



Community Health Workers (CHWs) Supporting Diabetes Self-Management In the Primary Care Setting

Hometown Family Health Overview

Hometown Family Health is a small provider-owned primary care and family medicine clinic located in Plankinton, SD. Hometown Family Health is committed to providing compassionate, quality care to all patients, treating them as part of their family. They use an integrative approach to treat the whole person, not just individual illnesses or injuries. Their focus is on treating current conditions and preventing future ones. Overall, the staff of Hometown Family Health understand that healthcare is not “one size fits all”, so the way they approach it can’t be either!



HOMETOWN FAMILY HEALTH
WE CARE ABOUT YOUR CARE - EXPERIENCE THE HOMETOWN DIFFERENCE

Hometown Family Health is staffed by three (3) Certified Nurse Practitioners, as well as nursing staff, administrative staff, and a Community Health Worker (CHW) and Spanish interpreter. A CHW is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker 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.

To learn more about Hometown Family Health and the services they provide to the Plankinton, SD Area Community, visit www.hometownfamilyhealth.org.

Community Overview

Plankinton is in rural, southeastern South Dakota in Aurora County. The 2020 census data for Aurora County showed a population of 2,747. The county has a median household income of \$45,230 and a median family income of \$55,588. Approximately 8.2% of the population lives below the poverty line. The racial makeup of the county is predominantly White, with 89.8% of the population identifying as non-Hispanic White.



Plankinton, SD

CHW Workflow for Working with Patients with Diabetes

CHWs play a vital role in bridging the gap between healthcare providers and the patient, particularly in diabetes education and management. Their unique position allows them to build trust, provide education, and support patients in making sustainable lifestyle changes. This document outlines the key areas where CHWs contribute to improve diabetes outcomes.



Initial Visit with the Healthcare Provider

Provider sees patient at Hometown Family Health

CHW Referral

If patient has prediabetes or diabetes, a CHW referral may be recommended

Referral Forms

Provider completes the CHW referral form along with the PRAPARE Social Determinants of Health (SDoH) Screening

CHW Documentation Form
Hometown Family Health
PO Box 35/104 W Commerce St.
Plankinton, SD 57368
605-299-8234

Name: _____ Date of Service: ____/____/____
Address: _____ Start time: _____ End time: _____
City, State: _____ Referring Provider: _____
Phone: _____ Individual or group: _____ Group (# in group): _____
DOB: _____ Medicaid number: _____
Location: _____ # of units (unit=30min): _____

Qualifying conditions:
____ Asthma _____ Cancer _____ COPD
____ Depression _____ Diabetes _____ Heart Disease
____ Hypercholesterolemia _____ Hypertension _____ Mental Health Conditions
____ Musculoskeletal & neck/back disorder _____ Obesity _____ Prediabetes
____ High Risk Pregnancy _____ Substance Use Disorder _____ Tobacco Use
____ Use of multiple medications (6 or more classes of drugs) _____ Other: _____

Qualifying barriers:
____ Geographic distance from health services _____ Lack of phone _____ Cultural/language barriers
____ Social Determinants of Health

Written Objectives:
____ Assess and assist with social determinants of health needs as related to qualifying condition(s) and/or qualifying barrier(s).
____ Provide health system navigation and resource coordination as related to qualifying condition(s) and/or qualifying barrier(s).
____ Provide health promotion and coach regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.
____ Provide health education regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs.
____ Other: _____

Specific Services Required for Meeting Written Objectives
____ Health system navigation and resource coordination
____ Health promotion and coaching
____ Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects

Work with patient up to _____ units per day (a unit = 30 min) with a maximum of _____ units per week. Assess CHW services after six months, or prior if patient is ready to be discharged from CHW services.

The role of the CHW is in extending the reach and impact of healthcare services. They work to reinforce and expand upon the information shared by the licensed healthcare provider, improving patient health literacy.



CHW Meets with Patient

- After the preliminary conversation with the provider, the CHW meets with the patient to assess needs and set goals using the My Personal Physical Activity Plan
- Education is based on patient's goals
- Patient can keep a copy of the Physical Activity Plan for reference at home.

CHW
Hometown Family Health
PO Box 35/104 W Commerce St.
Plankinton, SD 57368
605-299-8234

My Personal Physical Activity Plan

My goal is to spend _____ minutes per week in physical activity.

