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Webinar: The Influence of Social Determinants of Health on Diabetes Health Disparities

Virginia Diabetes Prevention Program Annual Networking Meeting

February 5, 2020

Today's Objectives

- ✓ Describe the social determinants of health (SDOH) and their impact on health and diabetes outcomes;
- ✓ Discuss the role of the Community Health Worker in addressing SDOH;
- ✓ Explain the role of Community Health Workers within health care teams to promote a holistic approach to chronic disease management;
- ✓ Provide examples of Community Health Workers currently addressing SDOH to impact persons with chronic diseases such as diabetes.

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Image Reference

The Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

-World Health Organization (WHO)

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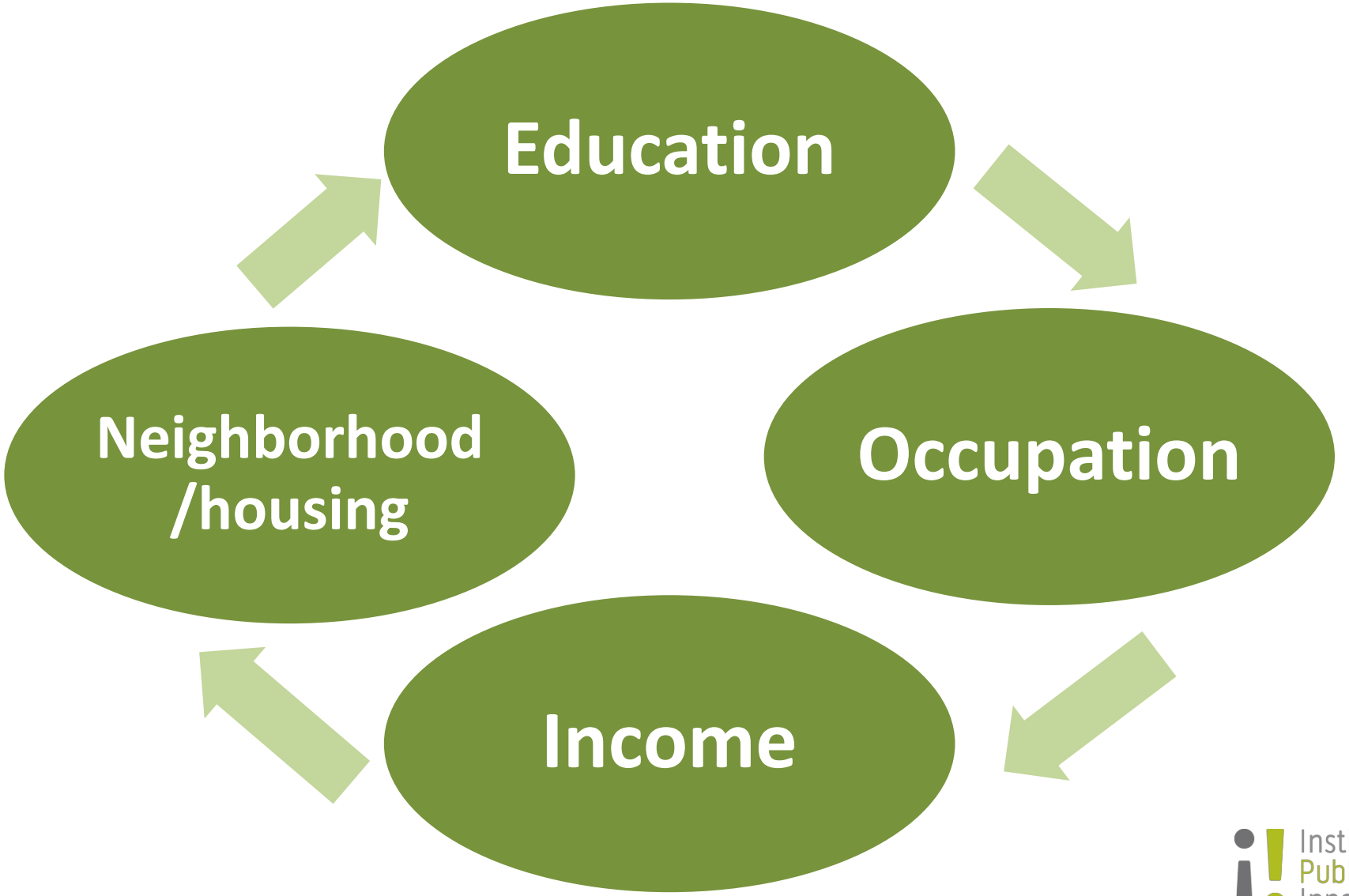
http://www.who.int/social_determinants/en/

