must be part of an endogenous process of change, with organization leadership ownership as a critical factor
- No quick fixes or easy formulas work well in all circumstances

Implications for Diabetes Educators

- The increase in the prevalence of diabetes and the need for lifestyle interventions and health care delivery modifications call for collaboration between providers and diabetes educators!
  - CHWs are providers too!

Implications for Diabetes Educators

- If organizations are strong in their capacity, they can succeed and thrive in accomplishing their missions
  - DEs - Engage local community stakeholders to: identify underserved populations in greatest need, conduct outreach to the target population, provide them with educational classes, and develop and deliver sustainable diabetes programs.
  - Establish relationships with CHWs to generate new referrals.

Recommendations

- Diabetes educators should support continued research that explores and evaluates the roles, contributions, and effectiveness of CHWs.
- CHWs can be integrated as part of primary prevention efforts.
- Diabetes educators should support the role of CHWs in primary prevention.

Diabetes educators should value the role of CHWs in serving as bridges between healthcare providers, the health care system, and people at risk for diabetes
In simple terms, people at risk for diabetes need.....

• Someone with whom to figure out how & what they need to do to prevent their diabetes
• Opportunity to learn the skills they need
• Ongoing support to help them
  – figure out how to change their lifestyle
  – stay motivated when things get tough
  – get back in touch with the clinic/program, when they need to

Next Steps

Conduct a webinar (Date and Time- TBD)

For more information, call 1-800-CDC-INFO (800-232-4636)
Phone TTY 1-(888) 232-6348 or visit www.cdc.gov/info.
To request resources, visit www.cdc.gov/diabetes/ndep.

Thanks!
Questions?
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