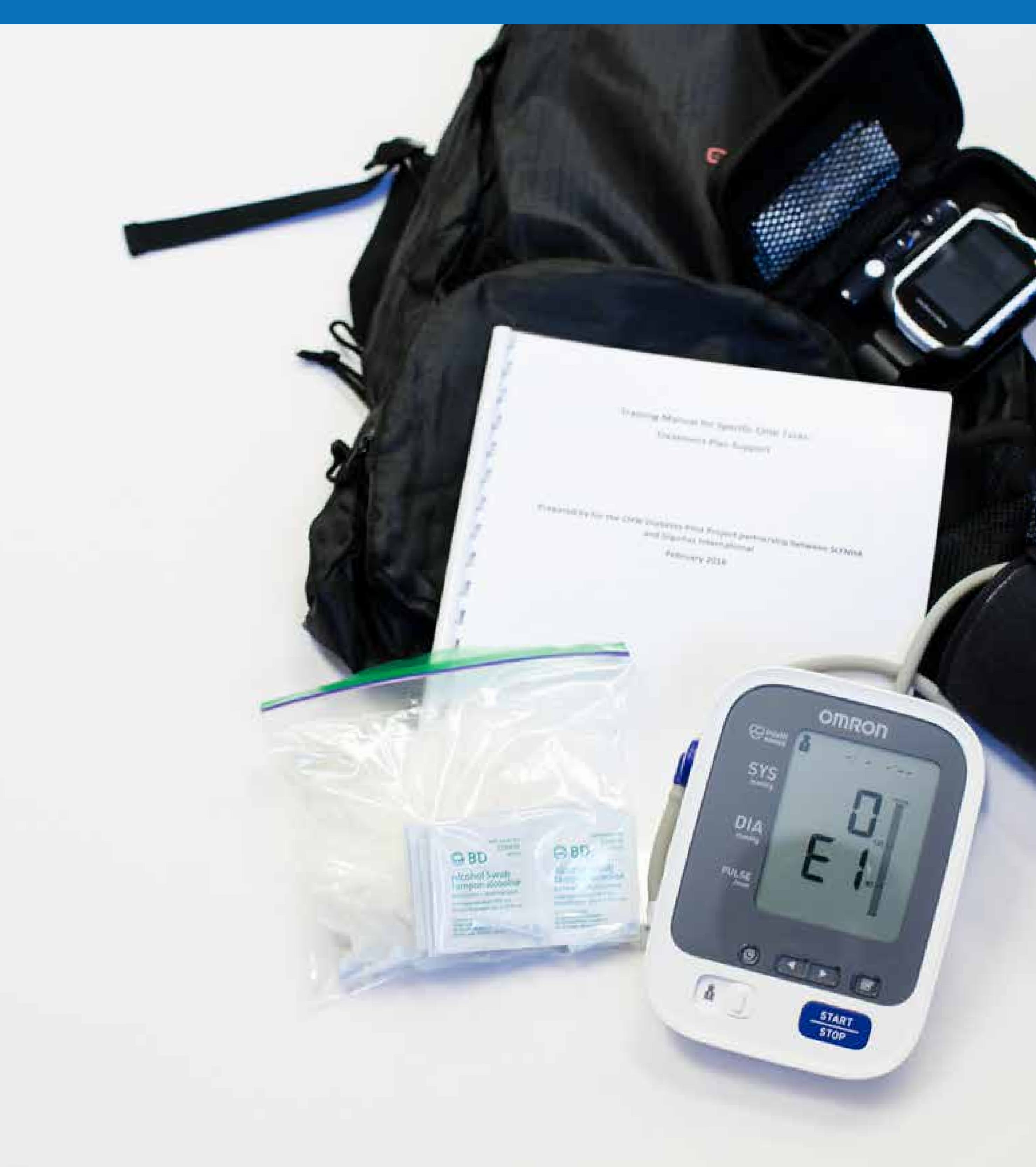
Community Health Worker Diabetes Program

TREATMENT PLAN SUPPORT



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Purpose

Purpose of this Manual

This training manual outlines specific tasks Community Health Workers (CHWs) will be responsible for carrying out as part of Treatment Plan Support. This manual was written to accompany the in-person training, and also as a reference guide for CHWs in their daily work.

This manual is organized as follows:

For each task, there is a description of:

- The **purpose** of the task
- A suggested **process** for how the task is carried out
- Some **suggested dialogue** that the CHW could use, if the tasks involves communicating something with the client

This manual and associated tools will be subject to revision to make sure their content is up-to-date. The most recent version can be found at www.chwconnect.ca.

This project is a partnership between Sioux Lookout First Nations Health Authority (SLFNHA) and the University of Toronto Department of Family and Community Medicine. We are developing a community-based case management model of diabetes care for the Sioux Lookout Area, with best practices from other parts of the world about how to run CHW programs effectively and successfully. Treatment Plan Support was identified by Health Directions as one of three top priorities for improved care of type 2 diabetes in First Nations communities in the Sioux Lookout area. The other two priorities were Self-management Support, and Community Education and Health Promotion. These two priorities will be addressed in future training sessions.