The Social Determinants Can Be Cyclical



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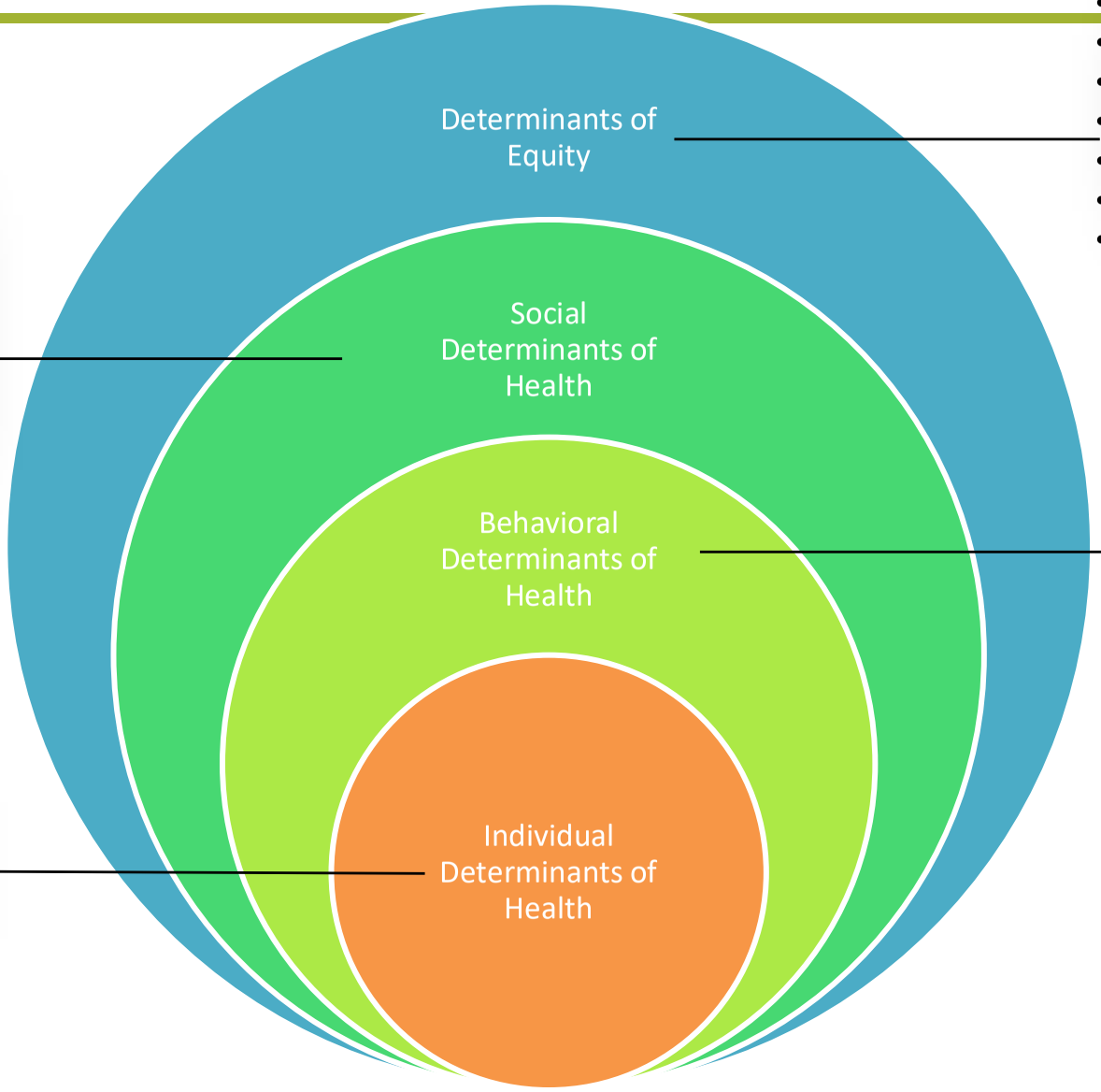
Determinants of Health

