NYU School of Medicine
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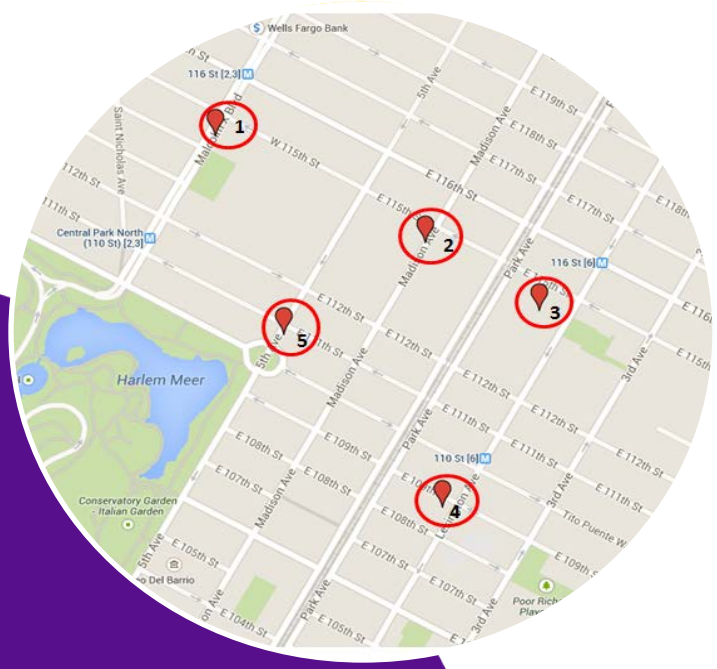


HARLEM HEALTH ADVOCACY PARTNERS (HHAP): A Place-Based CHW Initiative in Public Housing

NYU Department of Population Health

May 19, 2015

- Formative Assessment
- Intervention Development
- Next Steps

FORMATIVE ASSESSMENT
Study Design

- Qualitative focus groups designed to explore barriers and facilitators of chronic disease management, and solicit community input on the CHW intervention
- Participants recruited from resident council meetings and community events, as well as snowball sampling
- Focus groups held at local DPHO office or CUNY
- Focus group participants were later recruited for participation in the HHAP Community Activation Team (CAT)

FORMATIVE ASSESSMENT
Overview

- 6 focus groups held
- 12/6/2014 – 12/20/2014
- n = 55
  Females: 45 (82%)
  Males: 10 (18%)
- Mean Age: 58 y/o
  Age range: 30 - 82 y/o

Participant Representation Breakdown		
Building	**N**	**%**
Johnson	37	67
Taft	9	16
Lehman	5	9
King	3	5
Clinton	1	2
Participant Disease Status Breakdown		
Disease Status	**N**	**%**
HTN only	8	14
Diabetes only	2	4
Asthma only	6	11
Diabetes and HT	31	56
All 3 conditions	8	14

FORMATIVE ASSESSMENT
Analysis

- Grounded theory approach
- Codebook developed a priori based on facilitator guide
- 2 independent coders used for each FG transcript
- Inter-coder reliability verified after 50% of coding completed
- Analyses will include major themes by code and will include illustrative examples

FORMATIVE ASSESSMENT
Findings

Main Themes:

- Managing multiple chronic diseases
- Barriers & Facilitators of Healthy Eating
- Barriers & Facilitators of Physical Activity
- Medication Adherence
- Provider Communication / Continuity / Trust
- Access to Care & Systems-level Barriers

FORMATIVE ASSESSMENT
Findings

MANAGING MULTIPLE CHRONIC DISEASES

"Now because of my hypertension I have had two strokes and that is why I have to go to physical therapy now and a lot of cognitive skills that I used to have like my short time memory and long term memory all that stuff has been affected and my vision."

"Me, I am a constant hospital person because of diabetes. It has affected my life really bad. It is like breaking my body down. My A1 is so high that they cannot bring it down and that is the main thing. I just came from the doctor with 800. I have been hospitalized so much I have to stay in there."

