

CDC, Division of Diabetes Translation

Enhancing Access, Protecting Tomorrow for People With Diabetes: Role of Community Health
Workers

November 3, 2022

Transcript

Slide 1: Title Slide

Betsy Rodriguez: Good afternoon and good morning to viewers on the West Coast, Alaska, and Hawaii. Welcome to our webinar, *Enhancing Access, Protecting Tomorrow for People With Diabetes: Role of Community Health Workers*.

Slide 2: Moderator

This webinar is part of our efforts to recognize the International Diabetes Federation's 2022 World Diabetes Day theme of *Access to Care, Education to Protect Tomorrow*. World Diabetes Day will be celebrated on November 14. My name is Betsy Rodriguez, and I will be your moderator today. I am a senior public health advisor in the Health Education and Promotion Team in the Division of Diabetes Translation at the Centers for Disease Control and Prevention.

Slide 3: Disclosure Statement

Before we begin, I would like to go over some information about the webinar. At this time, we are required to share our disclosure statement. CDC, our planners, content experts, or their spouses and partners wish to disclose they have no financial interests or other relationship with the manufacturers of commercial products, suppliers, commercial services, or commercial supporters. [The] planner has reviewed content to ensure there is no bias. The content presented will not include any discussion of the unlabeled use of a product or products under investigational service. CDC did not accept commercial support for this continuing education activity. There are no fees charged for CDC continuing education activities. The findings and conclusions of these presentations are those of the authors, and [do] not necessarily represent the views of CDC.

Slide 4: Continuing Education

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Slide 5: Please Note

Please note, if you have never registered to TCEO online, you will have to create a new account and returning users should log in with their existing username and password. This webinar is being recorded, and an email will be sent once the recording is available. The recording will also be approved for continuing education credits. These slides and scripts of the webinar will be available with the recording.

Slide 6: Have a Question for our Speakers

During the webinar, if you have questions for our speakers, please type them in the Q&A box below. If you want to direct your question to a particular speaker, please feel free to note that in your question. We will do our best to answer all questions during the Q&A portion of this webinar. If you have questions about obtaining continuing education credits, where to access this webinar once it's over, or other technical questions, please use the chat box feature.

Slide 7: Director Welcome

I will [would] now like to invite Dr. Christopher Holliday, Director of the Division of Diabetes Translation at CDC, to give the opening remarks.

Christopher Holliday: Thank you Betsy and good afternoon, everyone. It is my pleasure to be here with you today. I'd like to begin by thanking Ms. Paulina Duker and the Association of Diabetes Care & Education Specialists for collaborating with us on this webinar. Thank you also to CDC's Betsy Rodriguez for moderating. The International Diabetes Federation's theme for this year's World Diabetes Day is *Education to Protect Tomorrow*—calling attention to the need for better access to quality diabetes self-management education and support (DSMES) services. Keeping with that theme, today's webinar not only highlights the importance of access to quality DSMES services for people with diabetes and their families, but also brings awareness to the role that community health workers play in increasing that access. As we know, people with diabetes require quality care and support to manage their condition and avoid or delay

complications. However, millions of people with diabetes around the world do not have access to this care and support. Increasing access to life-changing and sometimes life-saving support doesn't just mean improving therapeutics. It means meeting people where they are, in the places where they live, work, learn, play, and pray, and addressing the conditions of these physical and social environments. Those social and structural determinants of health are often enduring barriers to optimal health and well-being, causing inequities and inequalities for many communities, and addressing them is a public health priority. They are part of the HealthyPeople 2030 goals and one of the four top priorities of CDC's National Center for Chronic Disease Prevention and Health Promotion. Now, CDC's Division of Diabetes Translation is also committed to reducing the health inequities that exist among populations that are disproportionately impacted by diabetes and at risk for type 2 diabetes. One way that we've been addressing health inequity for some time now is by enhancing the engagement of community health workers. The *American Diabetes Association's 2022 Standards of Medical Care and Diabetes* includes recommendations based on strong evidence that clinicians should address food insecurity, housing insecurity and homelessness, financial barriers, and social community support to inform treatment decisions and referrals. These guidelines also recommend the provision of diabetes self-management education and support services to patients from lay health coaches, navigators, or community health workers when available. The Community Preventive Services Task Force recommends interventions engaging community health workers for both type 2 diabetes prevention and management. The findings listed in the Community Guide show that this

