FROM ONE CHW TO ANOTHER:  
A Community Health Worker’s Guide 

MIAMI HEALTHY HEART INITIATIVE
We dedicate this guide to all our patients and their family members who worked hard to learn how to manage their diabetes. We thank all health care personnel who assisted us in providing our services including the doctors and nurses at Jackson Memorial Hospital, the University of Miami Miller School of Medicine staff, all of our special guest speakers, as well as every agency and organization that collaborated with us in delivering our program to strengthen and improve the quality of life of our patients. We also dedicate this guide to all the Community Health Workers (CHWs) who make a great difference in patients’ health, lives and communities all around the world.
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The Cariño program is part of the Miami Heart Healthy Initiative (MHHI), a study to determine if community health workers (CHWs) can empower Hispanics/Latinos with type II diabetes with the necessary skills to take charge of their health. The purpose of this guide is to describe a community health worker intervention designed to help Hispanics/Latinos with uncontrolled diabetes develop the necessary skills to manage their health. The guide was created by the MHHI team members. All the pictures in this guide are original pictures taken of patients and CHWs at events hosted by MHHI.

This guide provides information about the tools used to deliver the program, our experiences when working with our patients, and the barriers we encountered. We hope this guide improves knowledge about the ways CHWs can help Hispanics/Latinos manage diabetes and provides the community and health collaborators with tools and information that may assist in implementing a similar program with a higher probability of success.

The program, directed by principal investigator Olveen Carrasquillo, M.D., M.P.H, was funded by the National Institute of Health (NIH); National Heart, Lung and Blood Institute (NHLBI) R01 HL083857 and was based at the University of Miami Miller School of Medicine.

The guide is intended for use by CHWs, health care providers, community members and others interested in implementing such a program. Although our focus is on Hispanics/Latinos and diabetes, many of our approaches are applicable to other populations and diseases.
According to the Center for Disease Control (CDC), at least 90% of people with diabetes suffer from type II diabetes which is associated with a family history, older age, obesity, and race/ethnicity. Hispanics/Latinos are 66% more likely to be diagnosed with diabetes and 1.6 times more likely to die from diabetes than non-Hispanic/Latino whites.1,2 According to the most recent findings by the Hispanic Community Health Study/Study of Latinos which included over 16,000 Hispanic/ Latino adults, 45% of participants in the 45-64 age group had prediabetes. Additionally, 1 in 4 in the middle age group (45-64) and 1 in 2 in the oldest age group (65-74) had diabetes.3

Multiple barriers contribute to poor diabetes outcomes among Hispanics/Latinos. When addressing these barriers it is important to understand that Hispanics/Latinos come from many different countries, each with their own culture, dialect and diet. For example, Caribbean Latinos traditionally eat white rice almost every day, while Central Americans usually eat both tortillas and rice. Equally important to understand is that many U.S. Latinos have acculturated to the American mainstream food culture and their diet can be filled with heavily processed foods found in most American homes.4 Our program was conducted in Miami-Dade County, one of the most ethnically diverse U.S. areas where approximately half the population emigrated from other countries. Approximately 30% of the adults in Miami-Dade County are uninsured.5

What made you want to participate in this program?

“I was curious to know what diabetes was and how it affects me because I didn’t know anything about it, nothing at all. It was this curiosity and the fear of the disease...is what made me get into the program to learn about it.” - L.A.
MIAMI HEALTHY HEART INITIATIVE

MHHI is a study of 300 Hispanic/Latino patients age 35-65 with poorly controlled diabetes, being cared for at Jackson Memorial Hospital (JMH), located in the City of Miami, the third largest public teaching hospital in the United States. Our goal was to determine whether CHWs can help reduce cardiovascular disease risk among Hispanics/Latinos with uncontrolled diabetes in Miami, Florida. In addition, MHHI examined changes in medication adherence, diet and exercise, as well as confidence in overall diabetes management, patient-provider communication, and lifestyle changes.

WHY IS A COMMUNITY HEALTH WORKER?