I plan to meet my goal by:

1. _____
2. _____
3. _____

I know my roadblocks to being more physically active are:

1. _____
2. _____

I will overcome my roadblocks by:

1. _____
2. _____

At the end of four weeks, I will reward myself. My reward is: _____

Signed: _____ Date: _____

Did you meet your goal?

Yes _____ Decide if you want to keep your goal or set a new goal, but keep going!

No _____ Review your roadblocks, set a new goal, and try again!

Community Health Worker's Key Focus

CHWs focus on enhancing patient understanding and supporting adherence to care plans. This summary outlines the key aspects of a CHW's scope of work.

- Educating patients about diabetes using comprehensive models that illustrate how it impacts the entire body – from the brain and nerves to the eyes and feet.
 - This can include PowerPoints or A1C viscosity bottles that show the thickness of blood when A1C goes up and up.
 - It's important to relate this back to the kidneys and heart and how hard they have to work as the blood gets thicker.
- Emphasizing the importance of **Knowing Your Numbers** (e.g., blood glucose, A1C, blood pressure, cholesterol).
- Sharing the significance of lab results, and promoting health literacy (but not interpreting those results).
- Providing nutrition education, portion size guidance, and physical activity planning.
- Providing support for weight management and diabetes self-management education.
- Facilitating goal-setting and serving as a vital communication link, reporting any concerns or observations from patient interactions to the healthcare provider.



During CHW appointments, the Diabetes Self-Management form is completed to help manage the patient's diabetes care. The CHW uses the form to identify areas where the patient might need extra support and works with them to set achievable goals. The form also ensures patients are up-to-date with essential appointments, such as those for adaptable shoes, dental checkups, and eye exams. The CHW helps coordinate health system resources and provides valuable education about what's covered for exams for people with diabetes.

Diabetes Self-Management
HOMETOWN FAMILY HEALTH

Patient Name: _____ DOB: _____
Date of visit: _____ Time spent w/ pt: _____

Type of visit
☐ Individual ☐ Individual prior/after OV ☐ Group (# in group ____)
☐ Telephonic ☐ With interpreter

Interventions during this visit:

☐ Self-management goal setting ☐ Review of previous self-management goal ☐ General diabetes information ☐ Nutritional education ☐ Exercise strategies ☐ Medication adherence strategies	☐ Lab ☐ Eye exam ☐ Podiatry ☐ Dietician ☐ Mental Health ☐ 100 Plus ☐ Other: _____ ☐ Information on classes: _____
--	--

Self-management behaviors

During the last seven days, how many days..... Circle number of days

Have you followed a healthful eating plan?	0	1	2	3	4	5	6	7
Did you do at least 30 minutes of physical activity?	0	1	2	3	4	5	6	7
Did you test your blood sugar?	0	1	2	3	4	5	6	7
Did you check your feet?	0	1	2	3	4	5	6	7
Did you take your prescribed diabetes meds?	0	1	2	3	4	5	6	7

Which one of these statements comes closest to the pt's plans for managing diabetes?

☐ I am not interested in managing my diabetes.
☐ I know it is important for me to make changes to manage my diabetes, but I am not ready yet.
☐ I plan to make changes to manage my diabetes in the next few months.
☐ I am ready to make changes to manage my diabetes.
☐ I have been able to meet and continue to meet the goal I have set to manage my diabetes.
☐ I have returned to my previous behaviors.

Self-management SMART (specific, measurable, attainable, realistic, time) goals:

- _____
- _____
- _____

How confident is your patient that s/he can achieve the identified goal(s)?

☐ Very confident ☐ Somewhat confident ☐ Neither confident or unsure ☐ Somewhat unsure ☐ Very unsure

The Health Provider-CHW Communication Bridge

Patients with prediabetes or diabetes are scheduled every 3 months with their provider. During these visits, weight and A1C are evaluated, and the provider discusses how CHW visits are progressing. Adjustments to medications are made if needed. It has been observed that fewer medications for diabetes are needed after patients participate in CHW diabetes education sessions.