intervention approach is effective in terms of health outcomes and health equity, as well as cost. We continue to support community health workers' roles in medical and social services by maintaining the CDC community health worker resources web page and facilitating ongoing work between states and community health workers for chronic disease prevention and management. CDC is also supporting states that are building the infrastructure to sustain community health workers as a workforce. The forthcoming evaluation of these programs and the translation of aggregate outcomes from states and from partners will provide meaningful models and information to programs using this workforce. We can only sincerely put patients at the center of care when we appropriately understand and address the circumstances affecting their ability to manage well their diabetes. Community health workers hold a key that can help unlock and open our awareness to all aspects of patient experience and serve as that conduit for education to protect tomorrow. Thank you for your efforts and all that you do to improve the lives of people with diabetes and your partnership in realizing a vision of a world free of the devastation of diabetes. I will now turn it back to Betsy.

Slide 8: Today's Objectives

Betsy: Thank you, Dr. Holliday. The objectives for today's webinar are to analyze inequities in access to diabetes self-management education and support (DSMES) services and identify opportunities to enhance and expand access. We're also going to be talking about the unique role that community health workers can play to deliver culturally sensitive DSMES services as part of team-based care models in both clinical and community-based settings. Lastly, we would like to explore tools and resources to

support capacity building of organizations and individual providers in implementing best practices for effectively engaging community health workers to reduce diabetes-related health disparities.

Slide 9: Today's Presenter

It is my pleasure to introduce to today's presenter. Paulina Duker is a 32-year veteran health care professional. Her background is in nursing with broad practice experiences that include critical care, clinical program development, outcome management, home care, and hospital performance improvement. She is graduate trained in public health with an MPH from Johns Hopkins Bloomberg School of Public Health. Her clinical specialty and subject matter expertise is in diabetes care and education. She has co-authored publications on standards of care in diabetes, including the *National Standards for Diabetes Self-Management Education and Support*. Paulina has worked internationally as part of a global diabetes team, developing diabetes content to support people with diabetes in such areas as the Middle East, India, and China. She currently serves as the vice president of practice and learning at the Association of Diabetes Care & Education Specialists. She's passionate about self-management education as a scalable intervention for chronic disease, and the potential it has to bridge the health equity gap. Paulina enjoys traveling and spending time with her family. She considers her best work to be raising her two daughters, and I have the honor to consider her my true friend.

Paulina.

Paulina Duker: Thank you, Betsy, for that very kind introduction. It is my honor to be here today to join the CDC to kick off Diabetes Awareness Month. I am very honored also to share some thoughts on diabetes self-management education and support and how to scale this intervention through leveraging community health workers. Before we get started, I'm going to invite you to work with me on answering this question.

Slide 10: Input

If you are a community health care worker and you're online with us today, or if you work with community health workers, I want you to go to Menti.com and put [enter] in the platform what the title of your community health workers are—so the different roles and different titles that are assigned to the community health worker category of workers.

Menti Poll Results

I can see the responses popping up now. As we can see, there are a myriad of titles that we use for this category of workers and part of the diabetes care team. Thank you.

Slide 11: Pharmacotherapy for T2D

The purpose of that exercise was really to point out that there are multiple titles that we use in various work practice settings to categorize this group of workers. At the Association for Diabetes Care & Education Specialists, we undertook this exercise of looking at all of these different titles that exist out there on this group of workers. What we came to—the conclusion we came to—was adopting a title diabetes community care coordinator.

Because we think that these are the group of workers that actually connect health care systems with the communities in which people with diabetes live and play and work and pray. There are a variety of names that we use for this group of workers, and we have acknowledged that. And part of that acknowledgment was really to create competencies, to clearly define the work that this group of people do, and also to create the competencies and the resources to support them. So, having done that, let's look at why this group of workers are so important. The slide that you're looking at right now shows the rapid acceleration of diabetes medications. The development of new diabetes medications from 1920 to 1950 and probably into the '60s—there were four classes of diabetes medications. There was insulin, sulfonylureas, metformin. Metformin actually came on the market and went off the market, so there were few drug classes, and then came the '70s and right in the '80s, when we have seen an explosion of diabetes medications. You can see we are up to 12, 13 classes of medications now. As we have learned more about the way diabetes manifests in people with diabetes, so all of the systems that are impacted by diabetes have led to all of these developments. These are medications, but we also have devices, other technological devices, and we have seen again, rapid advances in all of these to support people with diabetes.

