This product was developed by the diabetes self management project at Gateway Community Health Center, Inc. in Laredo, TX. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

Gateway Community Health Center, Inc.

Diabetes Self Management Project

Funded by The Robert Wood Johnson Foundation

CDC Diabetes Translation Conference

Miami, Florida

May 3, 2005

Improving Diabetes Self Management Education in Community Health Centers by Incorporating Promotores in the Health Care Team

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Gateway Community Health Center, Inc.

- Established 1963 in Laredo, Tx Along US-Mexico Border as Migrant Health Center.
- Designated as 501(c)(3) Non-Profit Corporation in 1989; Federally Qualified Health Center.
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- Two Clinical Sites in the community and two rural areas with staff conducting weekly clinics for over 15,000 users in Webb County.
- Over 72,000 Medical, Dental, and Clinical Visits Provided in 2003.

Webb County

Population

- 95% of the county's population resides in Laredo;
- 95% Hispanic;
- Over 32% fall below 100% Federal Poverty Level;
- Over 35% uninsured.

Diabetes

- In Webb County, one in six adults has type 2 diabetes;
- Webb County also has one of the highest mortality rates (55.5/100,000) for Type 2 diabetes in the state;
- Diabetes is the number one diagnosis at Gateway with 2,307 patients with diabetes.

Profile of a Patient with Diabetes

- **Female**
- **Age 43**
- **Hispanic**
- **Obese**
- **4 to 5 Children**
- **Uninsured**
- **Low Social Economic Status**
- **Multiple Family Dwelling**
- **Sixth Grade Education**
- **Hemoglobin A1C Higher than 7.5%**
- **Has a difficult time managing her diabetes**

Visits per year for patients with diabetes 3.21

Total Patients with Diabetes: 2, 307

Source 2003 UDS

GATEWAY DIABETES SELF MANAGEMENT PROJECT

Goal:

To build a consistent infrastructure and methodology that will assist patients with diabetes to maintain their HbA1c below 7.5% over an extended period of time by implementing and integrating Diabetes Self -management activities in a culturally sensitive manner.

- Patients
- Promotoras
- Medical Support Staff
- Medical Providers
- Administrators
- Board of Directors

Roles and Responsabilities

Medical Providers and Support Staff

Reinforce DSM process by:

- **Offering health education;**
- **Highlighting patients attendance to DSM classes;**
- **Celebrating patients accomplishments or supporting them to meet their goals.**

Certified Diabetes Educator

- **Teaches new patients diabetes survival skills;**
- **Case manages patients with complications;**
- **Develops an action plan individualized for the patients;**
- **Keeps the provider aware of patient progress.**

Administrators and Board of Directors

- **Administrators and board of directors support the process by attending at least one time to the DSM classes;**
- **Celebrate patients accomplishments;**
- **Talk with patients about their needs and suggestions to improve the quality of care.**

Promotor(a) Roles and Responsibilities

- **Provides informal counseling and social support;**
- **Culturally sensitive health education;**
- **Advocates for patients needs;**
- **Assures that patients receive the health services they need and provides referral and follow- up services.**

- **Is a valuable employee of the center and plays a key role on the delivery of DSM;**
- **They assist and guide the patient in the management of the disease process, in prevention and control of the disease, and the maintenance of Diabetes Self Management.**

Promotor(a) Training

- **Clinic Site Orientation**
- **Medical Records**
- **Diabetes Self Management**
- **Leadership**
- **Time Management**
- **Listening Skills**
- **How To Make a Home Visit and Referrals**

- **Stress Management**
- **Support Group**
- **Community Resources**
- **Depression**
- **Cardiovascular Disease**
- **Promotor(a) Safety**
- **Problem Solving**
- **Mental Health**

Over 300 Hours of Training

Gateway Diabetes Self-Management Intervention Flow Chart

Medical Provider Refers Patient to Promotora

Intervention Begins

10-week Promotora-Led SM Course (2 hours/week)

- **Baseline Behavior and Lab Assessment (knowledge, health beliefs, PHQ-9)**
- **Advise (Diet, Nutrition, Physical Activity)**
- **Advise (Prevention/Management DM Complications)**
- **Behavioral Goal-setting (individual) every week**
- **Buddy Support System (Choose and Support Buddy)**
- **Group Problem-solving Session Weekly (Barriers)**
- **Goal Follow-up weekly (revision/resetting of goals)**
- **Weekly telephone call (remind, answer questions, problem solve, support)**