B Role of CHW

Role of the Community Health Worker in Treatment Plan Support

Congratulations! You have been identified by your community as an individual who will be a who will be a CHW for type 2 diabetes.

Who can be a CHW?
CHWs are individuals, usually from the community, who are a key part of the health care team supporting the community-based case management of type 2 diabetes. The tasks they perform support the delivery of quality healthcare to those living with type 2 diabetes.

What is a Treatment Plan?
A treatment plan is a guide for care and management of type 2 diabetes created by the healthcare team and client. It includes important information that the client has been advised to follow for the best care.
It can include:

- Prescription medication
- Diet and exercise plans
- Testing and follow-up appointment information
- Specialist referrals
- Other important information

What is Treatment Plan Support?
It is the CHWs' responsibility to help clients follow their treatment plan. This support helps clients so that **no one falls through the cracks**. CHWs can support clients by:

- Monitor clients' diabetes by tracking blood sugars, blood pressure, weight, foot problems, and medication use
- Ensuring clients are taking their medications and using their blood sugar meter as prescribed
- Reminding clients of overdue lab tests or eye exams, and upcoming appointments
- Helping clients get to appointments by finding transport, childcare or other supports
- Providing any other support they need for health-related issues.
- Communicating with clinicians at the nursing station on any issues that a client may be having in following a treatment plan.

If CHWs detect a problem, they should alert a member of the healthcare team have the issue addressed right away, rather than allowing the problem to drag on, possibly leading to complications. Members of the healthcare team may include:

- Nurse in charge
- Home care nurse
- Diabetes nurse or dietitian
- Nurse practitioner or doctor

CHWs are the eyes and ears of the healthcare team when they are not present, as well as a voice for the client to advocate for needed support.

What is not the CHW's Role?

CHWs should clearly communicate their role to their client. Reassure the client that they are there to help, and that they can support and communicate with the healthcare team as directed by the client.
It's important to remember the CHWs' scope of practice, so safe care can be provided to all our clients living with diabetes.

Therefore, CHWs' do not:

- Create or revise plans or advise clients in any way on how to modify the treatment plan
- Prescribe medications or alter prescriptions
- Refer clients to any medical specialists, or order tests

Care plan support performed by CHWs is not intended to replace regular clinical follow-up. The primary health care provider (doctor/ nurse practitioner) and other health professionals (nurses/ dietitians) will continue to see the client but will now have better information to work with.

Diabetes Basics

1 What is Diabetes?

What is Diabetes?

Diabetes is a disorder where sugar (glucose) in the blood is too high for a long period of time. Its full name is diabetes mellitus (DM). There are different types of diabetes due to different causes.

Type 1 Diabetes
- Usually diagnosed in children and adolescents
- Cause: pancreas unable to produce insulin—hormone that controls the amount of glucose in the blood
- Treatment: insulin injections

Type 2 Diabetes
- Usually diagnosed in adults, but increasing in youth
- Causes: body does not effectively respond to the insulin that is produced and/or pancreas does not produce enough insulin
- Treatment: lifestyle changes, medications, insulin injections

We will be focusing on this type of diabetes as it is the most common

Prediabetes
- Usually diagnosed in adults, but increasing in youth
- A warning that someone is likely to develop type 2 diabetes in the next few months or years
- Treatment: lifestyle changes, sometimes medication

Gestational Diabetes
- Occurs during pregnancy. After baby is born, blood sugar levels return to normal and mother no longer has gestational diabetes. However, mother and baby are both at higher risk for type 2 diabetes later
- Cause: body cannot produce enough insulin for both mother and baby
- Treatment: lifestyle changes, medications, insulin injections

2 Blood Sugar, Glucose, and Insulin

Blood Sugar, Glucose, and Insulin

In type 2 diabetes, there is often too much sugar in a person's blood. In this section, we will look at where blood sugars come from, symptoms of high and low blood sugar, foods that cause blood sugars to increase, and the role of insulin managing blood sugars.

Sugar in our blood comes from:

- Carbohydrate foods
- Stored carbohydrates in the liver

In diabetes, blood sugars can get too high and too low.

Symptoms of high blood sugar, or hyperglycemia:

- Unusual thirst
- Frequent urination
- Extreme fatigue or lack of energy
- Weight loss
- Increased appetite
- Blurred vision
- Warm, dry skin
- Restlessness, drowsiness, or difficulty waking up

Symptoms of low blood sugar, or hypoglycemia:

- Sweating
- Nervousness, shakiness, weakness
- Extreme hunger
- Dizziness and headache
- Blurred vision
- Cannot concentrate
- Confusion and irritability
- Unable to walk

Glucose:

- Glucose, or sugar, comes from carbohydrate foods. These foods increase blood sugars.

Examples of foods that have carbohydrates:

- Grains and grain products: pasta, rice, bread, cereal, oatmeal, crackers, bannock, pancakes, waffles
- Fruits: apples, grapes, oranges, berries
- Sweets: chocolates, candies, pop, juice crystals, fruit juices, chocolate milk, pudding, ice cream, pies, cookies, cakes
- Milk and dairy products: milk, yogurt
- It is important for someone with diabetes to know which foods cause blood sugars to increase. This can help them manage their diabetes.