Slide 12: No Improvement of A1c in Patients With Diabetes

Despite all of these advances, what we know is that people with diabetes are not doing better.

Hemoglobin A1C—which is the classic clinical measure to really see how people with diabetes are doing, how well they're doing—those measures are not improving over time, in fact, they're slightly going down. So people with diabetes are not doing better,

despite all of those advances in technologies and medications that we have seen. And why is that?

Slide 13: Disproportionate Workforce

So, one of the reasons we know is that there's a disproportionate diabetes workforce. We have 8,500 endocrinologists, that's one for every 4,300 people with diabetes; 11.3 percent of the US population have diabetes, and so that's where that one in 4,000 proportion comes from. If we look at certified diabetes care and education specialists, there are 20,000 of them, not quite, but almost 20,000 certified diabetes care and education specialists. That works out to be about one certified diabetes care and education specialist for about 1,800 people with diabetes. Of course, we have primary care physicians where most people with diabetes are receiving care. We have non-specialists, nurses, dietitians, and pharmacists who also participate in the care of people with diabetes. We have community health workers or diabetes community care coordinators, peer supporters, who all participate. But just for comparison, we have about 7.2 percent of the US population that have heart disease, and we have about 33,000 cardiologists. We have about 5.2 percent of the population with cancer, and for that, we have about 22,000 oncologists. That is not to say that we want to shift resources anywhere. There are not enough physicians, period. But if you look at the proportions, you can see that the endocrinologists to number of people with diabetes is acutely limiting.

Slide 14: DSMES Is Underutilized

What else do we know? We also know that we have a benefit. Medicare pays for diabetes self-management education and support as a service, but only very few people are accessing the service. 1997 is when the Balanced Budget Act allowed for payments of diabetes self-management education and support services. But not much has changed since 1997. Five percent of people on Medicare are accessing this benefit. For people with commercial insurance, the numbers aren't any better; [the] percentage is only slightly better than the Medicare population, 6.8 percent. That tells us something. The design of this service is not serving people with diabetes.

Slide 15: Who and Why

What else do we know? The people who are at increased risk for experiencing poorer health outcomes, these are the same people who have been persistently underserved. The outcomes—they have poor health outcomes because of the inadequate service they receive.

Slide 16: Prevalence of Adults Aged 18 years or Older, United States, 2017–2020 by Race/Ethnicity

And who are these people? You can see here who has diabetes. If you break it down by ethnicity, people of Black, non-Hispanic, ethnic background have a higher rate of diabetes than the rest, as you can see. Not only do they have the highest rates of diagnosed diabetes, but they also have higher rates of undiagnosed diabetes compared to White non-Hispanic. It's almost doubled, the percentage of undiagnosed Black non-

Hispanic people with diabetes. That just predisposes them to higher risk and poorer outcomes.

Slide 17: Community Health Workers

Here's why community health workers come into the picture. What we know is that diabetes self-management education works. It took us a while to get to that, but we now know that when people receive diabetes self-management education and support, they do better. Their A1C is improved, and it's those who receive it, whether they do it in group settings or in one-on-one settings—it's the support that helps them. It is dose related; the more education and support they receive, the better their outcome seem to be. How can community health workers help us here? Community health workers often share the same characteristics as these communities that we've talked about, those who are at higher risk of experiencing poor diabetes outcomes. Community health workers, they serve the same communities by delivering culturally appropriate care through their lived experiences. These community health workers tend to be part of these communities. Their lived experiences, the languages they share, the religion where they pray, the foods they eat. All of these characteristics help them be ideal supporters for these people who are at highest risk for diabetes in supporting them.