Community Health Workers (CHWs) are frontline public health workers who are trusted members of and/or have a close cultural and linguistic understanding of the community they serve. This trusting relationship enables CHWs 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.9

HISTORY OF CHWS

The origins of lay people’s involvement in basic health services have been dated as far back as 17th century Russia. During this period, a shortage of doctors increased the need of basic medical care for both military personnel and marginalized populations alike, giving rise to “feldshers,” the beginnings of community health workers. Perhaps a better-known example, are the “barefoot doctors” that emerged in 1950’s China, providing basic medical care to rural populations in the absence of conventional health services.10 The success these early CHW’s had in addressing the health care needs of villagers, propelled China’s barefoot doctor program to a nationwide level by the 1960’s. Shortly after, a number of countries around the world began training programs for village health workers (VHW’s) and “Promotoras,” which became a strong movement in Latin America, addressing similar concerns as the Chinese.10-11 In the United States, CHW programs began to emerge in the 1960’s and became an integral part of community health centers. Since then, the evolution of CHWs has included national, state, and regional coalitions. In January 2009, the Executive Office of the President’s Office of Management and Budget officially published the 2010 Standard Occupational Classifications (SOC) listing for the US Department of Labor which included for the first time a unique occupational classification for Community Health Worker (SOC 21-1094).
Community Health Workers (CHWs) are key players in helping individuals and their communities to improve their health. They present culturally appropriate health information and education; provide support to individuals based on their medical concerns and needs. CHWs help patients learn about health issues and how to access community resources, such as housing and food banks. As members of the very community they serve, CHWs share the same ethnicity, socio-economic status, cultural norms, and communicate in the language of the community.\(^\text{12}\) Although referred to as CHWs throughout this guide, the title may vary in different countries or regions of the world, including “promotoras” or “promotoras de salud” patient navigators, outreach worker, lay health advisor, peer health promoter, community health advocate, and village health worker, just to name a few.

The role of community health workers is to provide members of the community, who traditionally lack access to quality health care, with information and support from a culturally competent point of view that they can understand.\(^\text{12}\) In addition, CHWs help patients acquire/schedule medical appointments and help individuals to become empowered towards the navigation of the health care system.\(^\text{13}\) CHW’s role is complex and requires certain characteristics and dedication to successfully work through obstacles that patients alone may not be able to overcome.

"When I first started, I had no idea what a CHW was. However, I quickly found that a CHW has a critical role in the community they serve. I have become exposed to the issues and realities facing my fellow community members. I feel very fulfilled in that I now have the tools to be a voice for my community.”

- C.Y. (CHW)

For more information on CHWS go to these helpful websites:
www.cdc.gov/diabetes/projects/comm.htm
www.apha.org/membergroups/sections/aphasections/chw/
www.floridachw.org
CHW TRAINING

As a CHW it is important to master key principles that are necessary to be successful and to be trained in other proficiency areas that are tailored to the needs of the community being served. One of the trainings provided in our program was from The Collins Center for Public Policy in Miami developed a 35 hour curriculum covering core competencies for our CHWs (expanded in figure 1.2 below).

In addition, it is also essential for CHWs to be informed on current affairs from a national and local perspective surrounding specific diseases, changing health policies and social barriers that may affect the patients you serve. This educational development may be achieved through attending health disparities conferences and/or trainings on specific health conditions and community coalition meetings. Attending additional trainings or lectures outside of healthcare to gain insight on issues, e.g. immigration and housing, will strengthen your service delivery. In addition, having standing meetings with your case manager is also vital in building service performance and problem solving skills. Meeting with your supervisor is also an opportunity to review patients’ charts, track progress, and find solutions to issues. **TIP:** Meetings at least once a week is recommended.

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**Figure 1.2: CHW Core Competency Areas Overview:**

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CARIÑO: PROGRAM OVERVIEW

From this section and on, we will share with you our program to help you better understand what we offered our patients and how we accomplished it. CHWs in our CARIÑO program offered many services such as: one-on-one home visits that often included other family members, support through phone calls, educational groups, exercise walks, immigration referrals, housing and food assistance, mental health referrals, job hunting, and companionship to medical appointments and health fairs. Our program was tailored for a 1 year follow-up for each patient. You can find a more detailed graph of the program in the appendices section, Appendix A. We also developed forms to track our efforts. You can find them in Appendices B, C, D.