Determinants of Equity
- Racism
- Xenophobia
- Classism
- Sexism
- Ableism
- Homophobia/heterosexism
- Place of residence

Social Determinants of Health:
- Education
- Income
- Work environment
- Housing
- Food
- Social support and capital
- Neighborhood environment



Behavioral Determinants of Health:
- Physical activity
- Eating Habits
- Tobacco
- Sexual practices
- Alcohol and other drugs

Individual Determinants of Health:
- Age
- Genetics*
- Sex
- Knowledge
- Attitudes
- Beliefs

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Source: Virginia Department of Health

Health Inequities

A type of difference in health that is closely linked with social or economic disadvantage.

Health inequities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability differences.

-U.S. Dept. of Health and Human Services

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Health Equity

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

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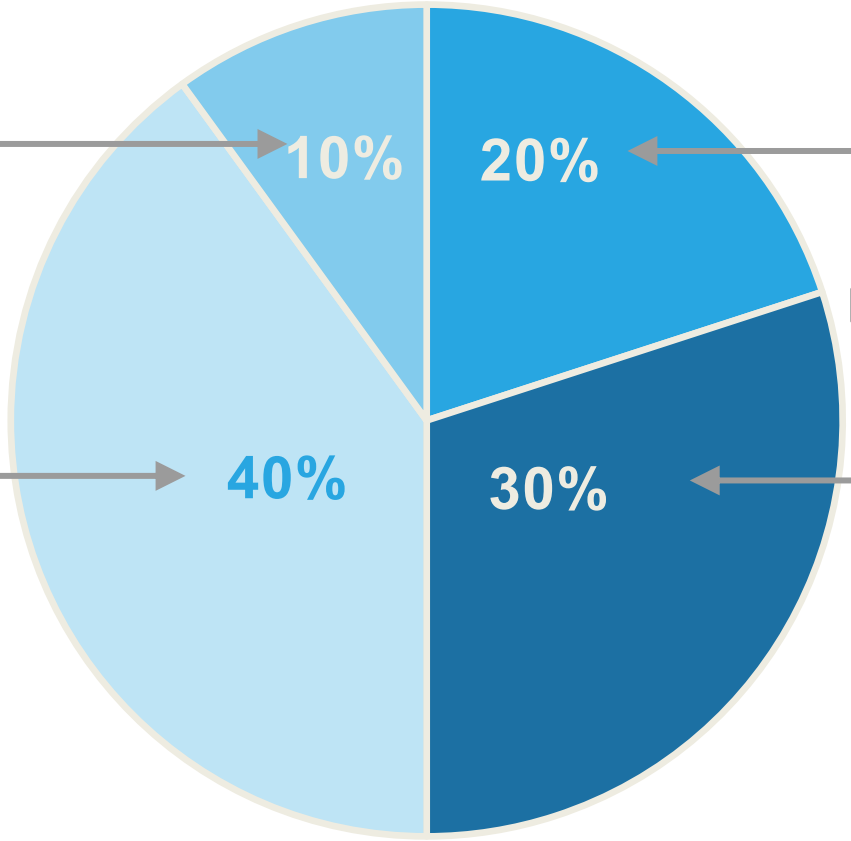
DETERMINANTS OF POPULATION HEALTH

Physical Environment
Environmental quality
Built environment

Socio-Economic Factors
Education
Employment
Income/Inequality
Child Poverty
Family/social support
Community safety



Health Care
Access to care
Quality of care

Health Behaviors
Tobacco use
Diet & exercise
Alcohol use
Unsafe sex

Source: Authors' analysis and adaptation from the University of Wisconsin Population Health Institute's County Health Rankings model ©2010, http://www.countyhealthrankings.org/about-project/background