10-biweekly Support Group Sessions (2 hours each)

- **Buddy Support System (Mutual Aid Model)**
- **Help in the control of feelings, thoughts, and behaviors**
- **Group Discussion to Problem-solve Barriers**
- **Additional advise (Prevention/Management DM Complications)**
- **Individual Goal Follow-up**
- **Biweekly telephone call (remind, answer questions, problem solve, support)**

Intervention Ends

Voluntary Biweekly Support Group Sessions

Baseline Data
HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam Flu Vaccine, Pneumovax, Hospitalizations, ER visits, Knowledge, Health Beliefs, and PHQ-9

3-month Data
HbA1c, Lipid Profile, BP, BMI, Knowledge, Health Beliefs, Retention Rate, and Patient Satisfaction

6 & 12-month Data
HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam Flu Vaccine, Pneumovax, Hospitalizations,ER visits.

Documentation

GATEWAY COMMUNITY HEALTH CENTER, INC.

Diabetes Self Management Goals

The following goals will help you gain/maintain diabetic control to reduce damage to your blood vessels and nerves.

What are YOUR Goals for the next 3 months? What do you want? I want my:
Blood sugar levels to be _____ Blood Pressure_____
Hemoglobin A1C _____ LDL _____ Statins _____.

Please choose goals you are willing to work on to better manage your diabetes.	Date Reviewed	Date Accomplished
 **Goal 1: Exercise** I will exercise _____ days per week. I will do _____ exercises _____ minutes a day. I will do this _____ times a day.		
 **Goal 2: Foot Care** I will check my feet daily. As instructed, I will bring the filament chart to my doctor at every visit.		
 **Goal 3: Meal Planning** I will eat 3 meals and snacks on time (daily). The times I eat are: Breakfast_____, Lunch _____, Dinner_____, Snacks_____. I will make an appointment to learn more about healthy eating_____. Other_____.		
 **Goal 4: Weight Loss** I will lose _____ pounds by my next office visit to reach my goal of _____ pounds at the end of the year.		
 **Goal 5: Medications** I will take my medication regularly as instructed by the doctor.		
 **Goal 6: Smoking** I will stop smoking. I will talk to my doctor about medications, gum and/or patches to help with cravings.		
 **Goal 7: Eye Exams** I will have an eye exam every year or as indicated by the doctor.		
 **Goal 8: Dental** I will have a dental exam every year or as indicated by the doctor.		
 **Goal 9: Blood Sugar Testing** I will check my blood sugar as instructed and will bring my record to next clinic appointment. I will call if my blood sugar is below 70mg/dl and higher than 180mg/dl more than two times per week.		
 **Goal 10: Stress Management** I will stop and take 4 deep breaths when I am feeling anxious or stressed. I will _____ take a walk, _____ take a bath, _____garden, _____ read, _____ talk to a friend/family, _____pray, other, when feeling too much stress _____.		

Patient's Name:_____ DOB____/____/____MR#_____
Patient's Signature_____ Nurse/MOA_____ Date:____/____/_____

Gateway Diabetes Self Management Project
Promotora Progress Notes

Patient Name: _____ MF#_____
Date of Birth: _____

Attendance Key: Yes or No

Participation Key: Good, Fair, or Minimal

Self-Management Course and Support Group Session Attendance and Participation

Course Module	Date	Attended	Participation	Additional Comments
Introductory				
Module 1: Getting Started				
Module 2: Understanding Diabetes				
Module 3: Monitoring Your Body				
Module 4: Get Up and Move				
Module 5: Practice and Review				
Module 6: Nutrition				
Module 7: Medications				
Module 8: Developing a Partnership				
Module 9: Complications				
Module 10: Coping with Diabetes				
Graduation				
Support Group Session				
Support Group Session 1				
Support Group Session 2				
Support Group Session 3				
Support Group Session 4				
Support Group Session 5				
Support Group Session 6				