Slide 18: Burden of Diabetes Treatment

Let's talk about the burden of diabetes treatment. What you see in pink, this looks like a very busy slide, but I'm going to summarize it for you what this means to the person with diabetes. In pink, what you're looking at is the burden that chronic disease puts on the

person with the chronic disease. People with diabetes are forced to perform tasks (medical tasks if you will): inject insulin, monitor their blood glucose, put insulin pumps on themselves. Families are affected by the same, by these tasks and the health care systems they have to operate in. They have to schedule appointments to see their doctors. They have to get referrals to see diabetes self-management, to access diabetes self-management education services. All of these tasks increase the burden of diabetes treatment. What you see in blue is the structures surrounding people with diabetes. Like I said, they may have to travel to a health system. They have to work, and they have to balance between work and attending health care appointments. Structures such as insurance—they may have insurance that allows them to have some medication and not others or buy one blood glucose meter and not the other. All of these impose additional burdens on the person with diabetes similar to other chronic diseases. And then in green what you see are the social impacts. This is why they experience not-so-great outcomes. These things get in the way of work and life, family life, and social life. They may not be able to attend all the functions they want to. They may not be able to eat healthily, or healthfully, as we expect them to. If you put all of these things together, the simple message is people with diabetes need support. This taxonomy of the burden of treatment was research done in multiple countries, about 30 countries, and all of these things showed up the same across the world. That chronic disease management puts burdens on the people who have chronic diseases, and the simple answer is that they need support.

Slide 19: Diabetes Self-Management – Need for Partnering with CHWs

People with diabetes are on their own most of the time. For the more than 8,700 hours in the year—they spend most of this time on their own. In the US where we have fairly good health care systems, folks with diabetes may be able to spend 15 hours. That's about an average of an hour a month with a health care professional. That's not enough. But more importantly, they have to do this work on their own, which is why we have to provide this service, the self-management education and support to equip them to be able to better do this. They're spending less than one percent of their time with health care professionals, and the goal is to really build their skills up and give them the support they need, so they can break through the structures and get to the services they need.

Slide 20: The Chronic Care Model – Leveraging CHWs

Even more important, maybe take the services to them. The Chronic Care Model instructs us of this. People do better when there's a linkage between the communities they live in and the health system they rely on for care. What we as health care professionals have to do is to design care delivery so that it meets people's needs right where they are and give them what they need. We can rely on community health workers to help us achieve this goal of bridging the community and the health care system. Sometimes they come to us where we are in the health care system, but they have to go back to their communities. What if we could design the delivery of the care so that we actually take it to them? They don't have to miss work. They don't have to take buses to get to us, and taxis, and just basically give up life so they can take care of their diabetes. Patient-centeredness is key to this, meeting them where they are, understanding exactly what it is they need

and building in them the informed patient that they need to be, to be able to interact with health care systems for the best outcomes possible for them.

Slide 21: CHWs Help Improve Diabetes Outcomes Around the World!

Again, community health care workers can help do all of that, bring the services into the communities. They share some of the characteristics with these community members—the language, the food. Evidence also shows that community health workers help improve diabetes outcomes. Again, this study was a global study, and some of the things that improved, some of the factors that get better when people with diabetes interact with community health workers is their symptom management. Their food intake—they improve on what they eat. Blood glucose levels get better, blood pressures get better, their BMIs get better, and this is evidence [from] across the world.

Slide 23: Four Critical Times to Provide and Modify DSMES Services

What are the four critical times? At diagnosis we have plenty of opportunities to serve people with diabetes, to bring services to them, and to support them with what they need. There's a lot of information to be consumed at that time, and it is ideal to deploy community health workers to support people with diabetes at this very critical time. Annually, if the people with diabetes are doing fine at least every year, we should be checking in on them. Or if they're not doing so well, when we see that the treatment targets are not being met, that is a good time to also intervene and support them if needed. When complicating factors occur, when they start seeing kidney complications, or eye complications and some of the other complications, that's also a good time to

intervene and support them. Then when transitions in life occur—when they change insurance, when they are admitted to a hospital, when they're discharged back home from the hospital. For younger people, when they attend college, these pivotal times can be very optimal for working with community health workers and others in the health care profession to support people with diabetes.

Slide 24: Factors that Indicate Need for DSMES Services: At Diagnosis

We talked about being newly diagnosed and the amount of information that people need at this time and why it is an optimal opportunity to support them. At the start of the new diagnosis, what happens is there's a lot of information. We try when we are interacting with them to give them as much as possible. The people with diabetes have to go into their communities, have to go back into their homes, and interact with their families to incorporate the information they get into their lives. That is the time when we need to follow up with them to ensure that the information they get becomes useful. They get to put it in practice. They get to have more questions that we can then answer for them and help them address.

