Community Health Workers Impacting Diabetes Care

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HOMETOWN FAMILY HEALTH

What is a Community Health Worker? (CHW)

A CHW is a trusted member of the community who acts as a bridge between individuals and healthcare systems, providing culturally appropriate health education, outreach, and advocacy to improve access to services and promote health and well-being.

CHW – Key Roles & Responsibilities

Outreach and Education:

CHWs connect with community members, share health information, and promote healthy behaviors.

Advocacy:

CHWs advocate for individual and community health needs, helping people navigate the healthcare system and access resources.

Cultural Sensitivity:

CHWs understand the unique cultural, linguistic, and social contexts of the communities they serve, ensuring that health information and services are relevant and accessible.

CHW – Key Roles & Responsibilities

Informal Counseling and Support:

They provide informal counseling and guidance on health behaviors, offering social support and encouragement.

Direct Services:

In some cases, CHWs may provide basic health services, such as first aid or screenings, depending on their training and the specific needs of the community.

Liaison:

They act as a bridge between healthcare providers and community members, ensuring that individuals receive the care they need.

Who benefits from CHW services?

Vulnerable populations:

CHWs are particularly valuable for reaching underserved communities, including those living in remote areas, facing language barriers, or experiencing health disparities.

Individuals with chronic conditions:

They can help people manage chronic diseases like diabetes and cardiovascular disease by promoting healthy behaviors and providing support.

Families:

CHWs can provide support and guidance to families, particularly in areas like maternal and child health.

Workflow for Diabetic Patients

Provider sees pt at Hometown Family Health.

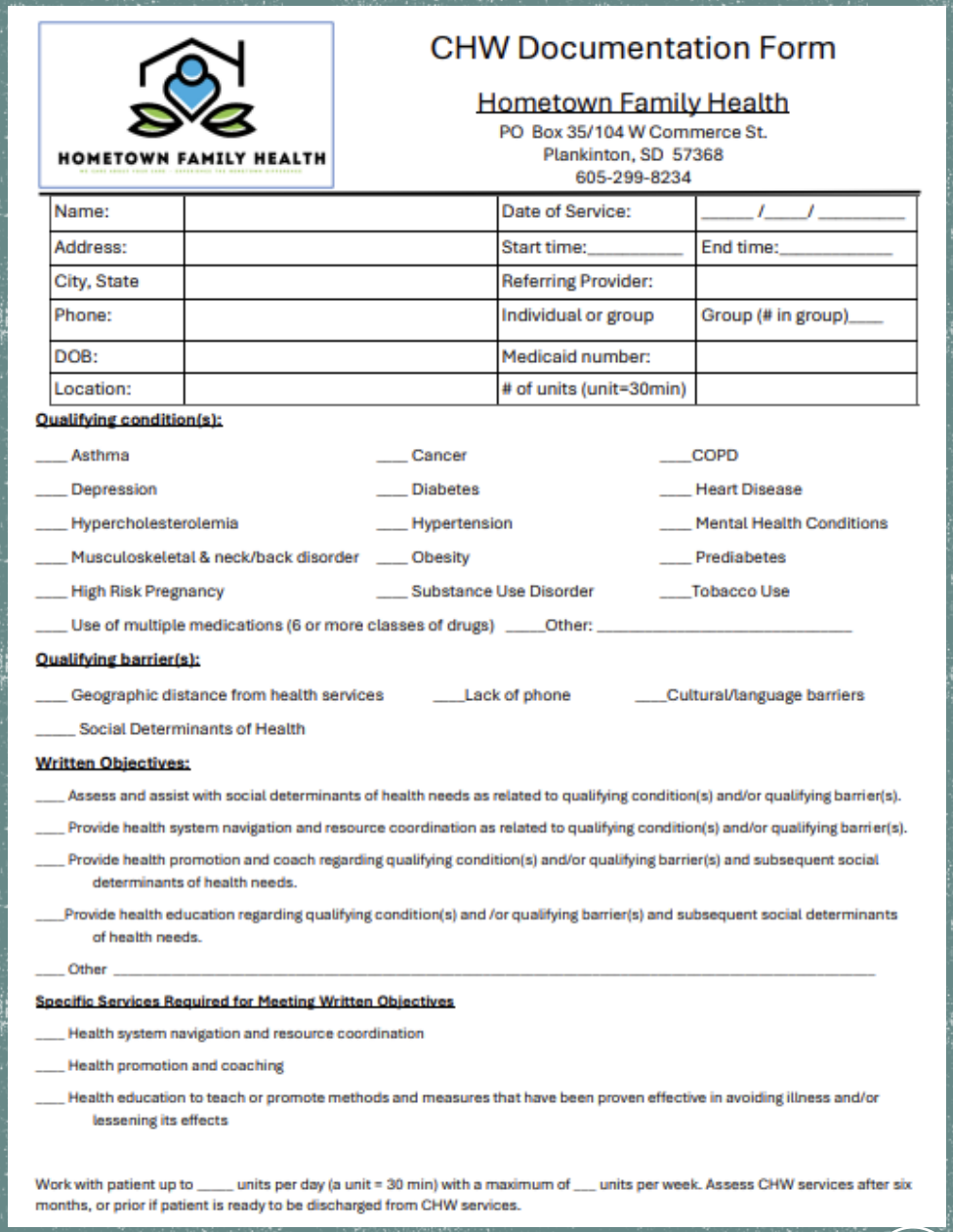
If pt is prediabetic or diabetic, a CHW referral is recommended.

