



**Community Health Workers in Diabetes Management and Prevention**  
AADE Practice Synopsis  
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**Introduction**

Diabetes Self-Management Education (DSME) has long been acknowledged as an essential component of care for people with diabetes, as well as for persons at risk for the development of diabetes. Current statistics from the Centers for Disease Control and Prevention<sup>1</sup> indicate that the rate of incidence and prevalence for diabetes continue to be greatest among ethnic and minority communities. The disparate incidence and prevalence are in part connected to the disparities in access to care, which is common in these communities. Using the Community Health Worker model to mitigate disparities in access to diabetes education is a strategic and practical approach, with favorable evidence to support its efficacy<sup>2,3</sup>.

Standard 5 of the National Standards for Diabetes Self-Management Education and Support recognizes that health educators (e.g. certified health education specialists and certified medical assistants), case managers, lay health and community health workers, and peer counselors or educators have been shown to contribute effectively as part of the DSME team and in providing diabetes self-management support (DSMS). Individuals who serve as lay health and community health workers and peer counselors or educators may contribute to the provision of DSME instruction and provide DSMS if they have received training in diabetes management, the teaching of self-management skills, group facilitation, and emotional support. For these individuals, a system must be in place that ensures supervision of the services they provide by a diabetes educator or other health care professional and professional back-up to address clinical problems or questions beyond their training.

The American Public Health Association defines a Community Health Worker (CHW) as a frontline public health worker who is a trusted member of and/or has an unusually close

understanding of the community served. This relationship of trust enables the CHW 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. 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.<sup>4</sup> Additionally, CHWs are able to provide local support and resources in their communities.

Community Health Workers are known by a variety of names, including community health worker, complimentary healthcare worker, community health advisor, outreach worker, community health representative (CHR), promotora/promotores de salud (health promoter/promoters), patient navigator, navigator promotoras (navegadores para pacientes), peer counselor, lay health advisor, peer health advisor, peer supporters and peer leader.

Individuals in the CHW role function as educators, outreach coordinators, supporters of social needs, and advocates. They also have demonstrated an important role in providing ongoing support. They have a general academic understanding of the role of healthy eating and exercise in relationship to diabetes and are able to communicate basic, evidence-based lifestyle recommendations. In the communities most affected by diabetes, CHWs can help them facilitate development and implementation of DSME, augment potential for program success, and broker pathways toward reducing morbidity, mortality, and incidence of diabetes among the persons they care about most. Indeed, in some minority communities, health education services would be completely inaccessible without CHWs. AADE and the 2012 National Standards for Diabetes Self-Management Education and Support have acknowledged their role in delivering DSME to specific populations and in connecting the more than 100 million Americans with diabetes and those at risk for development of diabetes. Community health workers, are recognized as Level 1 Diabetes Educators Associates (DEA) by AADE. Some of the CHW functions include:

1. Work with diabetes care providers to identify and overcome cultural barriers to self-care or behavior change.
2. Make referrals when indicated to providers, and accredited or recognized diabetes education programs.

3. Provide culturally-specific basic health information.
4. Convey diabetes self-management information and healthcare provider recommendations accurately to the person with diabetes.
5. Participate in the evaluation of program, unit, or agency using clinical practice guidelines.
6. Assess the person with diabetes' support systems.
7. Work with the healthcare team using basic concepts of behavior change to assist person with diabetes with effective self-management.
8. Support people with diabetes in their efforts to make changes in daily routine.
9. Serve as a link between people with diabetes and diabetes healthcare team.
10. Develop community coalitions to meet the needs of a specific population.

Training and empowering CHWs to deliver current, accurate, and evidence based information can do much to benefit self-care behaviors, problem solving skills, and optimal outcomes in people affected by diabetes in their communities. The CHW should be trained by a diabetes healthcare professional who understands evidence based guidelines for diabetes education.

### **Role and Competencies of Community Health Workers**

CHWs function as a Level 1 Diabetes Educator Associate according to the Diabetes Educator Practice Levels guidelines.<sup>5</sup> Performance of activities at this level of care should be conducted under the direction of a qualified diabetes healthcare professional, such as a diabetes educator, who has training and expertise in areas relative to direct care and ongoing support services.<sup>6</sup> In this capacity, the CHWs serve as important community-based resources who increase outreach to underserved racial and ethnic minorities to facilitate access to health care and serve as liaisons between health care providers and the communities they serve.<sup>7</sup> They provide a bridge between health care systems, communities, and people diagnosed or at risk for diabetes.<sup>8</sup> CHW's have multiple roles and responsibilities. They can provide basic lifestyle recommendations, provide support, facilitate communication between the patient and provider and assist with care coordination.<sup>9</sup>

