Overview and Training Profile:

A Community Health Worker in a Diabetes Self-Management Education and Support Program

This document has been created as an overview of the experience of the Kentucky Diabetes Prevention and Control Program (KDPCP) as they explored ways to integrate a Certified Community Health Worker (CCHW) into a Diabetes Self-Management Education and Support (DSMES) program. Kentucky may differ from other states as we have a certification process (see Kentucky Office of Community Health Worker (KOCHW) program website for details). This pilot project was conducted within our umbrella hub arrangement for DSMES programs, called Healthy Living with Diabetes (HLWD). We found this pilot to be successful in offering support for both diabetes educators, as well as DSMES participants, and addressing social determinants of health (SDOH) related barriers that may impede a person with diabetes' (PWD) ability to access DSMES services or improve self-care behaviors.

Guiding Principles	Operational Definition
A description of the **values and principles** that undergird the program or practice.	A CHW working within a Diabetes Self-Management Education and Support (DSMES) program helps to improve overall participant outcomes by increasing equitable access to healthcare and social services, removing social determinants of health (SDOH) barriers, and providing support and health coaching that facilitates participant self-efficacy.

Core Component	Operational Definition	Activity	Training & Core Competency
Resource Liaison	• Identifies and connects patients to local, state, and/or national resources that address individualized needs and gaps in accessing health care, including but not limited to Social Determinants/ Drivers of Health (SDOH) related issues. ***Examples of Areas to address related to health care access and SDOH gaps:*** • Includes but is not limited to: ○ insurance eligibility, ○ medication assistance, ○ scheduling doctor's visits, ○ transportation (direct cost of private or public transportation, fuel money, access to rides with family/ friends/ community members), ○ medical devices, ○ food insecurity assistance, ○ access to healthy foods, ○ housing,	• Identifies/assesses potential SDOH issues that may need to be addressed before, during or after a Diabetes Self-Management Education and Support (DSMES) series. • Applies knowledge of gaps in care related to social determinants of health when reviewing client's DSMES assessment and when talking with client to determine appropriate individualized support, in collaboration with the diabetes educator. • Uses a variety of strategies to identify potential resources for addressing Social Determinants of Health (SDOH) that may be a barrier to accessing and/or utilizing diabetes care and services. • Uses communication techniques with clients to elicit thorough responses and help collaboratively address needs/ gaps/ resources.	• May use the PRAPARE Lite or similar standardized assessment tool for people with diabetes or at risk for diabetes to assess and address social needs. Parts of a chosen tool may also be integrated into existing assessment forms (paper or electronic). Follow this link for a Getting Started with PRAPARE Lite training opportunity. • Integrating Social Needs Screening for PWD (Person with Diabetes) • Review a comprehensive DSMES cycle and identify opportunities for Certified Community Health Worker (CCHW) involvement (see handout- 2022 Initial Comprehensive DSMES Cycle)

	○ utility assistance, ○ foreign language interpretation, ○ technology access (broadband access, affordability of technology devices and/or internet services, knowledge of technology use) ○ physical activity accessibility (gyms, group fitness classes, affordability of indoor facilities, safe outdoor spaces, location of physical activity of choice nearby, etc.), ○ access to diabetes support groups or peer support activities, ○ and others.		• Facilitate electronic referrals to and from the CCHW via a secure electronic referral platform or integrated electronic health record (EHR) (Kentucky uses Kentucky Health Information Exchange (KHIE) CareAlign platform). • Strategically add diabetes-specific resources to existing resource directories, per Certified Community Health Worker (CCHW) experience and basic certification training. • Complete onboarding for an online resource directory (Kentucky uses kynect Resources). **Kentucky CCHW Core Competency #1,2,3,5**
Contribution to Output/Outcome	• Social and health needs are objectively identified and addressed. • Facilitates referrals to healthcare and non-healthcare services and ensures referral loop is closed. • Increases health equity by removing barriers to allow Diabetes Self-Management and Education Support (DSMES) participants to meet their own health-related goals.		

Core Component	Operational Definition	Activity	Training & Core Competency
Patient Advocacy	• Patient advocacy is an essential element of the client-CHW relationship and is "defined as empowering not only the client but also the broader community so as to overcome social determinants of health (SDOH) and thereby attain health equity and social well-being." Micro-level advocacy focuses on smaller scale change for the individual client and smaller scale change at the organization. Macro-level advocacy is focused on broader change at the community and society levels. Professional-level advocacy is focused on making changes aimed at increasing awareness and legitimacy of the CHW profession." (Logan, 2019)* Being a community health worker means advocating at multiple levels. *Reference: Logan, et. al. Anthropology in Action, 26, no. 2 (Summer 2019): 9–18*	• Identifies/assesses potential areas in which CHW can advocate for person with diabetes (PWD). • Serves as a patient advocate by empowering patients to access and utilize the identified resources while respecting patient individual needs and supporting increased self-advocacy. • Collaborates with healthcare system and support services and establishes linkages for continued advocacy support as needed. • Given the opportunity, participates in advocacy for PWDs at a local, regional, state, or national level. • Uses a strengths-based approach to find the "just right" amount of support to access and utilize resources and services like making medical appointments, wellness checks, getting	• Diabetes Distress: Presented by Cecilia Sauter MS, RDN, CDCES, ADCES • Advocacy 101 Webinar presented by Dr. Sheila Schuster (KY Psychological Association & Advocacy Action Network) and Emily Beauregard KY Voices for Health) • **Effective Communication for Healthcare Professionals** • **https://www.train.org/ky/welcome** **Course Introduction** ▪ Course 1077848 (.15 hr) **Health Literacy** • Course 1077845(.3h) **Cultural Competency** ▪ Course 1077846(.45h) **Limited English Proficiency (LEP)**