"Everything. It affects everything, your mind and your body. You don't feel good. Sometimes I don't eat rice ever since I was diabetic. There was a time in my life that I ate everything before I was diabetic, but then I wound up in a coma for not doing the right thing. And now it is like, once in a while or a couple of days I am not eating and the doctor tells me to eat."

FORMATIVE ASSESSMENT
Findings

MEDICATION ADHERENCE

"I was on 17 pills in the morning, 10 in the evening/ afternoon and 4 at night. It would have me sitting there for hours like I was in space. I couldn't deal with that."

"Because those pills make me feel terrible; all of them 'Here, take more insulin.' I want to stop taking my insulin, because if I am going to die, this is how I want to be. I was in a coma in 96' and now I'm here. Everything hurts already."

"Sometimes people give you medicine that doesn't even work. They prescribe it and it doesn't work with me. I was doing a lot of medicine like that too. I stopped taking it and I felt better. The doctor even said, whatever you are doing, keep doing it. And then I didn't tell them that I stopped taking the medicine. Some of the side effects I was getting, it was like taking out my hair and you know, making me feel like in a different way. It was giving me symptoms that I didn't even have."

FORMATIVE ASSESSMENT
Findings

PROVIDER COMMUNICATION / CONTINUITY

"I had a doctor that I had for 10 years and he knew me, but when they started this HMO thing, I keep getting a new doctor every 6 months. I don't get a chance to know my doctor. If we don't know the doctor, if we don't have a chance, then we need to."

"They always have the person who is going to take their place to sit and talk to me. It's the change that gets to me. It makes me uncomfortable."

"My doctor does not do that hands on thing and I do not understand because I have private insurance and you think I would be getting that. You need to call me, if you see something off you should call me."

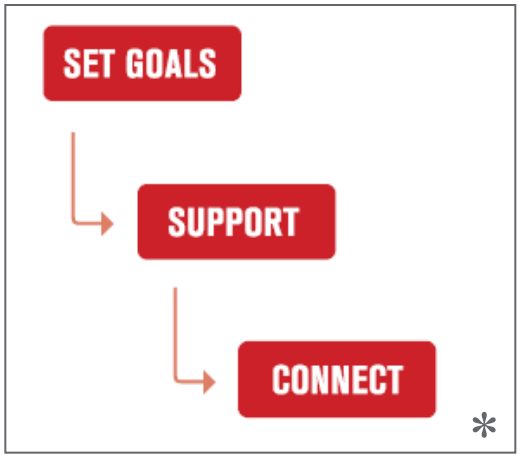
"They just try to pawn you off to someone else like the nutritionist or the other lady who looks at your sugar. The diabetic specialist. The doctors, they don't really have much time to talk."

- Formative Assessment
- Intervention Development
- Recommendations for Future

INTERVENTION DEVELOPMENT
Protocol Development

Core principles:

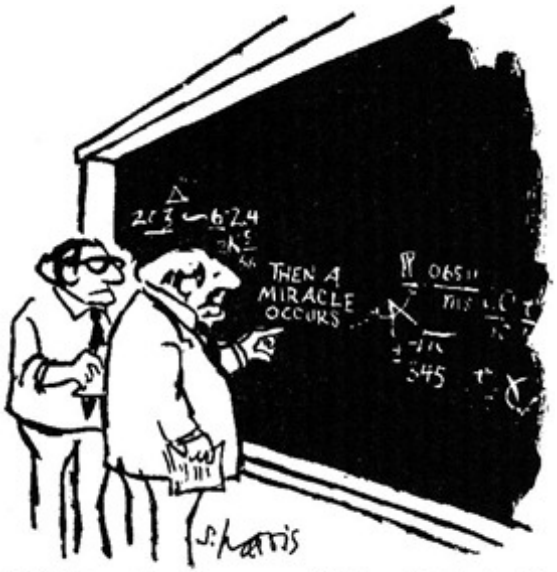
- Action-oriented goal setting
- Disease education
- Instrumental support
- Social support
- Clinical linkages



*Penn Center for CHWs

INTERVENTION DEVELOPMENT
Protocol Structure

- Developed comprehensive program protocol with guidelines for:
  - Recruitment
  - Assessment
  - Enrollment
  - Follow-Up
  - CHW Expectations & Guidelines
- Contributed to design of evaluation materials to help align evaluation with program design



"I think you should be more explicit here in step two."