Insulin

- Insulin is a hormone made by the pancreas. The pancreas is an organ located behind the stomach.
- Insulin tells the body's cells to move sugar from the blood to inside the cell.
- This allows the body to use the sugar for energy and decreases blood sugars.
- In type 2 diabetes, body's cells don't respond to insulin properly, or not enough insulin is produced. Without insulin, the body's cells don't get enough energy, and blood sugars are too high. This causes the signs and symptoms of high blood sugars and leads to diabetes complications over the long term

3 Diabetes: Gold Standard of Care

Diabetes: Gold Standard of Care

Control Blood Sugar

- HgbA1C, or A1C is a test that measures someone's average blood sugars over the last 2-3 months. This test does not require fasting
- A1C target is different for different people and is usually decided by the primary care provider and patient together.
- For many adults with type 2 diabetes, a target of <7% can help reduce diabetic complications
- A1C should be measured every 3-6 months

Control Blood Cholesterol

- LDL blood cholesterol <2.0 mmol/L
- Lowers risks for heart disease and stroke

Control Blood Pressure

- <130/80
- Lowers risks for heart disease and stroke

Foot Care

- Regular foot exams and treat problems appropriately
- Reduces risks for amputation

Eye Care

- Yearly dilated eye exam
- Reduces risks for blindness and other eye problems

4 Diabetic Complications

Diabetic Complications

Complications of diabetes include:

- Heart attack
- Stroke
- Kidney failure
- Blindness
- Amputation

These complications can be life-threatening and severely impact one’s health. If diabetes is well controlled, complications are less likely.

Data Management

Maintaining the Patient Registry

Purpose

The Patient Registry is a master list of all the people in your community who have type 2 diabetes. It is one of the most important tools in this program. It helps CHWs track each individual person so that no one falls through the cracks, and patients receive the clinical tests that can help keep them healthy.

Role

Your task as a CHW will be to enter diabetes data using standardized forms. These forms are very important as they help everyone keep track of each patient.

Preparation

Each CHW involved in using the Patient Registry should read, understand, and abide by the privacy and confidentiality guidelines.

Process

1. Review existing lists of diabetes clients. Most clinics will have some pre-existing list of diabetes clients. The CHW should sit down with the head nurse, review the list and think of any additional clients that should be added. If there appear to be some clients missing, the nurse can pull the chart, look to see if each client has diabetes, and then add the clients to the list.

2. Begin entering information from the list provided by the nursing station into the Patient Registry. If there is information missing, consult with the nurse or get this information from the patient chart.

3. After you have entered all the information about diabetes patients in your community, save a copy of your work so it does not get lost and you can update it later as needed. You can also print a copy for your records if you prefer working on paper.

4. Once every 3 months, meet with the nurse in charge to see if any additional patients have been diagnosed with diabetes. Add any additional clients to the registry as described above.

Diabetes All Patient Registry

CHW Diabetes Program

Community Name: ______________________________

Start date for this page (DD/MM/YY): ______/_______/_______

This is a list of all the diabetes patients in the community – needs updating every 3 months

Page Number: ___________

Client #	Date DD/MM/YY	First and Last Name	Sex M/F	Date of Birth DD/MM/YYYY	OHIP Number or Band Number	Date of Diabetes Diagnosis DD/MM/YYYY	Date of Last Retinal Exam DD/MM/YYYY
	/ /			/ /		/ /	/ /
	/ /			/ /		/ /	/ /
	/ /			/ /		/ /	/ /
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Patient Registry Example

2 Client Recall List

Purpose

The client recall list is the list of active patients that you are currently seeing. It will help to make sure that patients get follow-up visits when they need them. The recall list also helps CHWs identify which patients are struggling to control their diabetes and are in greatest need. CHWs can then devote more time to support these people with the greatest need to better manage their care.

Role

The CHW is responsible for maintaining an up-to-date list of active diabetes patients they are seeing and keeping this information confidential.

Preparation

Have the Patient Registry ready, along with the patients' latest A1C test results. If you have any questions, or is unsure of how to obtain this information, reach out to the CHW Program Manager.

Process

Fill out the name, most recent A1C value and test date for each patient. Visit each patient on the list. Based on the patient's A1C, choose the appropriate date for following up with them.

"Hello _______, this is ________ calling, the diabetes worker. It's been 3 months/ 1 month/ 1 week since we saw each other and it's time for a follow up."

"Would you like to come to the clinic, or would you rather that I come to your house instead?"

CHW Diabetes Program

Recall List

This is a list that shows how often to do patient visits

Patient Name	Most Recent A1C	Date of Most Recent A1c (DD/MM/YY)	A1C >9 See Every Week	A1C 7.5 – 9 See Every Month	A1C <7.5 See Every 3 Months
Rae, James	*8.4*	*15 / 08 / 19*		✓	
Mamakwa, Sandra	*9.3*	*23 / 11 / 19*	✓		
Anderson, Kevin	*7.2*	*14 / 01 / 20*			✓
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		/ /			
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Recall List Example

3 Weekly Log Sheet

Purpose

The weekly log sheet keeps track of the number of diabetes patients the CHW works with.