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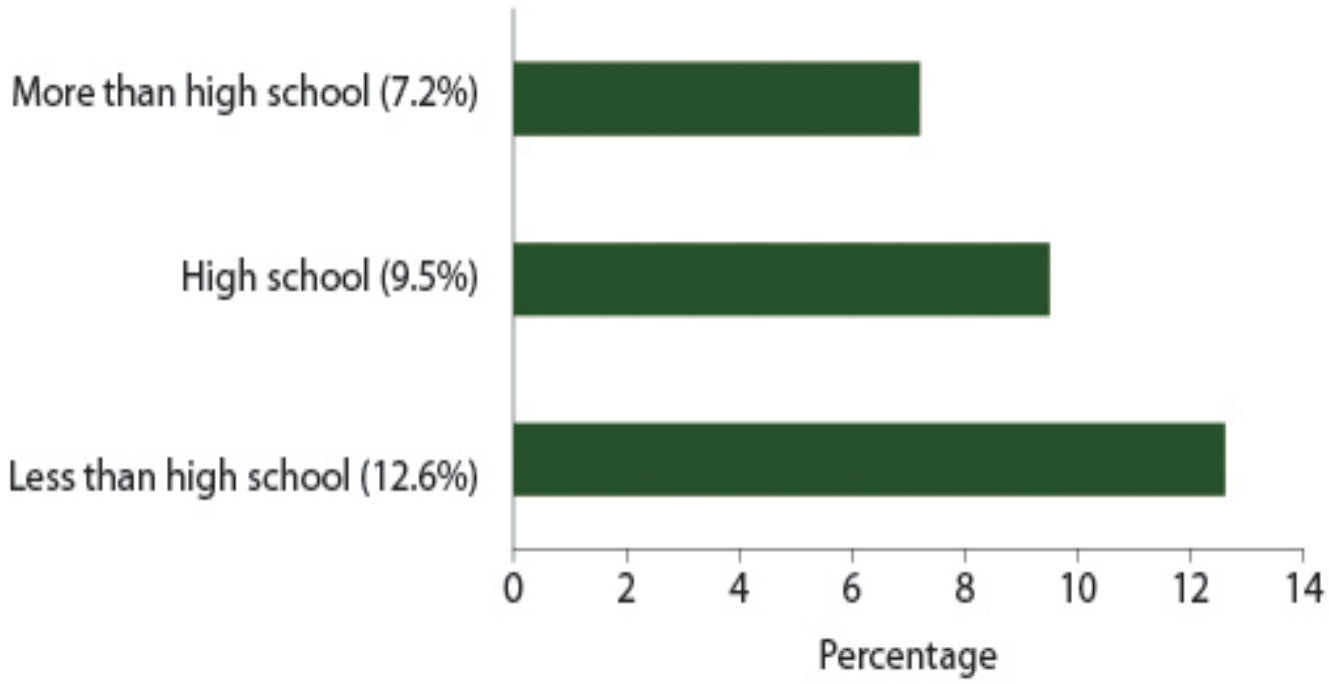
Percentage of US Adults Aged 18 or Older with Diagnosed Diabetes, by Education Level, 2013-2015

2017 Diabetes Report Card



https://www.cdc.gov/diabetes/disparities.html

Addressing Disparities in Diabetes

"To address race disparities in diabetes, policymakers should address problems created by concentrated poverty (e.g., lack of access to reasonably priced fruits and vegetables, recreational facilities, and health care services; high crime rates; and greater exposures to environmental toxins). Housing and development policies in urban areas should avoid creating high-poverty neighborhoods."

Disparities in Diabetes: The Nexus of Race, Poverty, and Place
Darrell J. Gaskin, PhD, Roland J. Thorpe, Jr, PhD, Emma E. McGinty, PhD, MS, Kelly Bower, RN, PhD, Charles Rohde, PhD, J. Hunter Young, MD, MHS, Thomas A. LaVeist, PhD, and Lisa Dubay, PhD, ScM

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Am J Public Health. 2014 November; 104(11): 2147–2155.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4021012/

Community Health Workers: One Strategy for Creating Economic Opportunities & Improving Health

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A COMMUNITY HEALTH WORKER IS…

…A community health worker is 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 worker 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 community health worker 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.