INTERVENTION DEVELOPMENT
Protocol Structure

Introduction to HHAP Program & Baseline Survey Completion

Short- & Long-Term Goal Setting using MI techniques

INTERVENTION DEVELOPMENT

LONG -TERM:

"For the next 6 months, I would like to work on … X"

SIX-MONTH ACTION PLAN

I plan to focus on my: (select one)	By 6 months from now, I will:
Weight 	Get my weight down to: _____ lbs or Maintain weight at _____ lbs
Blood Pressure (BP) 	Get my BP to _____ or Maintain BP at _____
Diabetes / Hemoglobin A1c (A1c) 	Get my A1c to _____ or Maintain A1c at _____
Smoking 	Quit Smoking or Reduce smoking to _____/day
Asthma 	Check all that apply: ☐ Have asthma symptoms AND use my quick-relief inhaler on 2 days a week or less. ☐ Have asthma symptoms that awaken me at night on 2 or fewer nights per month. ☐ Have no exacerbations that require me to use oral corticosteroid (OCS) medicine. ☐ Can exercise, work, and go to school with no limitations on my activity level.

SHORT -TERM:

"In order to get to X, I will ___ for the next 1-2 weeks"

SHORT-TERM ACTION PLAN

In order to reach my six-month goal, for the next 1-2 weeks I will:

(e.g. walk 3 times) _____

When I will do it (e.g. in the morning after breakfast) _____

_____

Where I will do it (e.g. around the block) _____

_____

How often I will do it (e.g. Monday, Wednesday, & Friday) _____

_____

What might get in the way of the plan (e.g. too cold outside) _____

_____

What I can do about it (e.g. use the treadmill in the community center) _____

_____

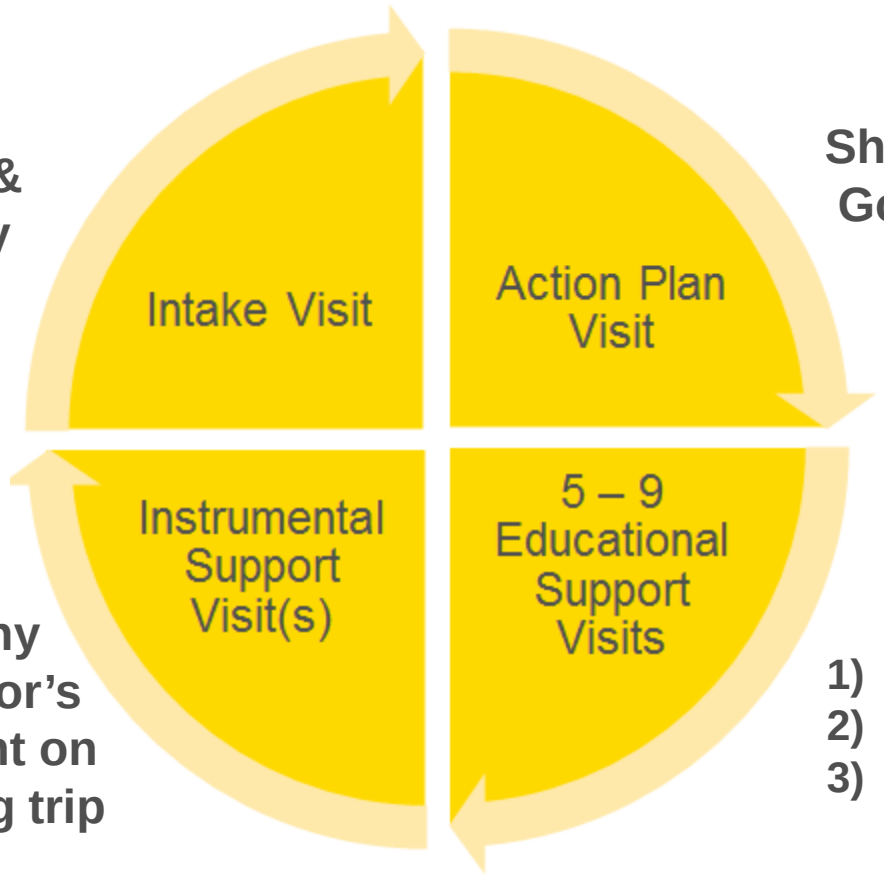
How confident am I that I can reach this goal: (circle one)