FIRST CONTACT

The first contact will be one of the most essential steps for you. Your first interaction with your patient may determine the level of involvement your patient will have with you. It is why it’s important to display trust and respect, and perhaps share commonalities with your patient’s culture and interests. Making your patient feel welcomed, respected and valued are key elements that will help you build a trusting and collaborative relationship. As they say, first impression matters. The first contact will also give you some insights about your patient’s needs. First contact is not about asking the patient too many questions, but to get to know each other and maybe schedule your first meeting together. In addition, the first contact is an opportunity to briefly explain what your role will be, share a little about the program and why you are contacting them. It is important to be sensitive if the patient will/not welcome your support. Tailoring and moving according to your patient’s needs, can create healthier outcomes.

Remember it’s not about you, it’s about your patient.

Build rapport with patients by discussing:

- foods
- celebrations or rituals
- places or cities
- celebrities/TV shows
- personal experiences in common
- current events
- doctor’s appointments

PHONE CALLS

Phone calls are necessary to maintain communication with your patients about upcoming activities and appointments. Some of the calls in our program were done in the evenings and some times during weekends to ensure some patients were reached. And with today’s technology, some patients preferred email or text messages.

Tip: Ask your patient how they prefer to be contacted and the kind of message you should leave will be instrumental for you. Maintaining confidentiality is vital.
HOME VISITS

Home visits is an invitation not just into the patient’s home but into their life. So we treated the visit with the upmost respect and a privilege. It consisted of casual dialogues between the patient and us, not so much an interview. Home visits provide an opportunity to gather information about patients, their lifestyles and to discover where they come from. It is during visits that we develop a trusting relationship with the patients and assessed their needs as we create a personalized plan to improve the patient’s diabetes management.

We found it helpful to plan in advance for home visits by reminding patient of visit and confirming their address. Prepare a brief agenda of the topics to discuss that day. Prepare educational materials beforehand. And inform a team member/supervisor of your home visit for that day.

Tip: Your safety is always the first priority. It is important to have a clear understanding of the standard procedure for home visits in your organization. Our team’s plan included: 1) Inform the team where you will be 2) Text the address to someone if you were in an unfamiliar area, and 3) Politely excuse yourself immediately if you ever found yourself in an unsafe situation.

GOAL SETTING AND IDENTIFYING BARRIERS

During home visits, patients get to share their concerns and what could be affecting their well-being. As patients share, it will allow you to assess the patient’s needs and concerns. We found a collaborative approach worked better for us and the patient. TIP: Remember to document your conversation and observations in your progress note. This will help you for your next visit. Some of the guidelines we followed in our program were:

- Identifying barriers and setting goals together with your patient is key
- We collaborated with patients in developing their goals to improve their diabetes management and well-being. One of the tools we developed was a blood sugar log to teach our patients how to track their glucose.
- When working on setting goals with our patients, we encouraged self-management by teaching them problem-solving skills, setting priorities, developing a plan, reviewing results periodically, and revising the plan as many times as needed during their participation in the program.
- Encourage all patients to create reachable and short term goals depending on their level of readiness to make changes. Our program used the small steps big rewards program created by the National Diabetes Education Program (NDEP) which suggests that when patients start changes with small goals the results tend to be greater. We also used the S.M.A.R.T goal model: Specific, Measurable, Achievable, Realistic, Timely.

Figure 1.3

Diagram describing the process of Small Steps, Big Rewards model.
FAMILY VISITS
Our family visits with patients were mostly used to deliver diabetes education. However, these visits can also be an opportunity to learn new information about the patient’s lifestyle, behavior and possible barriers in the home. It is important for CHWs to know how patients and their family members address, acknowledge, and manage their diabetes because this reflects the family’s beliefs about the health system.\textsuperscript{16-17} Family involvement can be an important form of social support that could benefit the patients or it can be a drawback. We have found that it is often easier for patients to change their behaviors and habits when family members are part of the entire educational/treatment process.