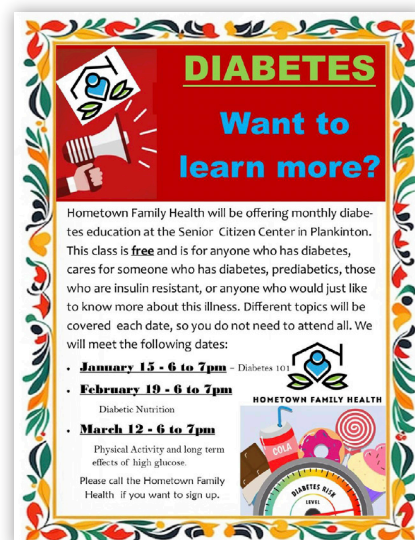


The most important aspect of care is the communication between the provider and the CHW. This involves open dialogue, discussion of patient progress, and the CHW serving as the eyes and ears for the provider, especially in the home and community setting. Communication between the CHW and the provider has allowed for medication dose changes earlier than the normal, three-month follow-up as information is being shared that may call for a medication adjustment sooner.

Communication can occur in person, via phone, or through the Electronic Medical Record. While direct face-to-face communication is ideal, it is not always necessary.

Community Diabetes Education Program

In the Spring of 2025, Hometown Family Health was able to use grant funding to host three community education classes, Diabetes 101, Nutrition for People with Diabetes, and Importance of Physical Activity. All classes were presented in both English and Spanish, with an average attendance of 12 English-speaking and 8 Spanish-speaking participants. The CHW from Hometown Family Health also works with some class participants as individual patients as well.





Success Stories

Success Story 1: Prediabetes Intervention

Overview

The patient was referred to the CHW by a nurse practitioner who had been working with her for several years. The patient's weight was a persistent concern, but despite various interventions, the provider was unable to get the full picture of the patient's health status.

When meeting with the patient, the CHW discovered that, although she was getting in physical activity, the patient did not like any type of vegetable and struggled with portion control, often consuming her largest meal in the evening. Therefore, the CHW concentrated primarily on nutrition, working on understanding food labels. For example, she liked 'Good Thins,' which claimed to contain vegetables. However, upon examining the label, it was clear that the product lacked substantial nutritional value and could not serve as a substitute for fresh vegetables. V8 juice was introduced into her diet to compensate for the lack of vegetables, but she did not like the taste. After consulting with her primary care provider, it was decided to use vegetable supplements as an alternative source of nutrition.

With the help and education from the CHW, the patient is so happy she's been able to alter things in her life to feel better.

Patient Information

- 54-year-old female
- Referral for prediabetes

Intervention Details

- CHW intervention: 5 months
- Focus areas:
 - Diabetes disease process education
 - Nutrition education (including reading food labels)
 - Portion control
 - Physical activity

Results

Metric	Starting Value	Ending Value
A1C	6.4	5.9
Weight (lbs)	192	178
Blood Pressure	111/73	104/72



Success Story 2: Type 2 Diabetes Intervention

Overview

The patient presented with significant anxiety regarding her diabetes and unstable blood glucose levels. It was discovered that she was inconsistently taking her prescribed medication. She would often forget to take her two doses and, upon remembering, would be unsure whether to take the missed dose or not, often opting not to. The solution implemented was a pill organizer labeled in Spanish, her native language.

A significant challenge for the patient was her low literacy level, as she had never attended school. This required a more hands-on approach from the CHW, who had to guide her through the educational materials more closely. The time constraints of providers in the clinic do not allow for such detailed guidance. If the patient had been at a different clinic, she might have been prescribed different or additional medications. The language barrier added another layer of complexity to her care.

The CHW’s role was crucial in bridging the communication gap between the patient and her healthcare provider. Taking the time to walk her through her care plan, utilizing a Spanish-speaking interpreter, and maintaining open communication with her providers were key elements of her care.

In addition to her medication regimen, the CHW also worked on improving the patient’s activity level. Although she worked in meat cutting, which involved a significant amount of labor, it did not provide the benefits of outdoor activity. The CHW emphasized the importance of spending time outside, and the patient began going on walks regularly.

It is anticipated that her increased physical activity, combined with consistent medication intake, will result in a significant decrease in her A1C levels. Furthermore, the mental health benefits of spending time outdoors cannot be overstated.