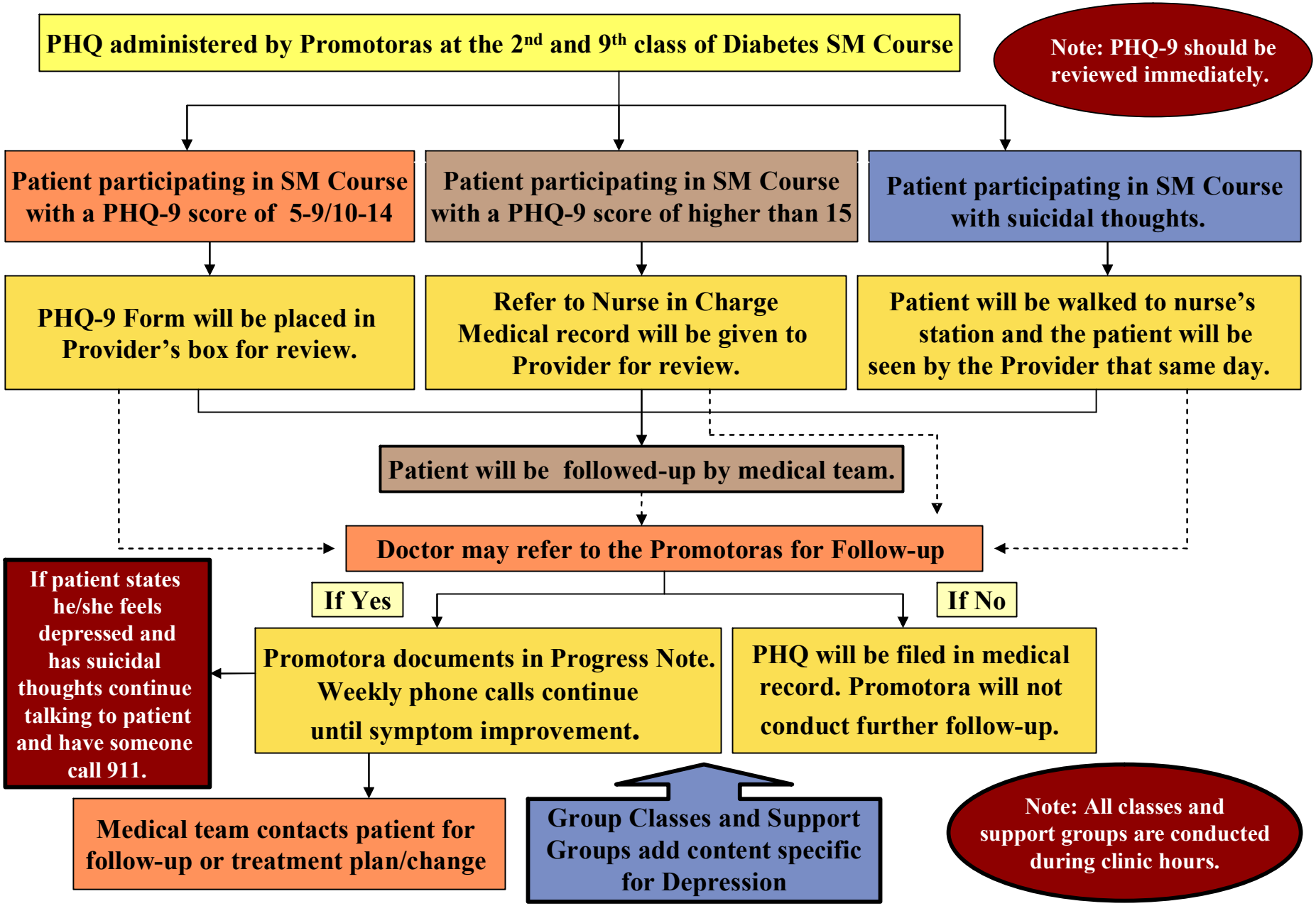
Goal Setting and Problem-Solving Barriers Summary

Date:
Goal/Revision:
Barriers:
Problem-solving Plan:
Comments:

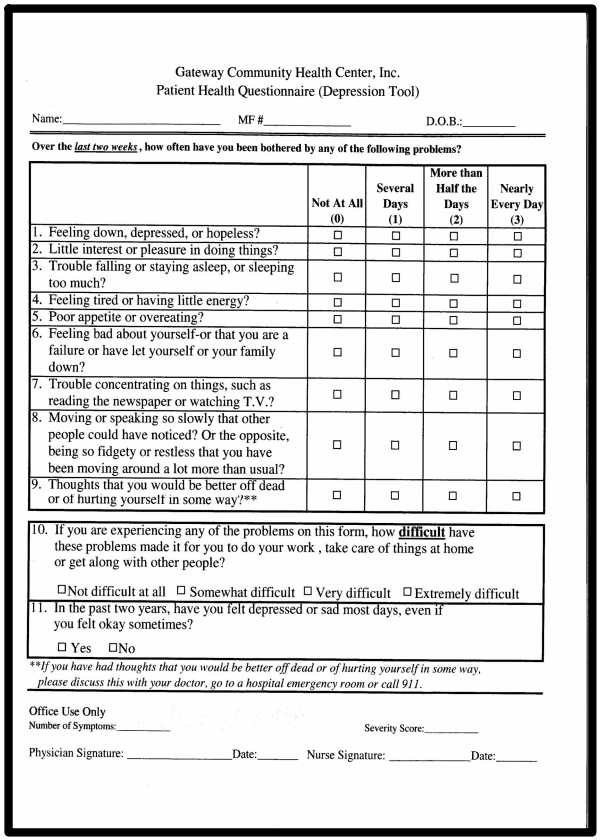
Gateway Community Health Center, Inc. *Diabetes Self Management Project*

Note: These forms are part of the patient's medical record and are completed by the promotoras.

Depression Screening and Follow-up Protocol



Documentation



Gateway Community Health Center, Inc.
Patient Health Questionnaire (Depression Tool)

Name:_____ MF #_____ D.O.B.:_____

Over the *last two weeks*, how often have you been bothered by any of the following problems?

	Not At All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
1. Feeling down, depressed, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired or having little energy?	☐	☐	☐	☐
5. Poor appetite or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching T.V.?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way?**	☐	☐	☐	☐

10. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work , take care of things at home or get along with other people?

☐Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

11. In the past two years, have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor, go to a hospital emergency room or call 911.*

Office Use Only
Number of Symptoms:_____ Severity Score:_____

Physician Signature: _____Date:_____ Nurse Signature: _____Date:_____

Mental Health Progress Report
HP Follow Up Form
(Draft 7-15-03)

Patient Name:_____ ID #_____ Date: _____

Time Started:_____ ☐Telephone ☐Clinic ☐Home ☐Other_____

NOTE: Be sure to obtain information on treatment plan prior to initiating Follow Up.

Weekly Follow Up:

Are you feeling sad, depressed, or anxious?
- ☐ More than usual
- ☐ About the same
- ☐ Less than usual

What is the biggest thing troubling you right now? _____

How are you dealing with it? _____

If any of the these are checked, contact provider immediately:	
☐	Are you having any thoughts of harming yourself or of committing suicide? (Check if "yes")
☐	(If medication is prescribed) Are you having thoughts or feelings that are going much faster than usual, or "racing"? (Check if "yes")
☐	(If medication is prescribed) Are you sleeping two hours less than usual, and not being tired during the day? (Check if "yes")

If medication is prescribed, ask the following:	
Have you filled the prescription for your medicine? If not checked, WHY?	☐Yes ☐No
What medicine for depression are you taking?	
How are you taking your medicine?	
Are you having any side effects or problems from your medication?	☐Yes ☐No

Have you been going to your doctor or therapist appointments?	☐Yes ☐No

Monthly Follow Up: Administer PHQ (See PHQ page)

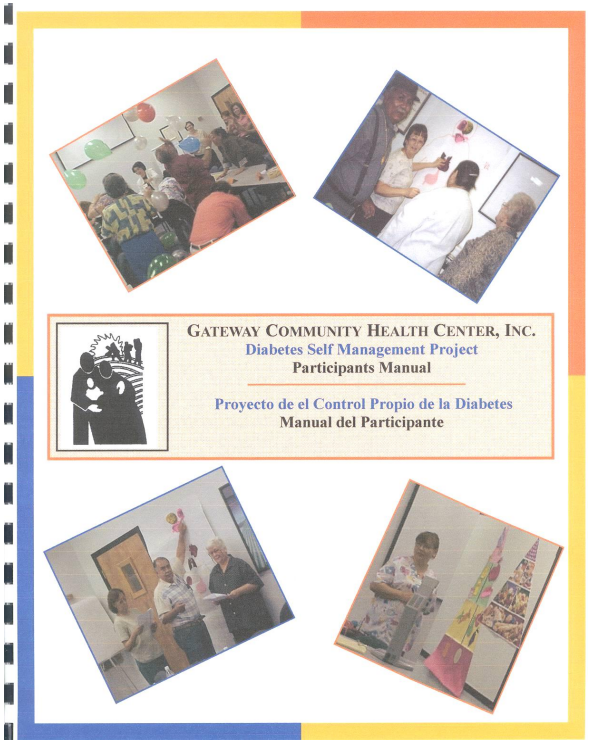
Notes:

Follow Up/Action: _____

Health Promoter: _____ Time Ended_____

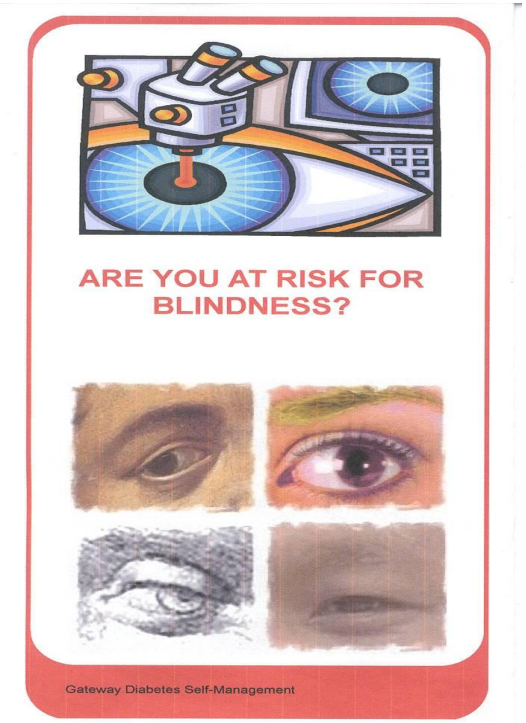
Note: PHQ-9 and Mental Health Progress Report are completed by the promotoras for screening and follow up, are part of the medical records.

Educational and Promotional Materials



Patient Booklet

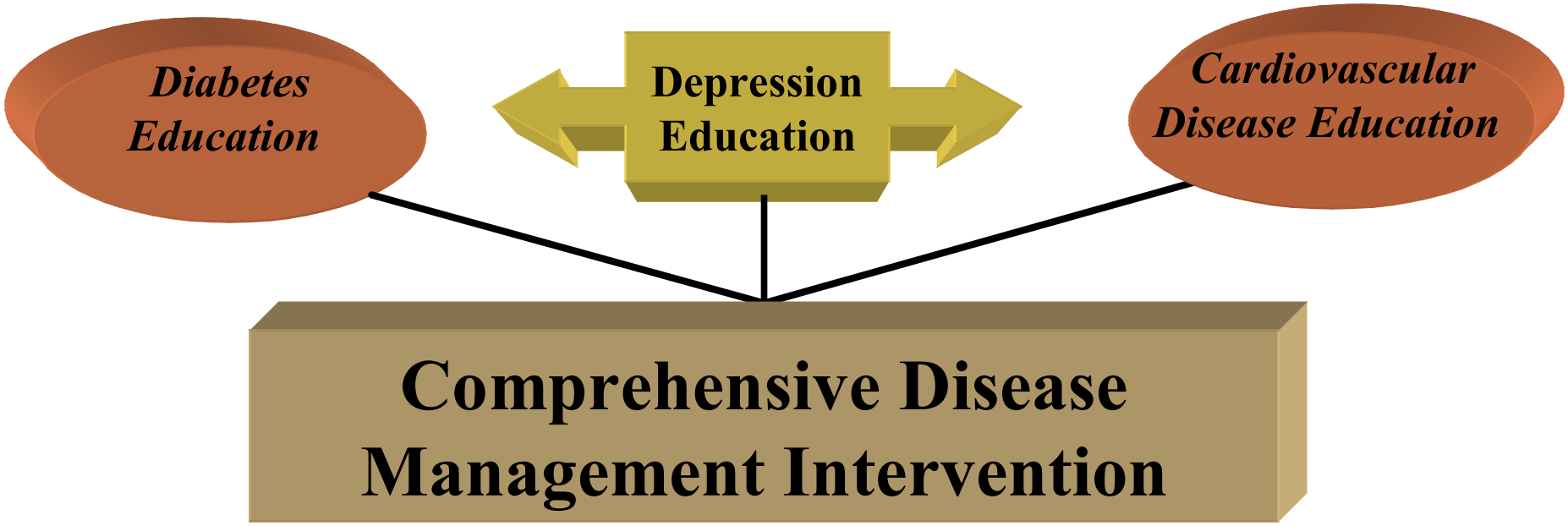
Newsletter



Handouts

- ***Note: All materials have been reviewed through focus groups. Culturally sensitive educational materials support the information provided in the self-management courses and the provider recommendations.***

Lessons Learned



Fact: *Out of 78 patients screened for Depression during phase I:*

6% severely depressed;
5% moderately depressed;
23% mildly depressed;
66% not depressed.