Family

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FAMILY MEALS
As studies have shown, planning family time through shared meal can strengthen family unity. However, many of our patients did not have the time nor the desire to plan family meals. Providing your patients with the tools that meets their needs is key. In our program, women with diabetes had the hardest time modifying their diet when eating with their family. They would prepare two meals, one for their family and one for themselves. We showed them how they can incorporate their favorite meals by just making a few modifications that the entire family would enjoy. One tool we provided was the “plate method”. We used a 9 inch plate, divide it into 1/4 protein (avoid frying), 1/4 starch/carbs, 1/2 vegetables and fruit. Serve with water and half a fruit, and your bound to be satisfied! Sharing healthier choices without changing your patient’s entire diet will be very much well received.
CLINIC VISITS

Visits to the doctor may be stressful and frightening for some patients. CHWs can help patients prepare for a clinic visit and develop better skills to interact with health care providers. Appendix B offers a clinic visit preparation form to aid the CHW in acquiring necessary information. Often, CHWs assist patients with doctor’s appointments by keeping a record of when it was time for a physical checkup and reminding patients to make appointments with health care providers and specialists.

“ To be honest, before I started [the program] my doctors wouldn’t fully explain things to me, or come to think of it, I just didn’t know what questions to ask. But as I continued through the program, I realized I needed to know more about my numbers, like my cholesterol.” - A.G.

Clinic visits may have time constraints. Some of the things we did with patients to maximize the visit time were: 1) teach patients about the proper levels of A1C, blood pressure, cholesterol, 2) record glucometer readings beforehand, 3) provide their doctor with more information at visit. In addition, patients were encouraged to write down any questions about their medications and/or symptoms that they wanted to discuss with their doctor. These steps helped patients prioritize their needs and gave providers an opportunity to focus on specific health challenges each patient may have been experiencing.

Facilitating the doctor-patient relationship is key

Communicating with your doctor

CHWs can also help the doctor and the patient speak the same language, literally and metaphorically. Many times the CHWs may act as interpreters for those patients who only speak Spanish. In our observations, we found that Hispanics/Latinos have a great deal of respect for their doctors. Paradoxically, this could sometimes act as a barrier to improved health. In some cases, patients are not aware they can provide feedback about their medication and treatment due to the respect they have for their doctor. We encouraged patients to have an open conversation about how they feel about their medication and treatment.

TIP: We recorded laboratory results at every clinic visit and used those values to educate and encourage patients during home visits. In reviewing lab results together, patients often exhibited confidence to take ownership of their health and this motivated patients to log their own lab results in future clinic visits.

Patient, provider, and CHW can all benefit from the joint effort. The clinic visit provides an opportunity for CHWs listening to the information given to the patients by the providers and further elaborate at a home visit.
Many of our patients faced barriers that interfered with their diabetes management. It is important as CHWs to be aware of these barriers and provide additional support by referring patients to community agencies, mental health providers, and/or any other resources that may be needed to increase and maintain the patient’s well-being. We also assisted patients with other services such as filling out and translating forms, making appointments, providing companionship to government agencies, functioning as an interpreter/translator or advocate, assisting with legal referrals, and linking them to food assistance programs. In providing social support, we found our patients gained confidence in better managing their health and the health of their family.

How we provided mental health support

The main purpose of our program was to assist patients with their diabetes management, it is important to note we experience substantial need from our patients regarding mental health care, some with previous clinical diagnoses going untreated. Our patients experience challenges related to their mental health, including depression and anxiety, that affected their ability to exercise, seek employment, adhere to medication, test their glucose, keep medical appointments, meet with CHWs, or even answer CHW’s phone calls at times. As a result, many of our patients found themselves in a cycle where their mental health affected their diabetes and their diabetes affected their mental health. For this reason, we believe it is important for programs serving patients with chronic diseases especially diabetes to include mental health services and/or referrals to obtain better results.

Strategies to encourage patients to practice when coping with depression and anxiety:

- Discuss the issue with your doctor or therapist
- Contact local mental health centers
- Seek the support of family and friends
- Join a local support group
- Utilize a spiritual outlet (church, healer, retreat)
- Incorporate daily physical activity
- Practice relaxation exercises (Deep breathing, Visualization)
- Practice meditation, Yoga or Tai Chi
- Increase exposure to natural light (i.e. it encourages vitamin D production and protects from seasonal mood changes)
- Get enough sleep (8-10 hours)
- Keep a journal
- Get massage
- Volunteer
- Take baths with candles and soft music
- Engage in fun activities (singing, dancing, arts and crafts)
GROUP SESSIONS

Group sessions were used to deliver education to patients on diabetes management and for patients to receive support from each other.

