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

Enhancement of Promotora-Led Self-Management Class Improves Sustained Metabolic Control

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation
Advancing Diabetes Self-Management
Building Community Supports for Diabetes Care

1. Introduction

Sustaining improved self management is central to meaningful improvements in metabolic control, reduced morbidity and improved quality of life in diabetes. Self management programs have often demonstrated improvements in all of these in the short term but have less often been shown to sustain these benefits. A successful, integrated Promotora-based diabetes program has been demonstrated at Gateway Community Health Center in Laredo, TX.

In a self-management class led by Promotoras, program enhancements resulted in greater maintenance of improved metabolic control over 12 months. The self-management class was based on the curriculum or the CDC-Diabetes Education and Empowerment program. During the 12-month implementation of the classes' improvements to the course included: incorporation of self-analysis and positive thinking activities to address emotional issues that may complicate self-management and incorporation of material on depression and on the link between diabetes management and prevention of cardiovascular disease. Additionally, the process employed in the group was revised to emphasize a mutual aid model as opposed to an emphasis on education and goal setting.

2. Gateway Community Health Center

-Located in Laredo, Texas which is situated on the U.S,-Mexico border;

-Funded by the U.S. Department of Health Human Services;

-501 (c) (3) private, non-profit corporation with a governing board of 15 directors whose responsibility is to oversee the overall operations of the Center;

-Began operations in 1963;
Center offers a wide array of medical care services provided by physicians and/or mid-level practitioners;

-Over 72, 000 medical, dental and specialty care patient visits were provided serving over 17, 000 residents.

Mission Statement:
To improve the health status of the people we serve in Webb County and surrounding areas by striving to provide high quality medical, mental and dental care; health promotion and disease management services in a professional, personal and cost effective manner.

4. Program Components

***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.*

Gateway utilizes all components within the Center to integrate the implementation of the self management intervention into the Center's medical practice.

Components

- Patients
- Promotores
- Medical Providers
- Certified Diabetes Educator
- Medical Support Staff
- Administrators
- Board of Directors

3. Demographics

Gateway	Texas	U.S.
-99% Hispanic -63% Uninsured -21% has diabetes	-32% Hispanic -25% Uninsured -8% of Hispanic adults have diabetes	-13% Hispanic -16% Uninsured -13.6% of Hispanic adults have diabetes, almost twice that for non-Hispanics whites.

Webb County

- 91% of county population resides in Laredo
- 95% Hispanic
- >32% falls below 100% FPL
- >35% lacks health insurance
- >50 *colonias* (most within 20 miles of Laredo)

6. Promotoras- Integration into Healthcare Team

Appt scheduled

MD Visit → **Assessment** → **MD Education** (verbal and printed handouts) → **Treatment Plan** Labs Medication Care Plan

Referral to Promotora program

Promotoras

Group classes and individual support

Extensive Education
- Using glucometer
- Education on medication use
- How to check feet
- How to identify complications
- Support for lifestyle changes
- Mental health screening

MD Follow up 1 month: Review labs & initial treatment plan

Patient educated and more informed

MD Follow up x 3 months, as needed

MD visits are more focused, less follow up required

Benefits of the Promotor(a) Program

To Provider
- -More efficient use of time
- -Reinforce treatment plan
- -Assessment of social needs
- -Extension of MD services
- -Health advocate/additional clinic services and referrals
- -Improved diabetes control

To Patient
- -More time received on education
- -Greater adherence
- -Individualized care
- -Improved access to care
- -Specific needs met by appropriate referrals
- -Improved health outcomes

8. Self-management Guidelines

Medical Provider Refers Patient to Promotora

Intervention Begins

10-week Promotora-Led SM Course (2.5 hours/week)
- ▫Baseline Behavior and Lab Assessment (knowledge, health beliefs, PHQ)
- ▫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)
- ▫Telephone call weekly (remind, answer questions, problem solve, support)

10-biweekly Support Group Sessions (2.5 hours each)
- ▫Additional advise (diet, nutrition, physical activity)
- ▫Additional advise (Prevention/Management DM Complications)
- ▫Group Discussion to Problem-Solve Barriers
- ▫Buddy Support System
- ▫Individual Goal Follow-up
- ▫Telephone call weekly (remind, answer questions, problem solve, support)

Intervention Ends

Voluntary Biweekly Support Group

Baseline Data
HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam, Flu vaccine, Pneumovax, Hospitalizations, ER visits, Knowledge & Health Belief, PHQ

3-month Data
HbA1c, BP, BMI, Knowledge, Health Belief, Retention Rate, and Patient Satisfaction

6 & 12-month Data
HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam, Flu vaccine, Pneumovax, Hospitalizations, ER visits, Knowledge and Health Belief PHQ

