Utilization of Community Health Promoters or Outreach Certified Nursing Assistants to Improve Outcomes of Diabetes, Cardiovascular Disease and Obesity in Vulnerable Populations.

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INTRODUCTION

- Diabetes and heart disease are two of the leading causes of death in the United States. Obesity is a major risk factor for both of these disease processes.
- There is a projected primary care provider shortage ranging from 12,500 to 31,100 by 2025.
- Nurse practitioners are collaborating with other disciplines to develop programs to improve chronic disease outcomes when the traditional provider visit may not be easily accessible.
- Community health promoters (CHP) and certified nursing assistants (CNA) can be included in the care team to improve access and outcomes of patients with hypertension, diabetes, and obesity.

EFFECTIVE ROLES OF CHP

Patient Educator

Patient Motivator

Patient Advocate

Identifiers of those at risk for DM, CVD, and with Obesity

Example of Accurate Screening for DM in Latino Migrant Population by CHP

Percentage Agreement of CHP and RN Generated Diabetes Risk Scores

	Agree (n,%)		Disagree RN – CHW (n,%)		Disagree CHW – RN (n,%)	
1	2	7.14	4	10.53	6	15.79
2	5	17.86	7	18.42	10	26.32
3	9	32.14	12	31.58	6	15.79
4	3	10.71	4	10.53	8	21.05
5	4	14.29	4	10.53	5	13.16
6	2	7.14	7	18.42	0	0
7	2	7.14	0	0	3	7.89
8	1	3.57	0	0	0	0
Pearson Chi²	df(7)		5.971 1	0.543	8.5312	0.288
Fisher's exact				.621		.312

Note: Farmworker sample N=66. RN vs CHW: Pearson chi2(7)=5.9711 Pr =0.543 Fisher's exact=0.621; CHW vs RN: Pearson chi2(7)=8.5312 Pr = 0.288 Fisher's exact=0.312

ROLES OF OUTREACH CNA

Address medication adherence

Educate on healthy eating

Creation of personalized exercise plan

Connect patients with health services

"I love when the girls visit. I am learning so much. I am proud of myself. My pressure is better than it has ever been." – Outreach Patient

OUTCOMES OF CHP PROGRAMS (Diabetic & Hypertension Patients)

1. Improve self efficacy
2. Improve diabetes knowledge scores
3. Improve diabetes and CVD clinical outcomes
4. Improve activity level
5. Improve dietary behaviors
6. Improved access to care for those with high risk scores

UVA DEPARTMENT OF FAMILY MEDICINE OUTREACH

Started in 2015

Grand-Aide curriculum

2-3 CNAs with DNP supervisor

Home visits by CNA

Patients with Diabetes, HTN or Obesity

DNP ROLE IN UVA OUTREACH PROGRAM

Curriculum development with Grand-Aides USA

Training of CHP or CNA

Liaison to clinic

Identifier of high utilizers or high risk patients

Real time assessments via telecommunication

PATIENT-CENTERED GOALS OF PROGRAM

Patient Goal(s):

___ Take medication as prescribed
___ Increase amount of physical activity
___ Improve healthy diet by limiting fatty and processed foods
___ Reduce sodium in diet
___ Increase amount of water I drink every day
___ Reduce stress
___ Monitor my blood pressure
___ Other, please list:

OVERALL PROGRAM GOALS

20% reduction in emergency department utilization

20% reduction in hospitalization rates

Statistically significant reduction in health care cost-per-patient

REFERENCES

- Grand-Aides hypertension, diabetes and obesity manual for University of Virginia Department of Family Medicine.
- Thompson, R., Snyder, A., Burt, D., Greiner, D & Luna, M. (2014). Risk Screening for Cardiovascular Disease and Diabetes in Latino Migrant Farmworkers: A Role for the Community Health Worker. *Journal of Community Health*, published online 4 July 2014. DOI: 10.1007/s10900-014-9910-2.