Fact: *77% of the patients that participated in SM courses in Phase I had diabetes and hypertension.*

Benefits of the Promotora Program

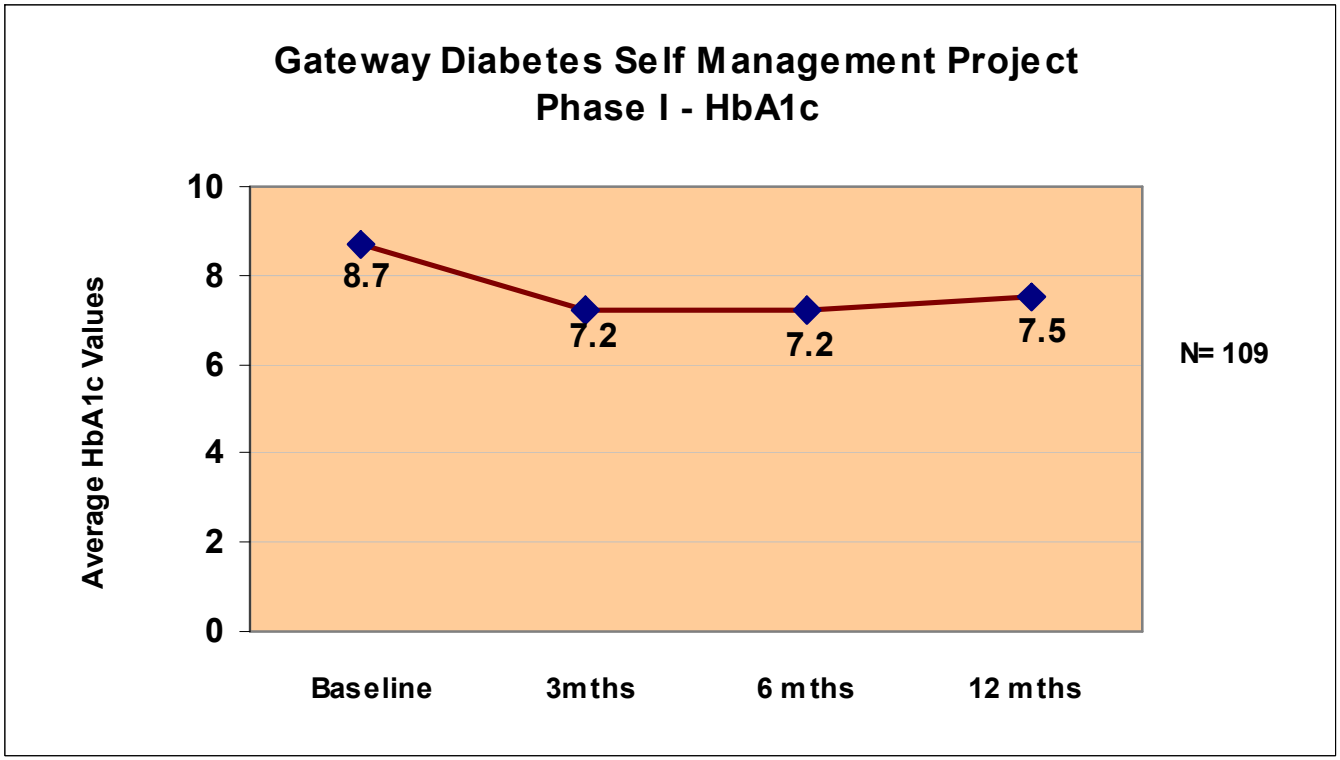
To Provider

- *More efficient use of time;*
- *Reinforce treatment plan;*
- *Assessment of social needs/concerns;*
- *Extension of MD services;*
- *Health advocate/additional clinic services and referrals identified;*
- *Improve diabetes control.*