11. Demographics- Phase 1 2003-04

Gender

Male: 28% (55)
Female: 72% (148)

Age Categories

20-39:	7%
40-59:	37%
60-79:	35%
80-100:	2%

Spanish as Primary Language: 74% (150)

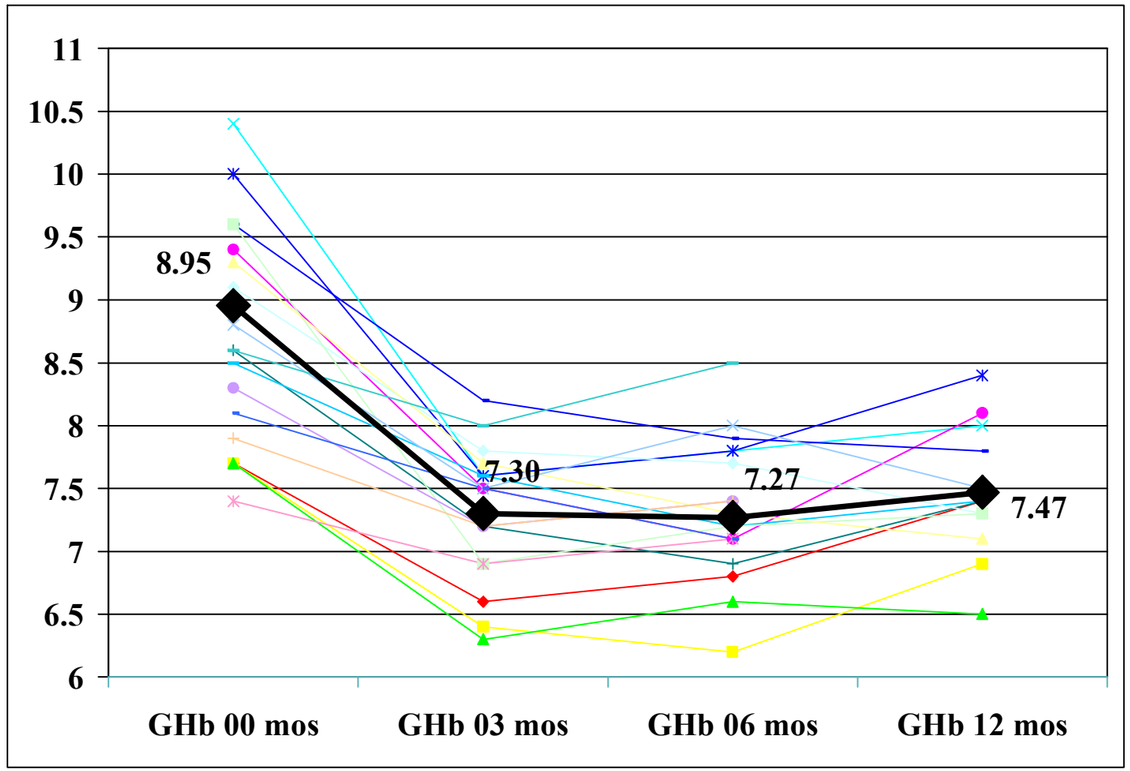
Household Income

<$10, 000:	52% (107)
$11, 000:-$20,000:	19% (39)
>$20,000:	9% (12)

Work Status

Working:	24% (49)
Not Working:	63% (128)
No Answer:	13% (26)

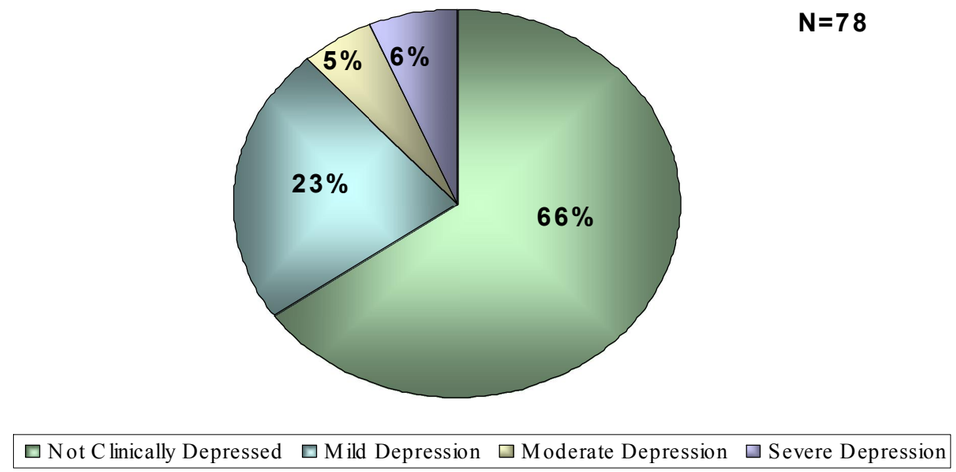
12. Results-Phase 1 HbA1c (12 Courses-203 Participants)