American Public Health Association. n.d. Community Health Workers. Available at: https://www.apha.org/apha-communities/member-sections/community-health-workers

How CHWs Care Teams

Within diabetes care, CHWs are a bridge between clinics and support service agencies and health care organizations.

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Image sources: Connecticut Health Foundation, June 2017 CHW report

CHW is a Professional Classification

- Patient/Peer Navigator
- Peer Counselor
- Lay Health Advisor
- Health Coach
- Peer Leader
- Peer Advocate
- Outreach Worker
- Outreach Advocate
- Linkage to Care Coordinators
- Promotora/ Promotora de Salud
- Healthy System Navigators
- Community Health Representative
- Community Health Advocate

… And many more

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Who are CHWs? – Virginia Definition

Individual(s) who applies his(her) unique understanding of the experience, language, and culture of the populations he(she) serves to promote healthy living and to help people take greater control over their health and lives and (ii) is trained to work in a variety of community settings, partnering in the delivery of health and human services to carry out one or more of the following roles:

(a) providing culturally appropriate health education and information;

(b) linking people to direct service providers, including informal counseling;

(c) advocating for individual and community needs, including identification of gaps and existing strengths and actively building individual and community capacity.

https://www.apha.org/apha-communities/member-sections/community-health-workers

Scope of practice & Core Competencies for Virginia

- ✓ Community Health Concepts and Approaches
- ✓ Service Coordination and System Navigation
- ✓ Health Promotion and Prevention
- ✓ Advocacy, Outreach and Engagement
- ✓ Communication
- ✓ Cultural Humility and Responsiveness
- ✓ Ethical Responsibilities and Professionalism


Community Mobilization and Outreach


Health Promotion and Coaching


Service System Access and Navigation


Care Coordination/Management


Community-Based Support


Participatory Research

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CHWs and Diabetes: The Evidence

CLIN CARE/EDUCATION/NUTRITION/PSYCHOSOCIAL

Outcomes at 18 Months From a Community Health Worker and Peer Leader Diabetes Self-Management Program for Latino Adults

Michael S. Spencer,[1] Edith C. Kieffer,[1] Brandy Sinco,[1] Gretchen Piatt,[1] Gloria Palmisano,[2] Jaclynn Hawkins,[3]

Diabetes Care 2018;41:1414–1422 | https://doi.or

OBJECTIVE

This study evaluated the effectiveness of a comm self-management education (DSME) program, fol to maintain improvements in HbA_{1c} and other clir over 18 months.

RESEARCH DESIGN AND METHODS

The study randomized 222 Latino adults with t control from a federally qualified health cente program or 2) enhanced usual care (EUC). After randomized to the CHW-led DSME were further r delivered monthly telephone outreach (CHW-on sessions delivered by peer leaders (PLs) with te to attend (CHW+PL). The primary outcome was blood pressure, lipid levels, diabetes distress, de of diabetes self-management, and diabetes s conducted at baseline and at 6, 12, and 18 r

RESULTS

Participants in the CHW intervention at the 6-mo in HbA_{1c} (−0.45% [95% CI −0.87, −0.03]; $P < 0$ points [95% CI −0.6, −0.03]; $P < 0.05$) compare maintained HbA_{1c} improvements at 12 and 18 m maintained improvements in diabetes distres participants also had significantly fewer dep compared with EUC (−2.2 points [95% CI −4.1 CHW-led DSME had significant improvements understanding of diabetes self-management these intervention effects were not sustained