GROUP CURRICULUM

Our curriculum was based in the program’s acronym CARINO consisting of seven topics and an open forum group. The topics were as follow:

C: Cuidado (Taking care of Diabetes)
A: ABCs (A1c, Blood Pressure, Cholesterol)
R: Riesgos (Risks)
I: Ingeniar su comida (Re-invent your food)
Ñ: No a la obesidad (Say No to obesity)
O: Obteniendo una vida sin estrés (Obtaining a life without stress)

Typical Agenda

5-10 minutes- Welcome and introduction
40- 50 minutes- Educational presentations
30 minute Lunch
5-10 minutes– Questions and answers
10 minutes– Fun activity is conducted to evaluate what they learned.

HOW TO ENGAGE ATTENDANCE AND PARTICIPATION

- Mail monthly reminders and calendars to all patients at the beginning of the month (**Appendix E**).
- Make reminder calls before each group or event.
- Provide lunch or refreshments during all activities.
- Provide free parking or vouchers for public transportation.
- Include fun/engaging activities to assess how much the patients learned and to promote interactive: Word Search, Crosswords, Jeopardy, Family Feud and other learning activities.
- Zumba, meditation classes, relaxation techniques and other activities may benefit the patients.
- Dedicate group sessions to holidays (Thanksgiving, Christmas and Valentine’s Day).
- Incorporate educational videos.
Cooking demonstrations were done throughout the program to engage patients in preparing healthy meals and provide healthy alternatives. Patients were exposed to the simplicity of preparing healthy foods and it was an opportunity to enjoy spending time with other group members while having a healthy meal. Patients with cooking background was also encouraged to do cooking demonstrations for the group. Attendances was pretty high when cooking and food was part of the group. Something to keep in mind when planning your groups.

For diabetes friendly recipes go to http://urbanext.illinois.edu/fiesta/

Grocery store group sessions were conducted periodically to strengthen the nutrition education held throughout the year. Patients toured the grocery store with CHWs aisle by aisle. CHWs provided examples of healthy, budget-friendly alternatives to foods that patients are accustomed to eating.

To promote physical activity we held group walks at a local park that was chosen by patients. Patients walked at different pace depending on their ability. We also provided exercise bands and taught stretching exercises.

Identifying a convenient location for your patients will increase participation. It is important to consider the weather, time, date, and location when facilitating a group outdoor event. TIP: Always have a Plan B and a patient’s contact phone list with you, in the case the event needs to be cancelled or changed.

Suggested Materials for Group Walks

- Camera
- First Aid kit
- Water
- Cereal bars and fruits
- Music/audio device
- Exercise bands and pedometers
HOW TO PLAN AND ORGANIZE FOR GROUP SESSIONS

Ideally it is recommended for group sessions to take place once or twice a month (every two weeks). Group dynamics may be more successful if the maximum amount of group attendees is 15 patients, takes between 1 to 2 hours, and is facilitated by two or three CHWs. CHWs should prepare by bringing a sign-in sheet, name tags, easel pad and markers, and visuals to group sessions. TIP: Remind your patients, confirm location and the food that will be provided a couple days before group session.

In addition to the CARINO curriculum, topics were added as a result of the feedback provided by patients during group education sessions. The original curriculum topics were complemented with chapters from the manuals Su Corazón su Vida (manual del promotor y promotora de salud) [http://www.nhlbi.nih.gov/health/prof/heart/latino/spanish/lat_mnl_sp.pdf] and Road to Health Kit [http://www.cdc.gov/diabetes/ndep/cdcinfo/ndep_pdf/road-to-health-toolkit-activities-guide-508.pdf].

Some of the topics from these manuals included:

- Risks of cardiovascular disease
- How to act and identify heart attack symptoms
- Reading and understanding food labels
- Plate method
- Controlling sugar intake
- Smoking cessation
- “Say yes to Physical Activity” and how to get started
- Medications and their side effects
- Glucometer use
- Involving the family when planning meals
- Eating healthy on a budget
- Depression and its effect in diabetes
- How to prepare for the holidays and continue eating healthy

Guest Speakers were invited from different health professions such as:

- Registered Nurse
- Nutritionist
- Endocrinologist
- Exercise Physiologist
- Medical Doctor
- Poison Control
- Department of Health
- Psychiatrist

This was very successful with our patients and many have stated it was one of their favorite parts of the group sessions.
DEMONSTRATING OUR COMMITMENT TO OUR PATIENTS

♥ Family picnics were held at a local park. Our patients were encouraged to bring a typical dish of their country. Several games were held that included everyone while encouraging physical activity. Gifts were given to the winners of the activities. Patients expressed their enthusiasm for more events like it.