Under the direction of a diabetes educator who is a licensed healthcare professional (e.g., RN, RD, RPh) and/or holds an advanced credential (e.g. CDE or BC-ADM); CHWs also promote

primary prevention (e.g. lifestyle changes) and secondary prevention (e.g. smoking cessation and self-management skills). In addition to promoting healthy lifestyle skills, the CHW can reduce the burden on other medical providers by supporting patient's needs that do not require the expertise of a clinician.<sup>10</sup> In this capacity, the CHWs should have non-technical and non-clinical instructional responsibilities and should receive ongoing informal and formal training.<sup>6, 8</sup> Integrating and supporting the role of the CHW as a member of the clinic team serves to promote trust between the provider and the CHW.<sup>10</sup>

CHWs use a number of core skills and competencies to provide this community-based system of care and social support. States that offer certification programs for CHW's provide a standardized education program that provides the CHW with the appropriate level of knowledge to accurately communicate health information to patients. Adequate training can enhance confidence and competence.<sup>10</sup>

These core skills and competencies include skill development in communication, interpersonal relations, capacity building, organizational development, problem solving, and assistance with obtaining access to care.<sup>10, 11</sup> They can be expected to perform the following activities, but these may vary based on the needs of the practice and community and the setting in which DSME/T is provided.

- **Basic Assessment:** Measure vital signs and anthropometric data, literacy assessment, and ability to follow protocols for patient intake. Assessment may include family and social support systems. Provide support, general information, and guidance regarding accessing care, available diabetes education offerings, and financial assistance.<sup>12</sup>
- **Goal Setting:** May help patients by providing basic information and assisting in setting basic goals for healthy eating and appropriate physical activity as defined by protocols.
- **Planning:** Follow the prescriber's orders and diabetes educator's guidance for implementing plan of care.
- **Implementation:** Refer/support diabetes management skill training, and offer guidance on accessing care and financial resources. Level 1 associate diabetes educators DSME providers may: a) lead support groups or organize a community physical activity (e.g., walking group); and b) refer to the prescriber or diabetes educator as needed.

- Monitoring/Evaluation: Monitor progress toward the plan and report findings to the prescriber and diabetes educator.<sup>6</sup>

### **Role of the Diabetes Educator**

Training and empowering CHWs for DSME delivery with information that is current, accurate, and evidence based can do much to benefit the self-care behaviors, problem solving skills, and health outcomes of people affected by diabetes.<sup>13</sup> When access to comprehensive and accredited or recognized diabetes education programs is limited, the significance of CHWs in the DEA role is elevated. The diabetes educator facilitates integration of the CHW as a member of the diabetes support team, and serves as a content resource to promote continuity in diabetes patient care. In supporting the CHW as a DEA, the CDE functions include but are not limited to the following:

1. Convey the evidence upon which DSMES national standards for diabetes care across the lifespan is based.
2. Identify educational materials appropriate for age, literacy level, cultural background, and physical and cognitive abilities of recipients.<sup>8</sup>
3. Assist in assessment of local and regional communities for effective support networks and resources important to patients with diabetes.<sup>8</sup>
4. Assist in identification of diabetes self-management barriers and plans to mitigate barriers to timely care.<sup>8</sup>
5. Teach, reinforce, or validate essential diabetes self-management skills, using principles of teaching and learning.<sup>8</sup>

### **Recommendations**

1. Community health workers can be integrated as part of the multi-level diabetes self-management education and support team.
2. Diabetes educators and other health care professionals should value the role of CHWs in serving as bridges between healthcare providers, the health care system, and people with and at risk for diabetes.
3. Diabetes educators and other health professionals should support the role of CHWs as diabetes educator associates in primary and secondary prevention.
4. CHWs serving under the direction of a diabetes educator or healthcare professional who is a licensed health care provider

(e.g., RN, RD, RPh or MD) and/or holds an advanced credential (e.g. CDE or BC-ADM) must receive annual training and mentoring of core diabetes skills and competencies.

5. There is a reciprocal exchange of information and support between CHWs and the healthcare team to facilitate the best outcomes for people with and at risk for diabetes.
6. Local needs should be assessed and resources identified that are currently used by others that can improve self-care efforts of persons with diabetes and their families, facilitate program implementation, and act as primary resource to the facilitator to assist in meeting needs of the group.
7. Diabetes educators and other health care professionals should support continued research that explores and evaluates the roles, contributions and effectiveness of CHWs.
8. CHW/associate diabetes educators should be involved in local network group events and activities at the regional and state levels to promote and improve the exchange in education, learning, support and mentoring with the regional diabetes experts in the field.

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