		yearly vaccinations and follow-up care. • Provides social support to empower client. • Actively listens to client and their experiences and situation as it relates to their self-management and living with diabetes. • Ensures client's voice is heard and listened to. • Supports client to achieve their own health care goals, in particular those related to diabetes management.	▪ Course 1077847 (.45 h) **Kentucky CCHW Core Competencies # 1,2,3,4**
Contribution to Output/Outcome	• Establishes link between clinicians and patient. • Increase patient self-advocacy. • Ensures the person with diabetes' (PWD) voice is being heard at multiple levels		
Core Component	**Operational Definition**	**Activity**	**Training & Core Competency**
Patient-Centered Health Coaching	• Strengths-based, just right, & patient-centered coaching and support that is responsive to behavior change stage: precontemplation, contemplation, preparation, action, maintenance, & termination.	• Uses strength-based language. • Assesses individual behavior change stages and responds appropriately to support the patient.	• Diabetes Distress: Presented by Cecilia Sauter MS, RDN, CDCES, ADCES • Motivational Interviewing: Presented by David K.

	○ *Strengths-based* because the CHW focuses on what can be done (solutions) rather than obstacles in the way (the problems) and uses positive language. ○ *Just right support* because the CHW assesses and builds their health coaching around where the client is along the readiness to change stages. ○ *Patient-centered* because the CHW's health coaching is built around what the client wants and needs and what the patient's goals are for him/herself (shared decision making).	• Recognizes how and when to use different patient-centered health coaching communication techniques (see Communication section) to address individual challenges and changing circumstances of patients' environment. • Helps Person with Diabetes (PWD) navigate the healthcare system when challenges arise (see Advocacy). • Uses techniques to support positive behavioral changes, such as emotional/ social support, practical support, encouragement, reinforcement of education provided by licensed clinician, appropriate use of health services, role modeling, harm reduction, etc. • Recognizes and incorporates culturally sensitive practices in order to best meet the needs of the client and overcome any cultural barriers to appropriate care.	Miller, RN, MS ED, DCES, FADCES • Mental Health First Aid (National Council for Mental Wellbeing). • ADCES DCCC modules https://www.diabeteseducator.org/product/CDCCC001 • Observe/ participate in a Diabetes Self-Management Education and Support (DSMES) Series • Review a comprehensive DSMES cycle, preferably with a diabetes educator, and identify opportunities for CCHW involvement. • Review current and relevant literature around health coaching such as: 5 Roles of Health Coaching

		• Reviews available documentation related to goal-setting to inform individualized health-coaching and enhance PWD self-efficacy. • Reviews the DSMES Diabetes Self-Management Support Plan to identify and address gaps in preventative care and health promotion activities to inform individualized and culturally responsive health-coaching techniques & reinforces guideline-driven care from a reputable source. • Facilitates connections between the PWD and family members, friends, community members, or organizations that can provide ongoing assistance, support, and accountability. • Serves as a bridge between the clinician and client; reinforces healthcare provider plan of care for person with diabetes, if available. • Recognizes when client may be at risk for acute diabetes-	A Qualitive Study of How Health Coaches Support Patients in Making Health-Related Decisions and Behavioral Changes **Kentucky CCHW Core Competencies # 1,2,5,6,**

		related complications and consults higher level provider when needed. • Provides self-management support; follows up with patient about challenges and successes with behavior goal after DSMES; offers ongoing support as needed. • Ensures that shared decision making is respected through all client interactions. • Facilitates continuity of care after PWD completes a DSMES series.	
Contribution to Output/Outcome	• Supports patient behavior change (behavior goal). • Supports patient in following a plan of care. • Increase patient self-efficacy.		
Core Component	**Operational Definition**	**Activity**	**Training & Core Competency**
Communication	• Uses effective, timely, and positive communication strategies with Persons with Diabetes (PWD), Diabetes Self-Management Education and Support (DSMES) team members, healthcare system partners, and community partners and organizations.	• Recognizes how and when to use appropriate communication techniques with PWD including (active listening, reflective listening, open-ended questions, motivational interviewing, role modeling, plain language, reassurance, open body	• Motivational Interviewing: Presented by David K. Miller, RN, MS ED, DCES, FADCES • Effective Communication for Healthcare Teams-TRAIN 1077848