♥ A bilingual resource guide was created to provide information how the resources that are available to the residents of South Florida who have diabetes, such as education, exercise, hospitals, and medical equipment.

♥ Participation incentives were given throughout the program such as program water bottles, pens, pedometers, measuring cups, resources guides, hand stress balls, team shirts, recycling shopping bags and more.

♥ CHWs and patients attended several health fairs together where many patients took advantage of free health screenings like body fat and eye and foot scans.

♥ CHWs collated several healthy Hispanic/Latino recipes from different sources and put together a cookbook for patients.

♥ Birthday Cards signed by the team were sent to patients during their birthday months. Several patients conveyed that although they did not participate in group activities, they felt cared for when receiving the cards. Refer to Appendix E for sample templates for birthday cards, calendar, and activity reminders.

Workshop

As unemployment intensifies stress, a career workshop was organized to educate patients on resume building skills and online search engines for employment. Additionally, other patients who did not attend that group also received assistance creating their resumes. As a result, two of our patients found employment.
Graduation ceremonies were held throughout the program. Patients that had already completed their one year program period were invited as graduates and the patients remaining in the program were invited as guests. Families and friends were also invited.

Diplomas were given to graduates and special awards were given to highest attendance and most improved patients.

Patients provided testimonials of their life changes.

Lunch was provided and music was played while patients ate to set a festive mood.

We made two short movies describing the progress of the patient throughout the program and shared it during the ceremonies.

Available here:

Una Perspectiva Diferente: https://www.youtube.com/watch?v=7xqGEBgf6MU

Un Año de Cariño: https://www.youtube.com/watch?v=U5bKTFLLTTc
Our final thoughts to you...

Being a community health worker may have its challenges at times, but it is also extremely rewarding. Remember, as a member of your community and an advocate for health, your work serves as a catalyst for change. From our team to yours, we truly hope that this guide will help shape your program and serve as a tool for you as you enter into the field of CHWs. Welcome!

All the best in your endeavor, have fun, and spread some Cariño along the way!

Sincerely,

The Miami Healthy Heart Initiative
Overview CHW Cariño Program

**Months 1 & 2**

**Assessment**

Objectives: Help participant develop a list of issues that affect his/her overall health and well-being

Type: Home visit

When: Within 1st month & prior to “goal setting” visits

CHW will address participant’s: (1) social context, (2) current knowledge about diabetes and its management, (3) current medications, (4) views on medication adherence, including perceptions of barriers or facilitators to adherence, (5) pertinent lifestyle and health behaviors, and (6) barriers to communicating and doing business with the healthcare system

**Goal Setting & Dealing with Barriers**

Objective: Assist participant in developing an individualized plan to advance his/her overall health and well-being

Type: Home visits

When: Within months 1 & 2 but after “assessment” visit

CHW efforts include: (1) stimulate self-management by teaching problem-solving skills (setting priorities, making goals, developing a plan, reviewing results, and revising the plan), (2) facilitate navigation of the healthcare system, (3) provide referrals to or assistance in accessing both social and medical community-based resources, and (4) give counseling & coaching aimed at the improving lifestyle behaviors

**Months 3-12**

**Group Interactive Discussions**

Type: Culturally tailored & interactive sessions lead by CHW (60 min. duration, 1 session/week, & 20 person max/cohort)

When: Throughout the one year enrollment in the program and each patient to continue to be invited after program completion

Objective: Stimulate lifestyle change by increasing knowledge and practice of healthy eating and physically active behaviors

CHW may organize additional sessions such as: (1) knowledge-building workshops addressing diabetes or health system navigation, (2) exercise excursions (i.e. participation in a walking club), or (3) nutritionally educational activities (i.e. healthy food festivals or farmers market field trips)