Slide 25: Factors that Indicate Need for DSMES Services: Annually

Annually. Why annually? Well for one thing, diabetes information changes rapidly. A lot is changing and new medications, new devices are all coming to market. Sometimes people with diabetes simply need new information and more information to help them self-manage. Remember the goal is to make them independent self managers of their diabetes. Checking in with them annually is ideal. Of course, there are times when we

need to do it more frequently than annually. That means then that we're seeing that the targets are not being met, and we need to check in with them. There may be changes in their medications and nutrition, there may be changes in their lifestyle, they may change jobs—in which case, what they did before doesn't work anymore. We have to help them find resources in the community that can support these changes. Again, community health workers can be the ideal support system during these times.

Slide 26: Factors that Indicate Need for DSMES Services: When Complications Occur

When complicating factors occur. People with diabetes do everything they can, but we know from the burden of treatment that sometimes they're not able to keep up with the work that they have to do to self-manage. Complications do happen. There are physical limitations as people age. There are emotional stressors. There is just the diabetes as a stressor itself—diabetes distress. Situations like pregnancies, changes like that, need extra support to help people transition smoothly and do the best they can to live with their diabetes. Again, what an ideal opportunity to deploy community health workers to support people with diabetes.

Slide 27: Factors that Indicate Need for DSMES Services: Transitions in Life and Care

Then finally, transitions in care. We talked about situations like change in the living situations. Maybe they move out of a family situation to now live by themselves. That may require arranging for more support. Co-workers may be stepping in to help, managing hypoglycemia, or hypoglycemic events. Discharging a patient from hospital to home. A lot of times when patients are in hospital, the treatment changes and so we need to

send them home on sometimes possibly something different than what they came to the hospital with. Great opportunity to have community health workers follow up with them through phone calls, through apps, through going physically into the community to places close to them that are more easy or easier for them to access care. There's a new clinical team, and they have to learn how to work with these new teams. Changes in medication, intensifying insulin regimens. These are all times [or] transitions that may require extra support. Insurance coverage changes, for those of us who know this, it can throw you off. Your previous insurance may cover your medication, annual blood glucose, and your testing strips. Then come January, you have new insurance, which you have no control over as a person living with diabetes, and you find that you're thrown into changes that may truly impact your diabetes care. Community health workers can help navigate the systems [and] figure out the best way to close the gap quickly so the care doesn't deteriorate too far. Age-related changes and self-management limitations. All of these changes can require additional support. Again, community health workers are in ideal positions to help us do that.

Slide 28: DSMES/Ongoing Support

We have to build these expectations when we're working with patients. We have to make them confident and understand that the support is there. Currently we have systems that require referrals and different scheduling appointments and patients traveling to places that sometimes are difficult to access. How about if we design the system? We can take the care to them. How about adding in the support that they need? Maybe follow-up phone calls, maybe partnering with social systems in their communities. Churches,

grocery stores, pharmacies, fitness centers. How about just knowing those resources that are available in their community so when they need support, we're ready to help them with those lists of resources. More important than anything is to create a system where community health care workers can document this care. This is what folks—other health care professionals on the diabetes care team—need access to, to know where these services are, to know what community health workers are helping people with diabetes, implementing access in their own communities so they can actually bridge the gap. This is how we improve care overall for people with diabetes, documenting that care. All of the team, the entire diabetes care team, can have access to the information and the strategies that are being implemented by community health workers. [This] is key to elevating care for people with diabetes. Ultimately, we want to improve outcomes, prevent or delay complications, and preserve tomorrow. This is how we do it, by building it into our systems and care delivery.

Slide 29: ADCES7

The ADCES7 self-care behaviors. These are the seven self-care behaviors that we know—if you work with people with diabetes—when you focus on these areas, they tend to do better. Problem-solving. Helping them figure out, if I have a low blood sugar, what do I do? If I run out of medication, what do I do? What is my backup plan? That's problem-solving. Reducing risks, helping them access care to prevent complications. Can they see an ophthalmologist and where does that ophthalmology services sit in the system that can help them access it as easily as possible. Dental care [and] other things to help them monitor, so they can delay or prevent the complications of diabetes. Monitoring is key.