0	1	2	3	4	5	6	7	8	9	10
Not at all		A little			Somewhat confident			Very sure		Totally confident

Follow-up Plan (how and when): _____

INTERVENTION DEVELOPMENT
Protocol Structure

Introduction to HHAP Program & Baseline Survey Completion

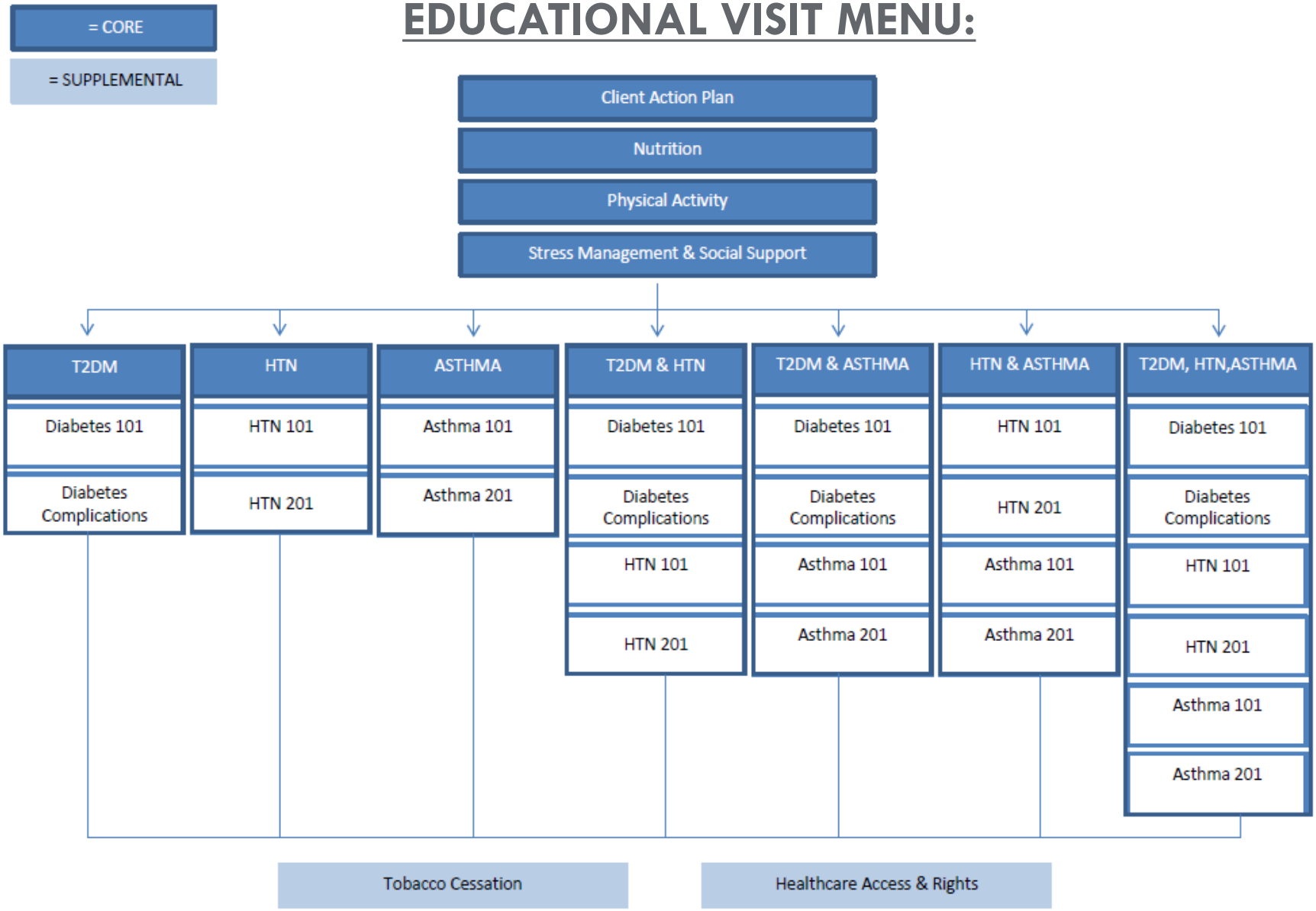


Short- & Long-Term Goal Setting using MI techniques

e.g. Accompany resident to doctor's visit, join resident on grocery shopping trip