**Telephone Consultations**

Type: Phone call (CHW may also utilize home visits)

Number: Minimum of 1 call/contact per month

When: Throughout maintenance phase (months 3-12)

Objectives: (1) help facilitate participant’s health goals by checking on progress of intended plan of action and addressing new problems (i.e. may follow-up on adherence to medications), and (2) continue healthcare system navigation assistance (i.e. providing appointment reminders, bridging communication with PCP regarding prescription refills, or rescheduling missed appointments)

CHW will utilize formalized scripts as a general guide which are designed to address anticipated issues (see progress notes)

**Evaluation**

Type: Home visit

When: Within months 11&12

Objectives: Evaluate participation’s adherence to the individualized plan created for them and to develop strategies to continue the plan without the CHW’s assistance

CHW efforts include: (1) evaluate participant’s progress throughout the program (2) recap successes and areas of growth, (3) provide strategies for continued efforts.
Appendix B

Use this form when you visit your patient as a tool to engage in dialogue and to log concerns and/or successes:

**CHW Progress Note**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Start Time:</th>
<th>End Time:</th>
<th>Patient:</th>
<th>Type of contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit #:</td>
<td>CHW:</td>
<td></td>
<td></td>
<td>□ In Person □ Phone</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>□ Mail □ Social Service</td>
</tr>
</tbody>
</table>

1. How have you been since the last time I saw you?

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

2. How has tracking your blood sugar been going since I last saw you? (CHW must check log for present week and last week).

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

30 Day Blood Glucose Avg: _________ mg/dL  14 Day Blood Glucose Avg: _________ mg/dL

3. Do you have any difficulty getting your medicines?              YES                              NO

If yes, is it because:

- RUN OUT MEDICINES
- DON'T UNDERSTAND LABELS
- DON'T HAVE MONEY FOR COPAY
- CAN'T KEEP INSURANCE UP TO DATE
- DON'T KNOW HOW TO RENEW MY PRESCRIPTION
- DON'T UNDERSTAND INSTRUCTION FROM PHARMACIST/DOCTOR
- DON'T KNOW WHERE PHARMACY IS
- PHARMACIST/DOCTOR

4. Have you had any trouble taking your medication?            YES                         NO

If Yes, Why?

_______________________________________________________________________________________________
_______________________________________________________________________________________________

5. Participant’s pledge for next visit:

_______________________________________________________________________________________________

Upcoming doctor's appointments:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Type</th>
<th>Accompanied/Not accompanied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_______________________________________________________________________________________________

CHW signature                                                                               Date
Appendix C

Every 3 months fill out this form as a way to check that you and your patient are on track and if any follow up is needed:

**CHW Quarterly Progress Note**

<table>
<thead>
<tr>
<th>Dates:</th>
<th>Patient:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month:</td>
<td>CHW:</td>
</tr>
</tbody>
</table>

Record patient’s response to the following questions:

**Where are you currently receiving your medical care?** ____________________________

**When was the last time you talked to your doctor about your diabetes?** ___/___/____

**When we first met we talked about what your ABC levels mean to you. Have you met with your doctor to find out about your ABC levels. What are they?**

A: HgA1C - Diabetes: ________________

B: Blood Pressure: ________________

C: Cholesterol (LDL): ________________

(HDL): ________________

(Triglycerides): ________________

**Have you been to the ER in the past 3 months?** □ Yes □ No

How many times_______Where____________

Reason_________________________________

**Have there been any changes to your medications?** □ Yes □ No

If yes, what changed?____________________________________________________________________

**Were you admitted to any hospital?** □ Yes □ No

Where_______________ Reason_____________________________________________________________

**How well is the client adhering to diabetes management:**

<table>
<thead>
<tr>
<th>Diet:</th>
<th>a) not adhering</th>
<th>b) sometimes</th>
<th>c) most of the time</th>
<th>d) all of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise:</td>
<td>a) not adhering</td>
<td>b) sometimes</td>
<td>c) most of the time</td>
<td>d) all of the time</td>
</tr>
<tr>
<td>Medication:</td>
<td>a) not adhering</td>
<td>b) sometimes</td>
<td>c) most of the time</td>
<td>d) all of the time</td>
</tr>
</tbody>
</table>