To Patient

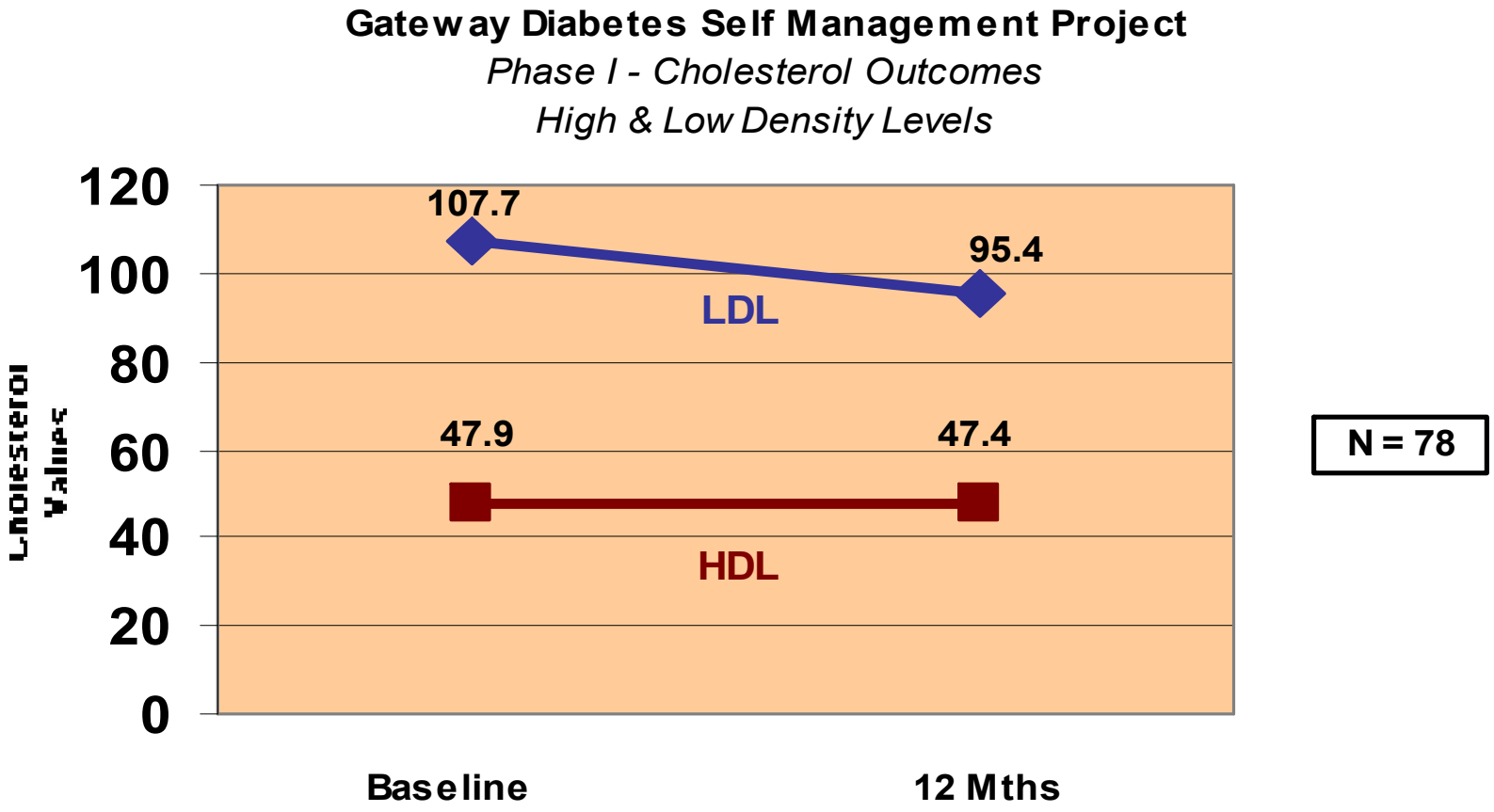
- *More time receive education;*
- *Greater adherence;*
- *Individualized care;*
- *Improve access to care;*
- *Specific needs met by appropriate referrals;*
- *Improve health outcomes.*

Preliminary Results



- 88% Retention Rate in SM Courses
- 49% of clients return to the support groups

Preliminary Results



Success Story

Profile

- **Mr. Emilio Resendez**
- **Hispanic**
- **29 years of age**
- **Patient since 2003**
- **Married**

