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

<table>
<thead>
<tr>
<th>Building</th>
<th>N</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Johnson</td>
<td>37</td>
<td>67</td>
</tr>
<tr>
<td>Taft</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Lehman</td>
<td>5</td>
<td>9</td>
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<tr>
<td>King</td>
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<td>5</td>
</tr>
<tr>
<td>Clinton</td>
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<table>
<thead>
<tr>
<th>Disease Status</th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td>HTN only</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Diabetes only</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Asthma only</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Diabetes and HT</td>
<td>31</td>
<td>56</td>
</tr>
<tr>
<td>All 3 conditions</td>
<td>8</td>
<td>14</td>
</tr>
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</table>
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:
  
  o Recruitment
  o Assessment
  o Enrollment
  o Follow-Up
  o CHW Expectations & Guidelines

• Contributed to design of evaluation materials to help align evaluation with program design
INTERVENTION DEVELOPMENT
Protocol Structure

Introduction to HHAP Program & Baseline Survey Completion

Intake Visit

Action Plan Visit

Short- & Long-Term Goal Setting using MI techniques
INTERVENTION DEVELOPMENT

**LONG-TERM:**
“For the next 6 months, I would like to work on … X”

<table>
<thead>
<tr>
<th>SIX-MONTH ACTION PLAN</th>
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<tbody>
<tr>
<td><strong>I plan to focus on my:</strong> (select one)</td>
</tr>
<tr>
<td><strong>Weight</strong></td>
</tr>
<tr>
<td><strong>Blood Pressure (BP)</strong></td>
</tr>
<tr>
<td><strong>Diabetes/Hemoglobin A1c (A1c)</strong></td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
</tr>
</tbody>
</table>
| **Asthma** | [Check all that apply]  
- Have asthma symptoms AND use my quick-relief inhaler on 3 days a week or more  
- Have asthma symptoms that prevent me from doing any normal activities for 2 or fewer nights per month  
- Have no exacerbations that require me to use oral corticosteroid (OCS) medication  
- 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)

<table>
<thead>
<tr>
<th>Not at all</th>
<th>A little</th>
<th>Somewhat confident</th>
<th>Very sure</th>
<th>Totally confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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Follow-up Plan (how and when) _____________________________

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INTERVENTION DEVELOPMENT
Protocol Structure

Introduction to HHAP Program & Baseline Survey Completion

Intake Visit

Action Plan Visit

Instrumental Support Visit(s)

5 – 9 Educational Support Visits

Short- & Long-Term Goal Setting using MI techniques

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

e.g. Accompany resident to doctor’s visit, join resident on grocery shopping trip
EDUCATIONAL VISIT MENU:

= CORE

= SUPPLEMENTAL

Client Action Plan
Nutrition
Physical Activity
Stress Management & Social Support

T2DM
- Diabetes 101
- Diabetes Complications

HTN
- HTN 101
- HTN 201

ASTHMA
- Asthma 101
- Asthma 201

T2DM & HTN
- Diabetes 101
- HTN 101
- HTN 201
- Diabetes Complications

T2DM & ASTHMA
- Diabetes 101
- Asthma 101
- Asthma 201
- Diabetes Complications

HTN & ASTHMA
- HTN 101
- Asthma 101
- Asthma 201

T2DM, HTN, ASTHMA
- Diabetes 101
- Diabetes Complications
- HTN 101
- HTN 201
- Asthma 101
- Asthma 201

Tobacco Cessation
Healthcare Access & Rights

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INTERVENTION DEVELOPMENT
Curriculum Development

• CHW curriculum adapted from standardized disease education curriculum including:
  o CDC, Diabetes Prevention Program (DPP)
  o NHLBI, “With Every Heartbeat is Life” curriculum
  o NIDDK/NIH, “What I Need to Know” series
  o 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
- Formative Assessment
- Intervention Development
- Next Steps
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
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  • NYC DOHMH and DPHO
  • NMPP
  • CSS

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• CHWs