1) **Goal Check-in**
2) **Brief Education**
3) **Instrumental Support**

EDUCATIONAL VISIT MENU:



INTERVENTION DEVELOPMENT
Curriculum Development

- CHW curriculum adapted from standardized disease education curriculum including:
  - CDC, Diabetes Prevention Program (DPP)
  - NHLBI, "With Every Heartbeat is Life" curriculum
  - NIDDK/NIH, "What I Need to Know" series
  - HHS, Million Hearts Program

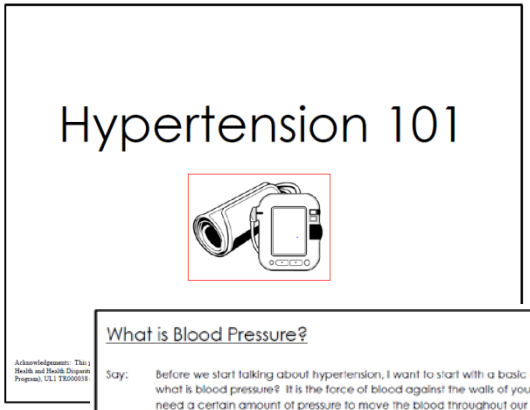
- NYC DOH resources incorporated into toolkit to promote ongoing city-wide campaigns (MyPlate Planner, Health Bulletins, BP self-monitoring protocol, etc).

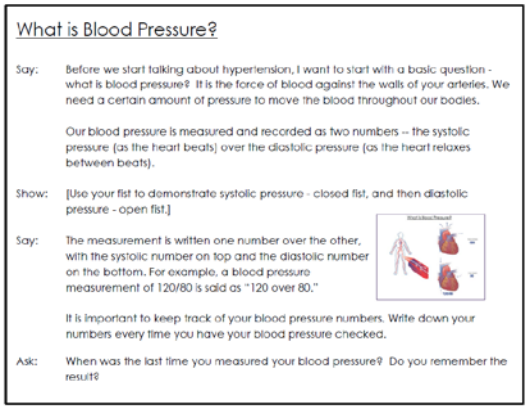
- Each session distilled into main points, 7-10 core concepts

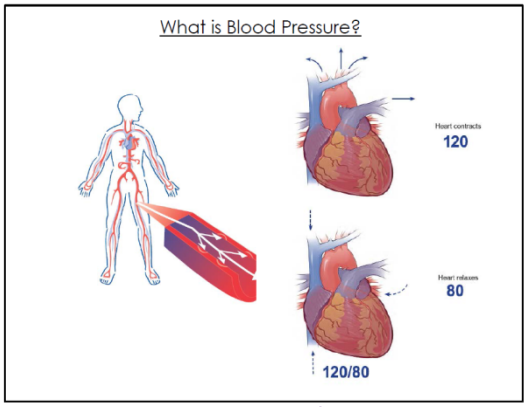
INTERVENTION DEVELOPMENT

CHW Toolkit includes:

- CHW Manual
- FlipCharts (to be used as printed materials or via tablet)
- Supporting educational handouts







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NEXT STEPS

- A report on focus group findings will be used to inform the next round of the intervention
- Mixed-methods report
- Ongoing technical assistance on CHW toolkit and curriculum
- Dissemination of toolkit to wider audience


someone
need
time
health
want
community
maybe
know
show
eat
explain
right
think
talk
one
just
take
come
people
tell
get
cook
knowledgeable
advocate
everything
doctors
emergency
generation
step
room
still
care
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though
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make
give
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help
diabetes
individual
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food

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