Role

As the CHW, you would fill out the log sheet each week to keep track of the number of diabetes patients you met with, and send this information to the CHW Program Managers.

Preparation

If you have any questions or concerns, reach out to the CHW Program Manager.

Process

1. Every work day, record the number of diabetes patients you meet with. Keep track of how many patients are new, and which ones you have seen before.

2. At the end of each week, record the total number of patients, the number of new patients, and the number of follow-up patients on the bottom of the log sheet. Send it to the CHW Program Managers via fax or email.

Weekly Log Sheet: CHW Diabetes Program

Community Health Worker: ______________________________________

Community: _________________________________

Week of: __________________________________ Date Sent: __________________________________

Day of Week	Number of Patients Seen
Monday	
# of New Patients: *# of Follow-up Patients:* *Notes:*	
Tuesday	
# of New Patients: *# of Follow-up Patients:* *Notes:*	
Wednesday	
# of New Patients: *# of Follow-up Patients:* *Notes:*	
Thursday	
# of New Patients: *# of Follow-up Patients:* *Notes:*	
Friday	
# of New Patients: *# of Follow-up Patients:* *Notes:*	

Total # of Patients Seen: ______________________

# of New Patients: ___________________________

# of Follow-up Patients: _______________________

Weekly Log Sheet Example

Physical Assessment

1 Height

Purpose

Clients should be monitored regularly for changes in blood pressure, weight and foot problems. If problems are identified earlier, the doctor and/or nurse can be alerted sooner, and problems can be dealt with sooner before they get worse.

Height and weight are used together to calculate a person's Body Mass Index (BMI). BMI indicates risks associated with being underweight and overweight. A BMI of 18.5-24.9 indicates a weight that is not underweight or overweight. A BMI of 25 or more is overweight, and this is associated with a higher risk of type 2 diabetes. For someone with type 2 diabetes who is also overweight, losing 5-10% of their body weight (about 8-25 lbs) can help them manage their blood sugars. BMI applies to most adults 18-65 years old. It should not be used for the elderly, children, and during pregnancy and breastfeeding.

Roles

The CHW's role is to do physical assessments on clients deemed at "high-risk", those who have very poor control of their diabetes and require more support. See section I below on how these clients will be identified. CHWs will use the CHW Diabetes Clinical Assessment Log Sheet to record visit information.

Prep

1. Tell client you will measure their height.

> "I'd like to take your height now. Do you have any questions?"

2. Ask client to remove shoes, bulky clothing, and hair ornaments, and unbraid hair that interferes with the measurement.

> "Please remove your shoes, hat, anything that can add height. Stand up straight here so we can measure your height, and please face away from the wall."

3. Take the height measurement on flooring that is not carpeted and against a flat surface such as a wall with no molding.

4. Ensure client stands with feet flat, together, and against the wall. Make sure legs are straight, arms are at sides, and shoulders are level.

5. Ask the person to look straight ahead and that their line of sight is parallel with the floor.

Do

6. Take the measurement while the person is standing tall and straight upright.

7. Use a flat headpiece to form a right angle (90 degrees) with the wall and lower the headpiece until it firmly touches the crown of the head.

8. Make sure your eyes are at the same level as the headpiece.

9. Lightly mark where the bottom of the headpiece meets the wall.

10. Measure from the floor to the marked measurement.

Record

11. Accurately record the height in the Log sheet, to the nearest 0.5 centimeter.

2 Weight

Purpose

Clients should be monitored regularly for changes in blood pressure, weight and foot problems. If problems are identified earlier, the doctor and/or nurse can be alerted sooner, and problems can be dealt with sooner before they get worse.

Height and weight are used together to calculate a person's Body Mass Index (BMI). BMI indicates risks associated with being underweight and overweight. A BMI of 18.5-24.9 indicates a weight that is not underweight or overweight. A BMI of 25 or more is overweight, and this is associated with a higher risk of type 2 diabetes. For someone with type 2 diabetes who is also overweight, losing 5-10% of their body weight (about 8-25 lbs) can help them manage their blood sugars. BMI applies to most adults 18-65 years old. It should not be used for the elderly, children, and during pregnancy and breastfeeding.

Roles

The CHW's role is to do physical assessments on clients deemed at "high-risk", those who have very poor control of their diabetes and require more support. See section I below on how these clients will be identified. CHWs will use the CHW Diabetes Clinical Assessment Log sheet to record visit information.

Prep

1. Tell client that you will measure their weight.

> "I'd like to take your weight now. We want to make sure it's healthy for your height. Do you have any questions?"

2. Ensure that client removes shoes, heavy clothing, items in pockets.

> "Please remove your shoes, heavy clothing, and things in your pockets that can add weight. Then, please step on the scale."