They're monitoring their blood glucose levels. For people with diabetes and other cardiometabolic conditions, they're monitoring their blood pressure, they're monitoring their blood fat levels. Different things that they have to monitor to know that they're doing well with their diabetes. How to communicate that back to their caregivers, their health care professionals. Community health workers can use these seven self-care behaviors. Even the self-monitoring guidelines and numbers that people are working on. Communicating with people with diabetes based on what they're monitoring can help guide where care needs to proceed to. Healthy coping, healthy eating, being active, helping them find resources in the community where they can do all of this. Taking medications. If checking in with people with diabetes, making sure that they are taking their medications as prescribed. If not, why not? Communicating that back to prescribers and letting them know, maybe they're not taking their medications and possibly why, so that we don't wait too long until the health care system actually discovers that people with diabetes are falling off and developing poor outcomes.

Slide 30: Summary

In summary, there are opportunities for us to interact with people with diabetes. We have to position diabetes self-management education services as a key way to help people with diabetes improve outcomes and integrating community health care workers to help us do this. To access the education, to improve clinical management, and ultimately to preserve tomorrow for people with diabetes. Community health workers can help activate the patient, meaning, give them information they need to better interact with the broader health care system. They can connect patients with the community

resources. They can help people with diabetes navigate the health systems. How to access additional care if needed, to get a head start on what may be complications developing or outcomes going sour. They can access care as soon as possible to reverse these trends. They can be key to improving systems quality. [In] a lot of our health care systems, we are constantly looking for best ways to improve outcomes and connecting services through community health care workers. Help us learn what it is in the community that we need to know to really do a better job of improving quality for people with diabetes.

Slide 31: Contact Information

At the Association we have lots of resources. We have competency lists. More important than knowing that we can deploy community health workers is really working with them. We have resources on training so that you can build resources to support community health workers to actually deliver on this big dream that we have. You can reach me at the Association at that email you see on the slide or at our website. We have plenty of resources that you can access, and we are always ready to partner with you to help you help the people with diabetes that you take care of. Thank you.

Slide 32: Question and Answer

Betsy: Thank you, Paulina. We will now begin our Q&A session. Please type your questions in the Q&A box and we will do our best to answer all of them. In fact, Paulina, I have here a very interesting question. I would like to start with the first one. Allow me—here, I have been copying and pasting these questions. This is an interesting one that says here,

we need the short version of the DSMES. People don't like to stick for [a] 12-month long education package.

Paulina: But I could not agree with you more. You do not have to stick with 12 months. That's what person-centered care is all about. That's what connecting people with diabetes with a community health care worker, for example, is all about. When you're with that patient, what you're assessing is what is most critical for that patient. It doesn't have to be a curriculum. It doesn't have to be a list of topics. It is only what that patient in that moment needs, and they will tell you. You can ask them. Those are the competencies that we help all people, all health care professionals develop. Asking the right questions so you can get to what that particular patient in front of you needs and address that particular need. No, we do not need 12 hours or 10 hours. We only have to address what each individual patient needs at the time, in the moment. That's how they get to build confidence and improve their self-care. And then they begin to build on it and get confident that they can, in fact, do more to self-manage.

Betsy: However, there's a dichotomy here, Paulina, because for reimbursement purposes, for example, in Medicare, they have to be ten classes of 10 hours, [inaudible]. I know that the ten is somewhere, somehow in the story, but yes, indeed it should be patient-centered. As diabetes educators, we have the ADCES7 behaviors that should guide that conversation, so services are provided with the patient at the center. In other words, patient-centered, individualized approach. That is the way it should go, because at the end, what we're looking [at] here is to join the people where they are in their journey while living with diabetes, right? Can you expand on that, please?