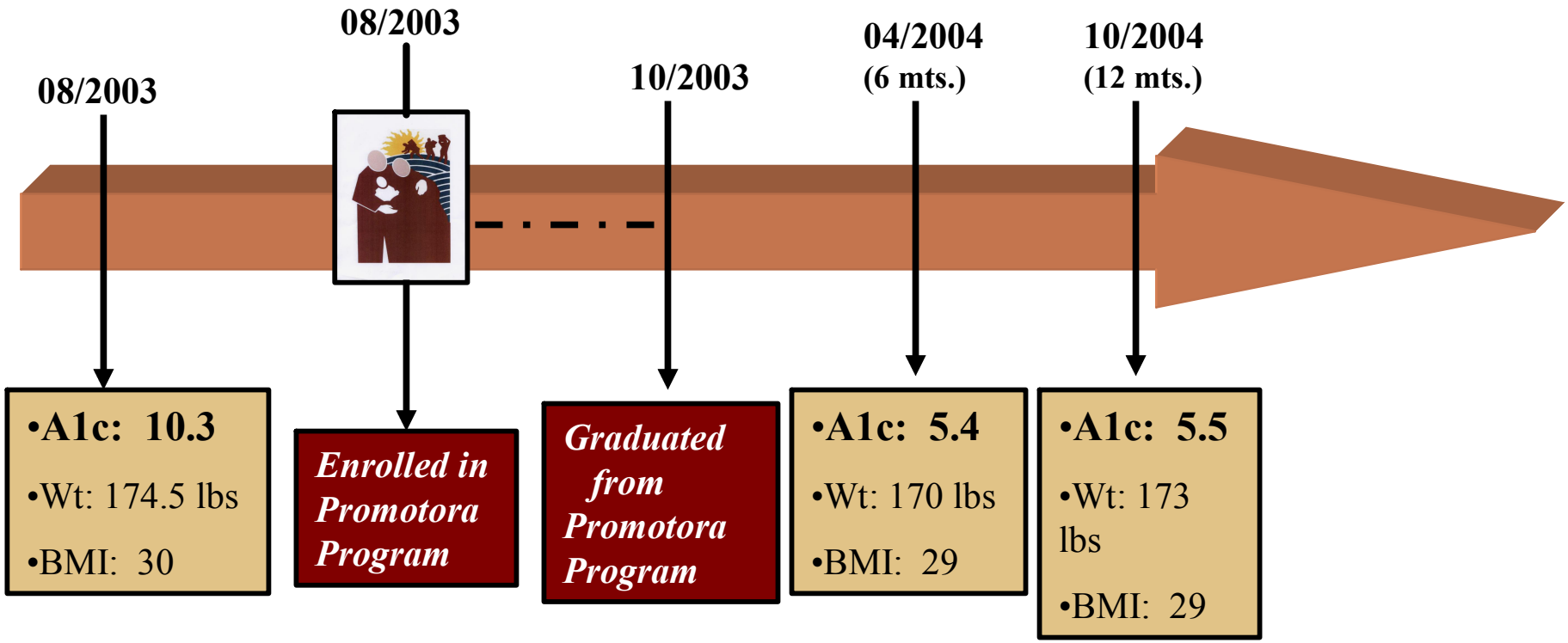
Medical History

- **Diabetes Type 2**
- **Hypertension**
- **Newly Diagnosed (1Yr.)**

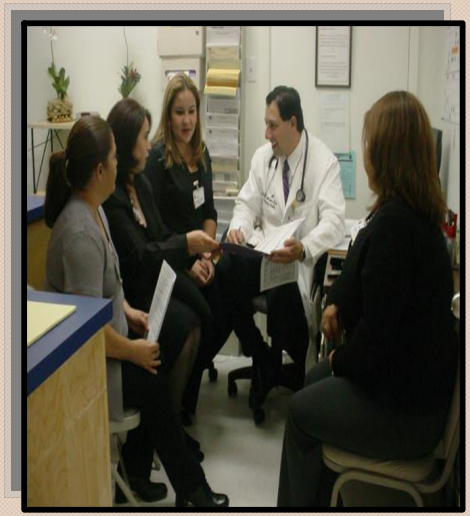
Medications

- **Glyburide 1.25 mg**
- **Enalapril 2.5 mg**

Success Story-Progress



Conclusion- Key Successes to Integration



- **Open and frequent communication;**
- **Wide organizational acceptance of promotoras;**
- **Regular status meetings to assess progress, identify issues;**
- **Extensive training for promotoras;**
- **Thorough documentation;**
- **Management support;**
- **Provider involvement (training, recruitment, support, participation);**
- **Regularly assess patient satisfaction/feedback.**

"It's a Team Effort"

A Team of Patients Working

Gateway's Team Working