3. Check that the scale is working and units are in kg.

4. Check that the scale is at zero.

Do

5. Have client stand on the scale (if a sliding scale, move weights until it balances).

Record

6. Accurately record client's weight on the Log sheet.

3 Blood Pressure

Purpose

Patients should be monitored regularly for changes in blood pressure. If problems are identified earlier, then the doctor and/or nurse can be alerted sooner and problems can be dealt with sooner before they get worse.

The blood pressure target for diabetes patients is 130/80. Not everyone can feel if their blood pressure is high, so accurate measurement is important to detect abnormal blood pressure.

Use the CHW Diabetes Clinical Assessment log sheet paper form to record visit information.

Roles

The CHW should take and record blood pressure at each visit and record this information using the Clinical Assessment Log Sheet. Any issues should be discussed with the nurse right away.

Prep

1. Tell the patient that you will be taking their blood pressure. Let them know that you will be taking it 4 times total. Taking it multiple times helps to make sure the readings are accurate.
Ask them to refrain from talking during this time.

> I need to take 4 measurements to make sure the reading is accurate.
> Please do not talk during this time.

> "I'd like to take your blood pressure now. We want to make sure it's normal. When it's too high, that can lead to strokes and heart attacks.
> Do you have any questions?"

2. Have patient sit down and rest for 5 minutes.

Do

3. Ask the patient to stretch their left arm out and rest it on a surface. Feel for a pulse from a big artery (the brachial artery). Put the arrow of the blood pressure cuff so that it points to where this pulse is.

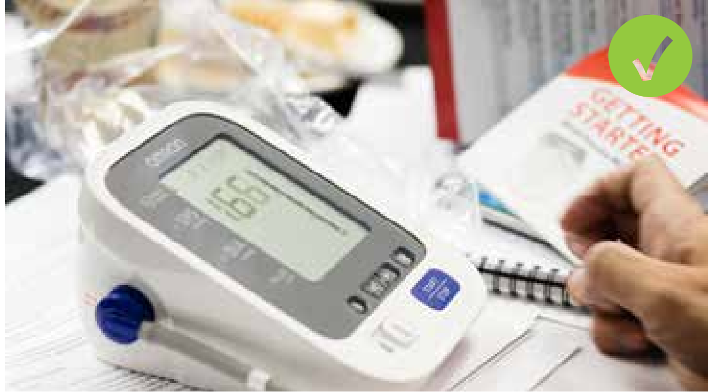
4. Put the cuff so that the lower edge is about 3 cm (1") above the bend of the elbow. Wrap the cuff around the arm and fasten it using the velcro.

(After putting on the cuff) "You'll just feel some squeezing of your arm. It won't last very long."

5. Ensure the patient has their feet flat on the floor and arms uncrossed.

6. Turn on the blood pressure machine and take the blood pressure in the left arm.

(after the first time) "I'm going to check it three more times once your sit and relax. I am going to test your sugars in between the 3 blood pressures."



7. In the same way, take the blood pressure in the right arm. Record the value.

Choose the arm with the higher systolic (top number) blood pressure. Take 2 more measurements on that arm, allowing 1-2 minutes between each measurement.

8. Calculate average of the last 2 measurements.

9. If average blood pressure is over 150/90, do the following:
   a. Dim the lights.
   b. Have patient lie down for 5 minutes.
   c. Take 3 more blood pressure measurements.
   d. Recalculate the average of the last 3 measurements and record on the log sheet.

Record

10. Enter the average blood pressure measurement into the Clinical Assessment Log Sheet.

Refer

11. If the blood pressure is **MORE THAN 150/90 after 3 times**, please refer to the nurse or doctor right away.

4 Glucose

Purpose

Testing blood sugars gives a snapshot of a person's blood sugar levels at that time. Blood sugars that are too high and too low can lead to potentially dangerous situations.

Testing blood sugars at an appropriate frequency can also give the patient and healthcare providers important data to help manage diabetes. Based on blood sugar testing, the patient and healthcare team can appropriately adjust diabetes medications, and engage in self-management strategies.

Testing blood sugars is especially important if a patient is using insulin. For these patients, testing should take place least as often as insulin is being given, up to 4 or more times/ day.

Roles

The CHW's role is to do physical assessments on clients deemed at "high-risk", those who have very poor control of their diabetes and require more support. See section I below on how these clients will be identified. CHWs will use the CHW Diabetes Clinical Assessment Log sheet paper form to record visit information.

Prep

1. Tell client that you will measure their glucose (blood sugar).

"Blood sugar should be checked regularly for everyone with diabetes to make sure it is being well controlled. If blood sugar stays high for a long time, then damage to the eyes, kidneys or heart can occur."

"Do you know how to check your blood sugar? Would you like me to demonstrate it for you?"

If client wants a demonstration, then: "I'm just going to go over each step with you and let you know everything that's happening. Please stop me anytime if you have any questions." (Then go through the steps and explain each step).

> "Do you think you could try doing that yourself?"

> "Why don't you try it once on yourself while I'm here so I can help you if you have any problems or questions?"