The provider completes the referral form.

The CHW meets with the pt to assess needs and set goals.

Future education is based on pt's goals.

Pt given clinic phone number which they call or text to communicate with CHW.



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CHW Documentation Form

Hometown Family Health
PO Box 35/104 W Commerce St.
Plankinton, SD 57368
605-299-8234

Name:		Date of Service:	_____ /_____/ _____
Address:		Start time:_____	End time:_____
City, State		Referring Provider:	
Phone:		Individual or group	Group (# in group)____
DOB:		Medicaid number:	
Location:		# of units (unit=30min)	

Qualifying condition(s):

____ Asthma ____ Cancer ____COPD
____ Depression ____ Diabetes ____ Heart Disease
____ Hypercholesterolemia ____ Hypertension ____ Mental Health Conditions
____ Musculoskeletal & neck/back disorder ____ Obesity ____ Prediabetes
____ High Risk Pregnancy ____ Substance Use Disorder ____Tobacco Use
____ Use of multiple medications (6 or more classes of drugs) _____Other: _____

Qualifying barrier(s):

____ Geographic distance from health services ____Lack of phone ____Cultural/language barriers
_____ Social Determinants of Health

Written Objectives:

____ Assess and assist with social determinants of health needs as related to qualifying condition(s) and/or qualifying barrier(s).
____ Provide health system navigation and resource coordination as related to qualifying condition(s) and/or qualifying barrier(s).
____ Provide health promotion and coach regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.
____Provide health education regarding qualifying condition(s) and /or qualifying barrier(s) and subsequent social determinants of health needs.
____ Other _____

Specific Services Required for Meeting Written Objectives

____ Health system navigation and resource coordination
____ Health promotion and coaching
____ Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects

Work with patient up to _____ units per day (a unit = 30 min) with a maximum of ___ units per week. Assess CHW services after six months, or prior if patient is ready to be discharged from CHW services.

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CHW

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PO Box 35/104 W Commerce St.
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My Personal Physical Activity Plan

My goal is to spend _____ minutes per week in physical activity.

I plan to meet my goal by:

1. _____
2. _____
3. _____

I know my roadblocks to being more physically active are:

1. _____
2. _____

I will overcome my roadblocks by:

1. _____
2. _____

At the end of four weeks, I will reward myself. My reward is:

_____

Signed: _____ Date: _____

Did you meet your goal?

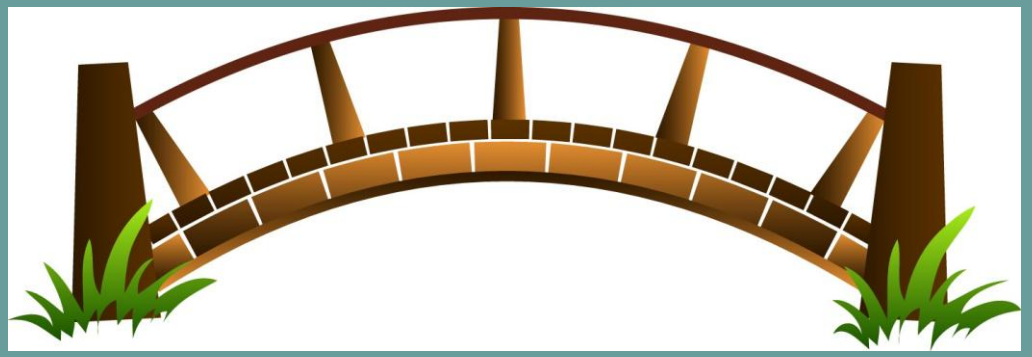
Yes Decide if you want to keep your goal or set a new goal, but keep going!

No Review your roadblocks, set a new goal, and try again!

- Educate patient about diabetes using diabetes models
- *Know Your Numbers*
- Lab results
- Nutrition education
- Portion size education
- Physical Activity Plan
- Weight Management Plan
- Help patient set goals
- The CHW communicates to the provider concerns that come up at the CHW appointment.