Patient Information

- 52-year-old female
- Spanish speaking, illiterate
- Referral for Type 2 Diabetes

Intervention Details

- CHW intervention: 7 months
- Focus areas:
 - Diabetes disease process education
 - Nutrition education
 - Physical activity
 - Medication compliance

Results

Metric	Starting Value	Ending Value
A1C	9.2	7.3



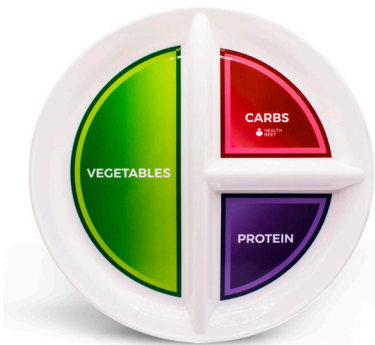
Success Story 3: Diabetes and Kidney Disease Education

Overview

A farming couple met with the CHW for diabetes management. The husband had been experiencing low blood sugar levels in the morning and high blood sugar levels in the afternoon and evening, with his blood sugar peaking in the 200-270 range. The CHW began by asking what the couple had for meals the day prior. The husband said he had peanut butter toast for breakfast and a regular lunch. For supper, they had a roast beef sandwich, potatoes, and peas.

The CHW started working on their nutrition, especially exploring non-starchy vegetables. She showed them a great teaching tool in the form of a physical plate with dividers, designed to help patients with diabetes manage their meals. This plate, which is a normal size, has been helpful for the couple’s weight loss journey and in controlling their portion sizes.

The husband was also having a hard time understanding his kidney disease. He received notes stating that his kidney function was stable, but he didn’t understand what that meant and was very concerned. The CHW printed off a chart that explains all the stages of kidney disease. The CHW also prints off his lab results each time so he can see his actual numbers and compare them to the chart. This has been a really helpful resource for him.



Patient Information

- Married couple in their late 70s
- Referred Both for Type 2 Diabetes - husband is insulin dependent, wife was newly diagnosed with Type 2 diabetes

Intervention Details

- CHW intervention for both patients: 5 months
- Focus areas:
 - Diabetes disease process education
 - Nutrition education
 - Portion control
 - Medication compliance

Husband’s Results

Metric	Starting Value	Ending Value
A1C	7.7	6.6
Weight (lbs)	16+ lbs lost	
Blood Pressure	No change	

Wife’s Results

Metric	Starting Value	Ending Value
A1C	6.5	5.7
Weight (lbs)	23 lbs lost	
Systolic Blood Pressure	147	127

* With the CHW’s intervention, the wife did not need to start diabetes medication.



Success Story 4: Managing Sugar-Intake

Overview

The patient was referred to the CHW due to her newly diagnosed Type 2 Diabetes. The CHW worked with the patient for three months, focusing on educating her about the diabetes disease process, physical activity, and nutrition.

During the three months, the patient made significant progress with her A1C levels, lost weight, and drastically reduced her soda intake, going from four 20-ounce Mountain Dew sodas a day to just one Coke Zero a day.

The patient is still working on increasing her physical activity. Despite her progress, she still needs caffeine, but she has made a significant reduction in her Mountain Dew consumption.

Intervention Details

- CHW intervention: 3 months
- Focus areas:
 - Diabetes disease process education
 - Physical activity
 - Nutrition education

Patient Information

- 37-year-old female
- Referral for new onset Type 2 Diabetes

Results

Metric	Starting Value	Ending Value
A1C	10.8	5.5
Weight (lbs)	17 lbs lost	

Success Story 5: Maintaining Progress

Overview

The patient was referred for diabetes management. He has been doing exceptionally well in terms of his health. He’s retired and his wife, who does not have diabetes, is responsible for meals and food preparation and accompanies him to all his medical appointments. The couple enjoys biking riding where the patient bikes 4 miles and his wife bikes 3.5 miles.

For his arthritis, the patient has been using WD-40 on his feet and calves. Despite attempts to introduce other treatment options, he remains steadfast in his choice. He does well with physical activity, and a significant part of his health improvement can be attributed to nutritional education. His wife has been creative in her meal preparations, even making celery work for his dental health. Overall, the patient’s health journey has been positive and he continues to make strides in maintaining his well-being.

Patient Information

- 87-year-old male
- Recently transferred care to Hometown Family Health

Intervention Details

- CHW intervention: 7 months
- Focus areas:
 - Diabetes disease process education
 - Physical activity
 - Nutrition education
 - Medication compliance

Results

Metric	Starting Value	Ending Value
A1C	9.1	6.6