2. Gather appropriate equipment (e.g. glucometer, lancet, test drips, and alcohol swabs).

3. Check that there is a sharps container nearby.

4. Tell client to wash his/her hands.

> "First, let's BOTH wash our hands."

5. Wash your own hands and put on gloves.

Do

6. Clean the finger to be pricked with alcohol swab.

7. Load the lancet into its holder and set the depth dial.

8. Put the lancet against the area to be pricked, and push the trigger.

9. Put test strip into glucometer.

10. Wait for glucometer to ask you to put drop of blood on strip.

11. Put just a drop of blood on the test strip.

12. Wait for the results.

13. Dispose of the lancet in a sharps container.

Record

14. Record the results onto the Clinical Assessment Log Sheet.

Refer

15. Refer the client to the nurse right away if the blood sugar is LESS THAN 4 or MORE THAN 25.

5 Logbook

Purpose

Clients should be monitored regularly for changes in blood pressure, blood sugar, and feet. If problems are identified earlier, the doctor and/or nurse can be alerted sooner, and problems can be dealt with sooner before they get worse.

A blood sugar log book allows the patient and healthcare team to easily review and act upon blood glucose test results.

Roles

The CHW's role is to do physical assessments on clients deemed at "high-risk", those who have very poor control of their diabetes and require more support. See section I below on how these clients will be identified. CHWs will use the CHW Diabetes Clinical Assessment Log sheet paper form to record visit information.

Prep

1. Tell client that you will be reviewing the logbook and glucometer.

2. Ask the client to see their logbook and glucometer.

> "If you brought your sugars logbook, may I review it with you?"

Do

3. Review the logbook and glucometer if available.

4. If no logbook, or no results in logbook/glucometer, explore reasons.

> If: Client has no logbook, and no results in glucometer are available: "It looks like you haven't been checking your blood sugars regularly. Can I ask you if there is anything that is preventing you from checking it? Is there anything we can help you with?"

> "Would you like a demonstration or refresher on how to take your blood sugar?"

5. If client has some results, but not as frequently as recommended, explore reasons.

Client has some results in logbook or glucometer, but not as frequently as recommended: "Thanks for capturing some of the results on your client log. That's very helpful. Do you think you could check blood sugar more often now? Is there anything we can help with?"

Record

6. If problems with equipment (broken, missing), record in the registry.

7. Record 5-10 most recent pre and post meal blood sugars.

8. Record frequency of blood sugar measurements on the Log sheet:
    a. No testing
    b. Testing 1-2 times a week
    c. Testing 3-6 times day
    d. Testing every day or more

6 Foot Checks

Purpose

Clients should be monitored regularly for changes in blood pressure, blood sugars, and feet. If problems are identified earlier, the doctor and/or nurse can be alerted sooner, and problems can be dealt with sooner before they get worse.

Checking the feet is important because people with diabetes lose their sensation and may not notice small cuts or tears in the skin. These problems can quickly get worse if not identified early and treated. Complications of cuts or ulcers include infections, which if not treated early enough can lead to severed infections, and even amputation.

Some clients may feel embarrassed to show their feet. In this case, you can ask them if they've noticed any issues like new cuts, broken skin, numbness or tingling. You can also ask if they have any pain or discomfort in their feet, or if they have any overgrown nails or corns. If they do report any of these problems and are not already receiving treatment, ask them if it would be okay for you to notify the nursing station about these issues. If there is a foot care nurse or chiropodist that sees patients, they can be referred to these specialists as well.

Roles

The CHW's role is to do physical assessments on clients deemed at "high-risk", those who have very poor control of their diabetes and require more support. See section I below on how these clients will be identified. CHWs will use the CHW Diabetes Clinical Assessment Log sheet paper form to record visit information.

Prep

1. Tell client you will be examining their feet.

> "Sometimes people with diabetes can develop problems with their feet, like infections. I would like to check your feet now. Please remove your shoes and socks."

2. Have client sit down.

Do

3. Remove the client's shoes and socks to fully expose the feet.

"Have you noticed any NEW cuts, open sores, or ulcers? Any NEW numbness or tingling? I will now check them myself as sometimes diabetes makes it hard to feel sensation in your feet."

4. Look and the top, bottom, and in between the toes of **BOTH FEET.**

5. **LOOK** for:
    a. Cuts, blisters, and bruises
    b. Open sores, or ulcers, where the top of the skin is scraped off.
    c. Areas of redness which persists even if you push on it.
    d. Overgrown or ingrown nails
    e. Skin callous buildup
    f. Cracks in the skin, either shallow or deep

6. Ask if the client is experiencing any:
    a. new numbness/ tingling sensations
    b. pain/ discomfort in their feet, especially during sleep or rest

Record

7. Record any findings from steps #5 and #6 in the log sheet.

Refer

8. If there are any NEW abnormal foot problems (cuts, ulcers, redness, numbness), please notify a nurse or foot care specialist right away and record this information in the Clinical Assessment Log Sheet.