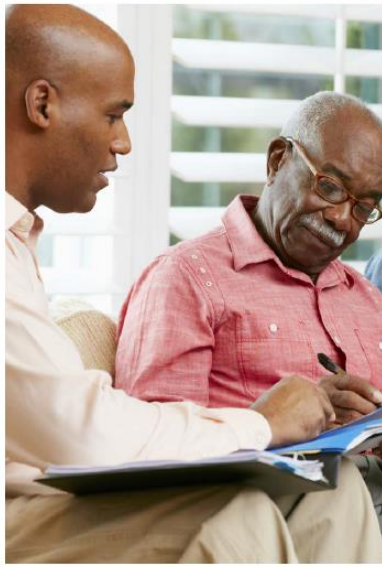
CONCLUSIONS

This study demonstrates the effectiveness of a diabetes outcomes and of a volunteer PL progra These are scalable models for health care ce achieving and maintaining improvements in key diabetes outcomes.

TECHNICAL ASSISTANCE GUIDE

States Implementing Community Health Worker Strategies

For the Centers for Disease Control and Prevent Health Actions to Prevent and Control Diabetes and Associated Risk Factors and Promote Schoo



National Center for Chronic Disease Prevention and Health Pro
Division for Heart Disease and Stroke Prevention

AADE American Association of Diabetes Educators

AADE PRACTICE PAPER

Community Health Workers' Role in DSMES and Prediabetes

Reviewed by AADE Professional Practice Committee

For every diabetes educator working in the United States, there are at least 1,000 people living with diabetes in need of diabetes self-management education and support (DSMES).[1] For every person with prediabetes seeking evidence-based care to prevent or delay the development of type 2 diabetes, there are another 5,600 who could join a lifestyle change program.[2] As the number of Americans living with diabetes and prediabetes grows and the population of the United States grows increasingly diverse, investing in an agile, culturally competent workforce to provide person-centered DSMES and diabetes prevention is critical; community health workers, promotores and community health representatives can be that workforce.

Introduction

The American Association of Diabetes Educators defines community health workers, or CHWs, as complementary healthcare workers who interact with people with diabetes or those at risk of diabetes. This group can be community health advisors, outreach workers, community health representatives (CHRs), promotores de salud (health promoters), patient navigators, navigator promotores (navegadores para pacientes), peer counselors, lay health advisors, peer health advisors, peer leader lifestyle coaches, or advocates.[3] Although they are known by a variety of job titles, based on the settings in which they work and the work they do within those settings, the term CHW is used as an umbrella occupational category to describe this important workforce.[4] CHWs are a trusted, frontline public health workforce. CHWs share many characteristics with the communities they serve. They speak a common dialect or language, empathize with community challenges, share cultural or religious beliefs, and can relate to the lived experiences of people with diabetes or prediabetes.[5]

settings, they can conduct home visits, lead faith-based support groups, assist with community-based screenings, promote healthy eating through Women, Infants, and Children (WIC) clinics or congregate meal sites, offer peer support in migrant health centers, and act as navigators inside large hospital systems. By working across settings, where community members live, eat, work, learn, play, worship, and access health services, CHWs understand the very real challenges to eating healthy foods, being physically active, taking medication, coping with stress, and accessing care that their own neighbors with diabetes and prediabetes experience.[6]

For that reason, CHWs play a valuable role in advancing health equity. While more than 30 million Americans have diabetes, and more than 84 million have prediabetes, certain populations, due to their ethnicity, gender, or socioeconomic status are disparately impacted by prediabetes, diabetes, and the complications of diabetes. According to the Centers for Disease Control and Prevention (CDC), diagnosed diabetes rates are highest among American Indians and Alaskan natives, Latinos,

Diabetes Preve Interventions E Community He

Snapshot | What the CPSTF Fou

Summary of CPSTF Finding

The Community Preventive Services Task Force (CPST health workers for diabetes prevention to impro outcomes among people at increased risk for ty

Economic evidence indicates these interventior interventions may reduce rates of progression t Interventions implemented in underserved com and enhance health equity.

Read less

Intervention

Community health workers (including promoto community health advisors, and others) are fro between underserved communities and healthc understanding of the community served. Comm and work without professional titles. Organizations may hire paid community health workers or recruit volunteers.

Read more

CPSTF Finding and Rationale Statement

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https://care.diabetesjournals.org/content/diacare/41/7/1414.full.pdf

WHY CHWs?