	Supports enhanced communication between DSMES participant and healthcare provider. Documents communications with all stakeholders.	language, strength-based language, summarization, teach-back, hands on demonstration, & rephrasing, etc). • Assists PWD to engage with and advocate for self with doctor to enhance client-provider communication, increase PWD knowledge of their health status, and engage in shared decision making around diabetes management. • Assists/supports patient to more fully understand their plan of care with their healthcare provider (e.g., develop a sick day plan, problem-solve short-term complications, and/or plan for self-management behaviors). • Ensures timely and consistent communication with Diabetes Educator (DE) in order to facilitate appropriate individualized plan of support for PWD. Plan of support includes actions the CHW can take to provide support to the	**Kentucky CCHW Core Competency # 1,7,8**

		PWD in order to fulfill the DSMES plan of care. Support can also include addressing and removing barriers to participation and engagement in DSMES. • Recognizes and bridges gaps in patient literacy (health, numeracy, insurance, technology, etc.). • Completes timely and accurate documentation of communication with and for PWD. • Maintains and protects client confidentiality, including verbal, written, and electronic information. • Ensures professional and timely response in communication with and for the PWD.	
Contribution to Output/Outcome	• Accurate and timely documentation of services supports communication with and for the Person with Diabetes (PWD) and increases fidelity and sustainability of the program/ organization. • Enhance PWD's ability to problem solve for acute complications and prevent unnecessary Emergency Department (ED) visits and hospitalizations.		

	• Use of communication skills supports all aspects of the person with diabetes' care, Diabetes Self-Management Education and Support (DSMES) experience, and ultimately their likelihood of achieving improved health outcomes through meeting their goals.

Addendum: Acronym Definitions

Glossary of Key Terms

Certified Community Health Worker (CCHW) – 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" (American Public Health Association, 2024). In Kentucky, the Kentucky Office of Community Health Workers "issues official certification for community health workers who successfully demonstrate all either core competencies through completion of qualified training or related work experience." Visit this link to learn more.

Department for Public Health (DPH) - The sole organizational unit of Kentucky's state government responsible for developing and operating all public health programs and activities for the citizens of Kentucky. These activities include health service programs for the prevention, detection, care, and treatment of physical disability, illness and disease.

Diabetes Self-Management Education and Support (DSMES) – DSMES helps individuals with diabetes learn how to manage their disease and be as healthy as possible. It focuses on seven self-care behaviors: Being Active, Healthy Eating, taking Medications, Healthy Coping, Reducing Risk, Problem Solving, and Monitoring. Programs may be "Recognized" by the American Diabetes Association (ADA) or "Accredited" by the Association of Diabetes Care and Education Specialists (ADECS). Being "Recognized" or "Accredited" means these programs have met national standards for excellence in diabetes education.

Emergency Department (ED) - Hospital facility that is staffed 24 hours a day, 7 days a week, and provides unscheduled outpatient services to patients whose condition require immediate care.

Healthy Living with Diabetes (HLWD) - The Kentucky Diabetes Prevention and Control Program (KDPCP), within the larger Kentucky Department for Public Health, facilitates an accredited umbrella program called Healthy Living with Diabetes (HLWD).

Kentucky Association of Community Health Workers (KYACHW) – A unified association of community health workers in Kentucky with the purpose of spreading knowledge and advocating for recognition of CHWs and our communities. Visit this link to learn more.

Kentucky Diabetes Prevention and Control Program (KDPCP) - The Kentucky Diabetes Prevention and Control Program (KDPCP) operates within the Kentucky Department for Public Health and the Cabinet for Health and Family Services. KDPCP's purpose is to lead Kentucky in improving health outcomes for people living with, or at risk for, diabetes through community education, capacity building and collaboration. Visit this link to learn more.

Kentucky Office of Community Health Workers (KOCHW) – The Kentucky Office of Community Health Workers (KOCHW) exists to strengthen, support and promote sustainability of the Community Health Worker (CHW) profession across Kentucky. This work has been developed in alignment with KOCHW Certification Core Competencies. Follow this link to view these competencies within the certification manual.

kynect resources- kynect resources is a place to find local programs and services. Through a partnership with United Way of Kentucky, kynect resources provide a mobile-friendly, managed directory to connect Kentuckians to the help they need. Learn more at the kynect website.

Licensed Diabetes Educator (LDE) – The Kentucky Board of License Diabetes Educators "examines and licenses all eligible candidates for entry into the profession of Diabetes Educators." In Kentucky, by regulatory statute 201 KAR 45:130, an individual may only refer to themselves as "diabetes educators" or "licensed diabetes educators" after completing and maintaining all licensure requirements as described by the Board. To learn more visit this link.

Local Health Department (LHD) – Kentucky has a total of 64 local health departments, serving regions or single counties, and covering all of Kentucky's 120 counties.

Persons with Diabetes - (PWD) - Refers to individuals with any type of diabetes using person-first language.

Social Determinants of Health (SDOH) - The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH Domains are economic stability, education access and quality, health care access and quality, neighborhood and built environment and social and community context. To learn more visit this link.