Paulina: Yes, I can expand on that. Medicare—we have to live with the reimbursement system set we have. I would agree with you: Medicare pays for 10 hours of diabetes self-management education and support services annually. When you're newly diagnosed, that is the amount that you're entitled to. Because that is the prescribed reimbursement amount, we take that 10 hours, and we use it for the patient in front of us. What we know is that if the patient is not ready, there are seven self-care behaviors we focus on that, ideally, you will talk to the patient and find out how they're doing in all those areas. But ultimately what you end up finding is that the patient may need more help in one area than the other. That's what you focus on. Because Medicare pays for 10 hours, we're going to use those 10 hours to meet the direct need of that patient in that time. That means we may not get to talking to them about complications. We may need to talk about survival skills. They need to learn how to monitor their blood glucose. They need to have basics of how to eat properly to prevent glucose excursions. We focus on those things that will help them thrive first. If we use all of those 10 hours, and we haven't gotten to the rest, that's what that patient needs. It is more important to build confidence in the patients, help them gain skills that they can use in an area. Then you have the opportunity to build on it. Medicare comes back and gives another two hours a year. Over the course of time, people with diabetes will get to learn all of the areas that will help them. But it's important for us to focus on their needs in the moment. If we're going to build the confidence that they need to self-manage and to build skill over time, we cannot overwhelm them with everything. If we try to deliver all those areas, they end up with nothing because they don't, in fact, become skillful in any area. The better

way is to assess, figure out what they need, provide that service, help them build the skill, and then build on it as additional time becomes available that we can use.

Betsy: Thank you. I have a comment here that I would like to read, because I think that [it] really touches my heart. This person said, I just wanted to say thank you for using people with diabetes instead of diabetics. I am a community health worker and a person with diabetes. I struggle with feeling guilty and having diabetes, thinking I did something to myself as diabetic insinuates. We don't refer to people with cancer as "cancerics." I really appreciate your efforts in this area. It's a good lesson for all CHWs as well as us [to] keep in mind. Can you expand on that comment? We have a "language matters" practice paper document, right?

Paulina: We do have the language document. It is part of the skills we'll have to build at a time. I don't even know if I can say that word anymore because it's always people with diabetes for me now. We understand that, and these are the skills that we strive to equip people with. Why is it important? Because that's what's important to the people with diabetes. We can relate to them, and they can relate to us if we have a common language that is respectful and supportive of them managing their chronic diseases.

Betsy: Thank you. Here is another question. It says, how beneficial are health fair screenings in recognizing early sign of prediabetes, to initiate prevention plans. Are health fair screens a rush?

Paulina: There are different schools of thought on health fair screenings. What I will say is this: If you are going to perform health care screenings in any settings, because sometimes

that's all that people have access to, then you should have a backup plan on what you're going to do if you, in fact, discover that they have hyperglycemia, and you have to refer them. If you screen, and you don't have the supporting services to send them to, that screening is really not helpful. In fact, it may cause anxiety and restlessness, and a person who now does not know where to go to access the services they need. Screening should always be paired with follow-up services. That is one thing to know. Otherwise, it doesn't help to really screen. We screen to help people for early diagnosis, so we can pick people up before it's too late. But if you pick up early diagnosis, if you pick up an early sign of diabetes or prediabetes, and you don't have the service to refer them to—to say here's how we can follow up with you, this is the support available to you, here's where you can go learn more information or get the support that you're going to need—then it is not helpful to do the screening.

Betsy: There's another question here that says, how [come] are some patients put on pills right away and others on insulin? Should they change their diet and exercise first before getting on insulin?

Paulina: Great question. We know from the pathophysiology and how diabetes manifests that everyone shows up at the time of diagnosis differently. They show up and their blood sugars are so high. So high that the pill is not going to take effect in time to really help them. They are already at risk. They may have type 2 diabetes, but you don't know that. What you do know is that their blood sugars are way too high. Some clinicians, physicians, primary care practitioners will start insulin because you need to decrease that glucose toxicity. Because at every moment that glucoses are high, there are

systems in the body that are compromised—their eyes, their kidneys, there are other things that are getting affected. What determines the treatment is how the patient presents at the time of diagnosis, how high their blood sugars are. The other important things like, have they lost weight? Things like that will indicate where you start from. But the ideal situation is to be with the health care system to have them monitored over time, so we can make changes and treatments as needed over time.

Betsy: Thank you, Paulina. This is another very interesting question right away here. It says, diabetes is the number one blinding eye disease among working-age adults. Up to 26 percent of people with diabetes have some level of vision impairment. Why it is so hard to find accessible materials, and why do so many programs not include information for people with diabetes with vision loss? Self-management skills have to be adapted for vision loss. This is a serious gap in care and education.

Paulina: I can only agree that there's a gap in care. I think there are so many challenges with managing people with diabetes, but I will agree that there's a limitation there. We don't have enough support systems for people with vision challenges. There are some, but there are not enough. Thank you for bringing that up because we all have to do better for people with diabetes who have vision challenges.