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Social Determinants

- ✓ Lack of transportation
- ✓ Lack of mental health resources
- ✓ Access to healthy foods
- ✓ Health literacy
- ✓ Secure housing
- ✓ Access to primary care
- ✓ Access to specialty care
- ✓ Reluctant to seek health and social resources due to stress and lower self-confidence

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CHWs are an Essential Element of Self–Management Programs & Community Linkage

- ✓ Leaders of self-management programs or serve in a supporting role.
- ✓ Providing post-program and ongoing support for patients
- ✓ Engagement in Community-Clinical Linkages such as:
  - ✓ Forging linkages and facilitating referrals
  - ✓ Following up on referrals to ensure that appointments are kept and patients are receiving provider recommended appropriate care.
  - ✓ Sharing linguistically appropriate health education materials
  - ✓ Conducting motivational interviewing to discover patient needs.
  - ✓ Facilitating relationships with social workers
  - ✓ Connecting patients to provide ongoing personal support….

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Roles for CHWs in Diabetes Management

- Working with diabetes/healthcare teams to identify and overcome cultural barriers to selfcare or behavior change
- Encouraging referrals to certified DSMES and CDC-recognized lifestyle change Programs
- Gaining insight into cultural understandings of prediabetes and diabetes and educating community members about these conditions
- Utilizing culturally connected strategies to confirm that individuals understand the information provided by diabetes educators and other healthcare professionals
- Participating in data collection, program evaluation, and continuous quality improvement initiatives
- Providing ongoing support to connect people with prediabetes or diabetes to community resources that address social determinants of health
- Collaborating with the diabetes/healthcare team to assist people with prediabetes or diabetes build effective self-management skills and sustain behavior change
- Supporting culturally informed changes to daily routines around healthy eating, being physically active, managing stress, and other self-care behaviors
- Serving as a bridge between people with diabetes, the diabetes healthcare team, and the healthcare system
- Building strong community connections through advisors, community health advisory boards, and multi-sector coalitions to inform healthcare providers about community needs, barriers to care, and facilitators for healthy behaviors

[Community Health Workers' Role in DSMES and Prediabetes]

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Role of the Community Health Worker

- ✓ Health Literacy
- ✓ Building partnership and advocating for the clients and community that we serve
- ✓ Leading by example
- ✓ Building trust to overcome barriers
- ✓ Follow with patients who need extra support, reinforce self management
- ✓ Attend office visits with patients
- ✓ Provide administrative support for diabetes educators
- ✓ Facilitate monthly support groups in PCMHs
- ✓ Facilitate community outreach events
- ✓ Perform risk screenings
- ✓ Organize Diabetes Awareness Events
- ✓ Facilitate Diabetes Prevention Program
- ✓ Daily diabetic logs/ food diaries
- ✓ Teaching recipes and showing heathy food options

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Recommendations for Diabetes Educators and other Health Professionals

Recognize how CHWs can transform practice and advance health equity

Acknowledge the unique skills that CHWs provide

Support CHWs as valuable members of team-based care while offering DSMES services and lifestyle behavior change programs

Provide ongoing mentorship, support, and direction to CHWs

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Recommendations for Diabetes Educators and other Health Professionals

- Invite CHWs to participate in the design, implementation and evaluation of the DSMES and DPP services
- Work with CHWs to assess community needs and identify resources to improve self-care and preventive behaviors
- Support continued research that explores the roles, contributions, and effectiveness of CHWs
- Involve CHWs in AADE trainings, workshops, seminars, and events
- Support CHWs in their education, skill building and professional development
- Support statewide efforts to integrate CHWs and build the CHW workforce
- Build awareness about the need for opportunities to sustainably finance CHWs in health care settings

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ASK

Resources

Community Health Workers' Role in DSMES and Prediabetes

American Association of Diabetes Educators

Technical Assistance Guide for States Implementing Community Health Worker Strategies

Centers for Disease Control and Prevention

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[Image Credit Pixabay]

Discussion

Contact us with questions:

Abby Charles, acharles@institutephi.org