Monitoring Progress

1 Medication Review

Purpose

Medications help control diabetes and prevent complications. However, clients may stop taking their medications for a variety of different reasons. For example, the meds may have not arrived, they got lost, the client thought they were to be taken only once rather than on an on-going basis, the client had side effects, or the client stopped them because they didn't think they were important. It is important that problems with medications be identified early so that they can be addressed.

Roles

The CHW's role will be to collect information about whether a patient is taking his or her medications. You will notify the doctor or nurse about any problems so they can take further action.

Prep

1. Tell client that you will be reviewing their medications/blister pack.

Do

2. Ask the client to see their medications/blister pack.

> "If you brought your medications or blister pack, may I review it with you?"

3. Review the medications or blister pack if available. Check to see if there are some bubbles in blister pack that should have been popped but weren't.

4. If medications are not being taken, or taken only sometimes but not as often as recommended, explore reasons.

> If: Client is not taking medications at all: "It looks like you haven't been taking your medications regularly. Can I ask you if there is anything that is preventing you from taking them? Is there anything we can help you with?"

"Do you ever have problems receiving your medication?"

Client is taking medications, but not as frequently as recommended: "Thanks for taking your medications on most days. That's very helpful. Do you think you could take them every day? Is there anything we can help with?"

Record

5. If problems with medications (lost, didn't arrive, client forgot), record on log sheet.

6. Ask the client if they are having any side effects from their medications.

Examples of potential medication side effects include:

- Nausea or vomiting
- Muscle cramps
- Loose stools
- Low blood sugar (less than 4.0)
- Excessive gas
- Headache
- Dizziness

7. Record the side effects on Clinical Assessment Log Sheet.

8. Notify the nurse if patient has not been taking medications as directed, or is having trouble obtaining their medications.

2 Self Management

Purpose

Managing diabetes requires careful attention to modification of lifestyle. This can include improving diet, exercising regularly, quitting smoking, and reducing or quitting alcohol use.

In order to achieve success, it is usually helpful to encourage the client to set specific goals with a time frame for achieving them. For example, a client's goal may be to "walk 10 minutes to the band office and back, three times a week. In two weeks, I will have accomplished this goal." This is specific because the time or distance is described as well as the frequency. It also includes a deadline by which the client will accomplish the goal.

These goals should represent small steps towards change, and the client should feel comfortable and confident that he/she can attain them. When a client is able to complete several small goals in a row, then he/she starts to feel more confident about making bigger changes. It is also helpful to assist the client in designing a method for tracking whether or not he/she is meeting a goal. This could involve writing down progress on a log sheet.

Roles

The client will receive information from many people on how to make lifestyle changes and set goals: the nurse, the doctor or the diabetes educator. We recommend that CHWs play a role in monitoring whether or not clients are following any self-management goals they may have set for themselves, with the support of doctors or health educators. If you feel comfortable, you can also ask individual patients if they would like to set self-management goals related to diabetes management.

CHWs should be meeting monthly with the care team (doctors, nurses) and discussing what self-management goals have been set by clients. CHWs should make note of these goals and reinforce them at their next visit with the client.

Prep

1. Inform the client that you will be speaking with them about their lifestyle.

Do

2. Ask the client what part of their lifestyle they are working on now – diet, exercise, smoking, alcohol or other.

> "Improving lifestyle is an important part of managing diabetes. Is there any area that you're trying to focus on these days? Diet? Exercise? Smoking? Alcohol?"

3. If you know the client has previously set a specific goal, ask if he/she kept track of progress and succeeded.

> "I understand that at your last visit with _______, you set a goal to ____________________. How is that going? Were you able to achieve your goal? Were you able to track progress? Did you keep a log?

4. If last goal was achieved, encourage a follow-up goal. If unsuccessful, ask about barriers, and discuss modifications to the goal to try next.

> If the last goal was unsuccessful: "What kind of difficulties were you having with your goal? Is there anything you'd like to do differently? Would you like to try to modify your goal?"

> If the last goal was successful: "That's great news, congratulations! Is there a new goal that you'd like to try?"

Record

5. Record goals on CHW visit log.

Teamwork

1 Communicating Issues

Purpose

CHWs may uncover problems that need prompt attention. These could be new symptoms or abnormal findings, such as high blood pressure, high blood sugar, or a new foot cut.

Roles

CHWs should contact the nurse when a client has a new symptom or abnormal finding.

Process

CHWs may uncover any of the following problems which require an appointment with the nurse. These Include:

- Blood pressure more than 150/90.
- Blood sugar LESS than 4.0 or MORE than 25.0
- A low blood sugar (less than 4.0) more than two times a week.
- New foot problems such as: an ulcer, a cut, redness, or numbness and tingling.
- The client is not taking their medications as prescribed.

The CHW Diabetes Clinical Assessment Log Sheet has specific areas which flag these situations. When these arise, please do the following

Do

1. Phone or see the nurse to inform him/her of your concern.

"Good afternoon Nurse. This is [insert your name] speaking, the CHW. I am concerned about [insert client's name]'s blood pressure. Do you think that they need to be seen today?"