Betsy: Well, I have news to share about this, Paulina. You might not even know this, but I have been working to develop a DSMES toolkit for people with low literacy issues and non-English speaking populations. That is about to be clear. Now we're moving into work in

areas for low-vision people and rural communities. For the person [who] raised these questions, stay tuned because as it says in the movies... coming soon.

Paulina: Coming soon. We need them, we need all the resources we can use to support people with diabetes.

Betsy: There is another question here. Are there any tips [to] engage with community health workers when DSMES services are delivered virtually?

Paulina: Are there any...?

Betsy: Are there any tips to engage with community health workers when DSMES services are delivered virtually?

Paulina: Tips when DSMES is delivered virtually?

Betsy: By, engaging community health workers.

Paulina: I think that in terms of virtual DSMES delivery, it is really seeing as much as possible.

You want to see as much as you can see. First you want to ask the right questions. In the virtual setting, you may miss some physical things that you can see when you're in-person, and so the idea is to ask the right questions. What is it that is really difficult for you? What one thing about your diabetes is getting in your way right now? Ask specific questions about what is happening now, because you may miss something in the virtual environment that you will see if you were in-person. Affect, the way they look, depression, and things like that may be difficult to pick up in the virtual environment. Ask questions and spend time listening to what they're telling you.

Betsy: Indeed. There is also another resource that we're working [on], and this one is for community health workers on diabetes prevention. It's called the *Road to Health Toolkit*. It has been in the environment for quite [a] long time, and now has been updated. In that particular one, in this new version that is going to be launched, we are going to be including tips on how to virtually engage communities for prevention. But I would like to say that the tips that we included in that resource will also be very helpful to engage community health workers while providing virtual services. I think you may want to consider exploring also engaging community health workers in those—what I'm calling virtual trainings—for lack of a better way on how to describe it. Because one of the legacies that we have, Paulina, from the pandemic, is that virtual meeting has become the way to go. We have been learning as we do, and I think that there are lot of opportunities to engage community health workers in the virtual space.

Paulina: I think the one thing I would say about those virtual environments is the ability for the person with diabetes to access care immediately. In the moment, if they have a question and they know that they have a community health worker that they can reach out to, it is excellent to have that.

Betsy: I will agree. There is another question here [that] says, why are the salaries so low for all the duties that community health workers have to provide?

Paulina: I wish I had a good answer for this [LAUGHTER]. All I can say is, if I had my druthers, it would be very different. And we continue to advocate for these services in tandem with

all diabetes self-management education services. I wait for the day when this question will not come up ever again.

Betsy: Well, I have news too. There is a group that is working on sustainability and financing mechanisms for community health workers. I cannot say more, but they're a group of people who have [inaudible] interested in working in this area so stay tuned.

Unfortunately, Paulina, we don't have time for any more questions. I tried to answer some of them in the Q&A section.

Slide 33: Menti Poll

Now that we are wrapping up, we have one more question for you, please. We will go back to Menti.com for this question. You can go to Menti and enter the code 8675615. After participating in this webinar, what is one thing you will try to do better to engage with community health workers in supporting delivery of DSMES services? I can see bubbles coming up. For instance, use better language with patients—good. Navigate insurance and provider changes for patients. Organizing training program—we are working on that. Provide support and engage often, education on self-management, be more understanding of patient and needs, provide the easy-to-use understand[able] teaching materials curriculum to use with community members. Support them when they need tools to engage with patients. Education for community health workers. Better organization and communication skills. Oh my God, [they] keep popping up. Providing enough training and support for community health workers. Activities and providing support to reduce barriers to engage community health workers. Listening to patients. Organizing training programs with common language. Focusing on [one]

social determinant of health issue at a time. The DSMES itself is complex to teach; provid[ing] ongoing training support (like monthly) will be helpful for community health workers who may be new to conducting DSMES services. Finally, these last two: be respectful and understanding when communicating. Be more perceptive to meet the patients where they are on their journey. I really like that one.

Slide 34: Thank You

I think that with this, this concludes our webinar. Be sure to get your continuing education credit. Instructions are on the screen and will be emailed to you. As a reminder, a recording of this webinar as well as the slides will be shared in the near future. Thank you for joining us today. Thank you. Thank you very much.