**Over the past three months, what is the total number of:**

- Home Visits____________
- Phone contacts__________
- Mail/letters___________
- Appointments CHW accompanied____________
- Social service referrals provided____________
- Groups client attended____________

__________________________    _______________________
CHW Signature                Date

Dates:

Patient: Month:

CHW:
Appendix D

Complete this form together with your patient before his or her next doctor’s appointment to assist them in having an open dialogue with their doctor

**PRE-MEDICAL VISIT**

<table>
<thead>
<tr>
<th>Date:</th>
<th>Start Time:</th>
<th>End Time:</th>
<th>Patient:</th>
<th>Type of contact:</th>
</tr>
</thead>
</table>
| Visit #: | CHW: | | | □ In Person  
 □ Phone |

Doctor: __________________________________________________________

Place where I will have my appointment: ________________________________________________________________

Appointment Date & Time: ___/____/_____ at _______ AM/PM

What are my main symptoms or complaints?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Do I need/have an interpreter?

________________________________________________________________________________________

Follow up problems/questions from my last meeting?

________________________________________________________________________________________

Questions for my providers

1. _______________________________________________________________________________________

2. _______________________________________________________________________________________

3. _______________________________________________________________________________________

4. _______________________________________________________________________________________

5. _______________________________________________________________________________________

Other tips:

Always bring all my medicine bottles and insurance card with me
Always ask for refills or new prescriptions for medications that are running low
Always ask my doctor about my test results: A1c_______ B/P _________ HDL_______ LDL_______
Always discuss any side effects from the medicines with my doctor
Remember to ask for any referrals as needed to a specialist (eye, foot, kidney, heart, liver, etc.)

CHW Contact information:

Name______________________________ Phone number__________________________________________

Date: __________ Start Time: __________ End Time: __________
Appendix E

Birthday Card

En este día tan especial queremos decirle...

FeliZ Cumpleaños!

Nuestro equipo Carita quiere hacerle una Feliz Cumpleaños y que el próximo año la brinde mucha salud. Esperamos poder seguir ofreciéndole nuestros mejores servicios y continuar apoyándole en su camino a una vida libre de Diabetes.

De su equipo en Carita
205-222-5993

Community Resources for Diabetes
2010-2011

Repetidores para el mes de Octubre

Lunes, 15 de Octubre, 11:30 am:

Sesión de Grupo Educacional - Universidad de Miami Campo Medico.

Bachelors' Children Institute 1580 NW 10th Ave, Suite 29C, Miami FL 33136

Demonstración de cocina y como cocinar saludable.

*Como siempre ofreceremos almuerzo, pases de autobús y parqueo complementario

Sábado, 6 de Octubre, 9:30 am:

Ejercicio en Grupo - Douglas Park: 2755 SW 37 Ave, Miami, FL 33133

Seguido por una Feria de Salud en El English Center: 3501 SW 28 Street, Miami, FL 33133

Sábado, Octubre 27, 9:30am:

Ejercicio en Grupo - Parque Juan Pablo Duarte

2800 NW 17th Ave., Miami, FL 33142

No se pierdan las actividades de este mes y el regreso de Nuestras Caminatas!

Si tiene alguna pregunta no dude en contactarnos al (305) 243-8893

Actividades del Equipo Carita del Mes de Noviembre

<table>
<thead>
<tr>
<th>Noviembre 2012</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11</td>
<td>12 Grup de Diabetes en la Universidad de Miami 1580</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>18</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>25</td>
<td>26</td>
<td>27</td>
<td>28</td>
</tr>
</tbody>
</table>

Fiesta de Salud: Magic City Casino 489 NW 37 AVE Miami, FL 33135

Grupos de educacionales: Universidad de Miami Campo Medico, Bachelors Children Institute 1580 NW 10th Ave, Suite 29C

Campana de Grupo: Parque Juan Pablo Duarte 2800 NW 17th Ave., Miami, FL 33142

Taller de Tratamiento: Oficina de Carita 1580 NW 10 Ave Suite 801 Miami, FL 33136

Cualquier pregunta no dude en contactarnos al 305-243-8893
References


Miami Healthy Heart Initiative
Division of General Internal Medicine
University of Miami Miller School of Medicine
Miami, Florida 33136