2. Ask the nurse what he/she wants done. Record instructions on CHW visit log sheet.

3. Make sure the nurse reviews the CHW log form.

4. If nurse requests that the client be seen by nurse or doctor, call client & arrange time and date.

5. Ensure that the client makes it to their appointment.

(After determining when the client will be seen with the nurse) “Thank you very much. I will make sure that the client attends their appointment and fill out the referral form for the chart.”

2 Recalling Labwork

Purpose

As noted above, diabetes clients have certain tests that should be done at regular time periods. For example, A1C (the three-month blood sugar average) should be done about every 3 months.

Roles

CHWs keep track of all their clients that are due for a physician visit or particular test and make sure that they get the tests or visits that they need.

Process for Recalling Labwork

1. Review patient information in the Recall List. Identify clients who are overdue for A1C (done every 3 months for most patients), an eye exam (at least every 1-2 years), or any other blood work that you are aware of.

2. Check with the nurses to find out if there are days or times over the next two weeks when clients should not come in for blood work.

3. Call each client on the recall list who is overdue and arrange for him/her to come in. If the client needs LDL, make sure he/she is fasting beforehand.

> Hello, _____, this is ________ calling. I'm the diabetes community health worker at the clinic. I'm calling because we'd like you to [select best response(s)]:

> Come to the clinic to get some blood work done because you're overdue. We'd then like to schedule a visit with the doctor a week later so he/she can go over the results with you.

> [the above response, plus] one of your tests is for cholesterol. You need to have nothing to eat or drink except water or plain tea with no milk or sugar, about 10 to 14 hours before.

> Will you need any help to get to your appointment? Do you need a driver? Childcare? An escort?

3 Patient Follow Up

Purpose

Visiting a patient multiple times allows trust to build in the relationship. Over time, both the patient and the CHW are able to be more effective in communicating their health concerns and generating potential solutions to problems. Another reason to follow up is that health changes over time, so CHWs need to continuously assess everyone with diabetes. Patients who have poorly-managed blood sugars should be seen more often because they are at higher risk for complications. CHWs also have have more opportunities to help these patients improve their blood sugars.

Roles

CHWs need to speak with the nursing station to keep their list of patients with diabetes up to date. They also need to follow up with diabetes patients according to their A1C. If someone has an A1C < 7.5, this patient needs to be followed up with every 3 months. If someone has an A1C between 7.5-9, this patient needs to be seen every month. If someone has an A1C <9, this patient needs to be seen every week. The recommended frequency of follow up is found in the Recall List

Process for Recalling Patients

1. Ensure you have the latest A1C results for your patient. This can be found by looking in a patient's chart. If you're unsure, ask a co-worker to show you where to look.

2. Take a look at the patient's latest A1C. If it is less than 7.5%, plan to visit them again in 3 months. If the patient's A1C is between 7.5-9.0, plan to visit them again in 1 month. If the patient's A1C is more than 9.0, plan to visit them again in a week.

3. Share your plan to follow up with the patient. Record the follow up date on a planner or calendar so you do not forget.

4. Follow up as planned.

5. After your follow up, check to see if a new A1C had been done. Plan your next follow up accordingly.

Patient Follow Up

"Hello ________, this is _________ calling, the diabetes worker. It's been 3 months/ 1 month/ 1 week since we saw each other and it's time for a follow up."

Would you like to come to the clinic, or would you rather that I came to your house instead?

4 Team Meetings

Purpose

Team meetings bring together key members of the care team and allow them to plan and coordinate their work better. Team meetings can serve to do the following:

- Client segmentation: identify which clients are at highest risk, who needs more intensive follow-up
- Assign clients to each CHW and agree on a schedule for how often these clients should be seen
- Discuss current treatment plans for clients (particularly high-risk ones) and ensure everyone is in agreement with the plan.

Roles

The CHW should participate and provide input during these meetings. The CHW can bring the Recall List, which contains the list of diabetes patients, their latest A1C test results, and the follow up dates.

Prep

Each community should identify:

- Who should attend the meeting. Typically meetings include doctors, nurses, the Health Director, and other staff involved in delivering diabetes care.
- The chairperson for the meeting.
- The person responsible for scheduling the meeting and frequency of meetings (e.g. every 2-4 weeks).
- The person responsible for documenting actions agreed on in the meeting.

Do

1. **Client Segmentation**
The team reviews the Recall List and decides on which clients are deemed high-risk. One simple criteria is to decide that all clients with an A1C >9 are high-risk. The team is free to use other criteria it wishes to identify high-risk clients.

2. **Treatment Goal Planning**
The team discusses client's current treatment goals. Ideally, this should be based on what the client has said he/she wants to do. The team then agrees to reinforce this goal at each opportunity. For example, if the client has told the doctor that she wants to walk 30 minutes every other day, then the CHW can ask the client how well she is doing with that goal and encourage her to stick to it.

3. **Documentation**

The person responsible for documenting the team meeting makes a master list of the high-risk clients, the CHWs assigned to each client, and treatment goals. This person distributes copies of this list to each CHW and keeps the original for review at the next meeting. Each person receiving a copy of this report is responsible for ensuring this report is kept in a locked or designated, secure place.