The CHW's Role

Provider



CHW

- Patients with insulin resistance, prediabetes or Type 2 diabetes are scheduled every 3 months with their provider.
- Weight and A1C are evaluated.
- Provider discusses how CHW visits are going.
- Adjustments to meds are done if needed.
- We have found fewer diabetic meds are needed after the CHW DM education sessions.

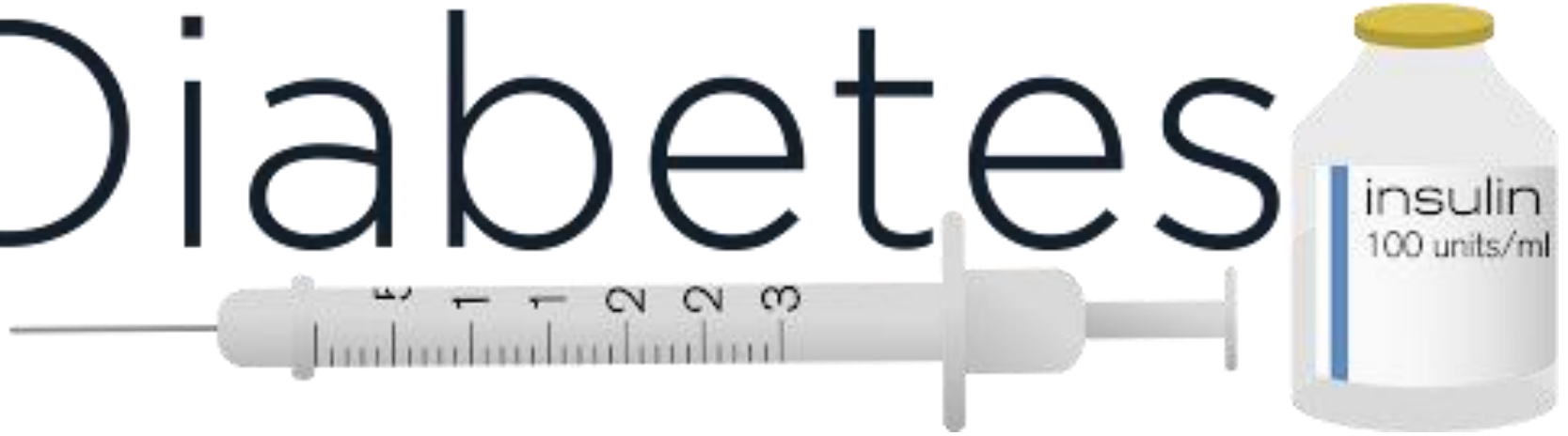
Our 100 Plus program has been helpful with some of our CHW diabetic patients.

The 100 Plus program helps patients monitor blood pressure, weight, blood sugar, oxygen and heart rate at home.

Data is then transmitted to Hometown Family Health.

Remote Patient Monitoring

Diabetes



Case Studies

Susie

- Susie is a 54 yof, given a CHW referral for prediabetes.
- CHW worked with patient for 5 months.
- Focus was on education about the diabetes disease process, nutrition education (including reading food labels), portion control and physical activity.
- During those 5 months:
  - Pt's A1C went from 6.4 to 5.9
  - Weight decreased 14 pounds (192 to 178)
  - BP decreased slightly from 111/73 to 104/72

Maria

- Susie is a 52 yo Spanish speaking female, given a CHW referral for T2DM.
- CHW worked with patient for 7 months.
- Focus was on education about the diabetes disease process, nutrition education, physical activity and **medication compliance**.
- During those 7 months, patient's A1C went from 9.2 to 7.3.
- Pt was given a pill organizer with days written in Spanish.

John & Joan

- John and Joan are a married couple in their late 70s.
- Both patients have T2DM. John is insulin dependent.
- CHW worked with both patients for 5 months.
- Focus was on education about the diabetes disease process, nutrition education, portion control, and **medication compliance**.
- During those 5 months:

John's
- A1C went from 7.7 to 6.6
- Pt lost 16 pounds
- No change in BP

Joan's
- A1C went from 6.5 to 5.7
- Pt lost 23 pounds
- SBP went from 147 to 127

Both patients use the remote patient monitoring 100+ service. CHW had noticed that John was having lows after lifestyle changes. CHW alerted PCP and insulin doses were changed immediately.

Tanya

- Tanya is a 37yof, given a CHW referral for new onset T2DM.
- CHW worked with patient for 3 months.
- Focus was on education about the diabetes disease process, physical activity, and nutrition education.
- During those 3 months:
  - Patient's A1C went from 10.8 to 5.5
  - Patient lost 17 pounds
  - No change in BP.

Questions?

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