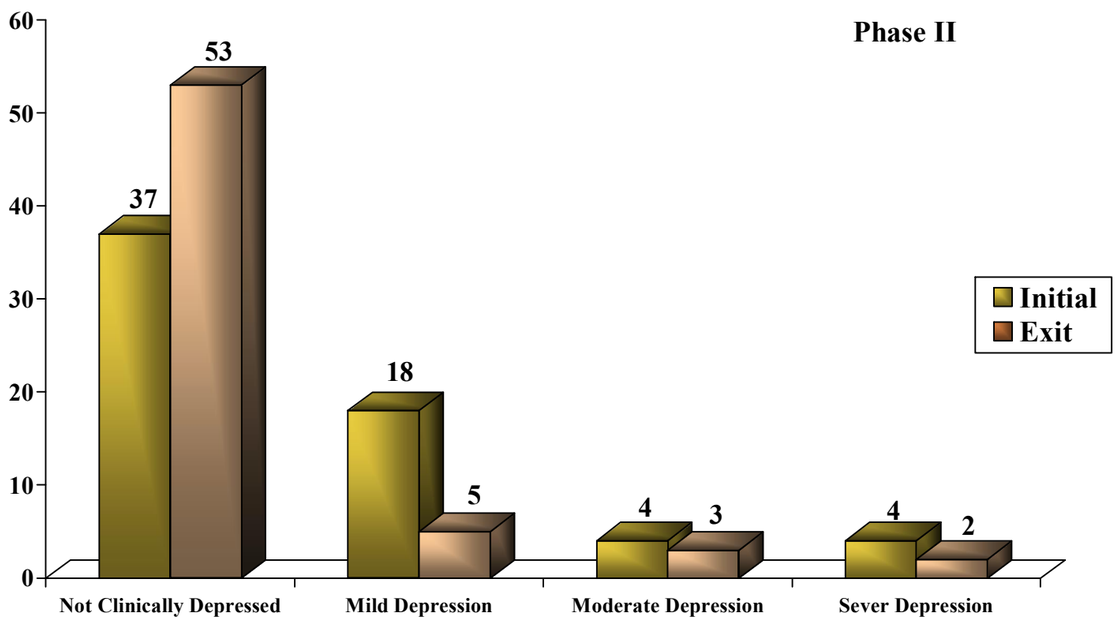


All analyses used the course as the unit of analysis to avoid exaggerations of changes caused by a few participants. Across all 12 classes, the mean GHb at the start of the class was 8.71(standard Deviation=.879) and that at month 12 was 7.47 (Standard Deviation=.511;p for change < .001).

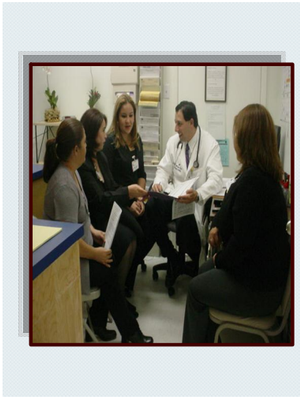
13. Results PHQ9 Screening

Phase 1





14. Conclusion



- 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

9. Depression Screening Protocol

PHQ administered by Promotoras at the 2nd and 9th class of Diabetes SM Course

Note: PHQ should be reviewed immediately.

Patient participating in SM Course with a PHQ score of 5-9/10-14

Patient participating in SM Course with a PHQ score of higher than 15

Patient participating in SM Course with suicidal thoughts.

PHQ Form will be placed in Provider's box for review.

Refer to Nurse in Charge- Medical record will be given to Provider for review.

Patient will be walked to nurse's station and the patient will be seen by the Provider that same day.

Patient will be followed-up by medical team.

Doctor may refer to the Promotoras for Follow-up

If Yes

If No

If patient states he/she feels depressed and has suicidal thoughts continue talking to patient and have someone call 911.

Promotora documents in Progress Note. Weekly phone calls continue until symptom improvement.

PHQ will be filed in medical record. Promotora will not conduct further follow-up.

Medical team contacts patient for follow-up or treatment plan/change

Group Classes and Support Groups add content specific for Depression

Note: All classes and support groups are conducted during clinic hours.

10. Comprehensive Disease Management Intervention

Diabetes Education

Depression Education

Cardiovascular Disease Education

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

6% severely depressed
5% moderately depressed
23% mildly depressed
66% not clinically depressed

Fact: 77% of the patients that participated in SM courses had both diseases.

Benefits of integration:

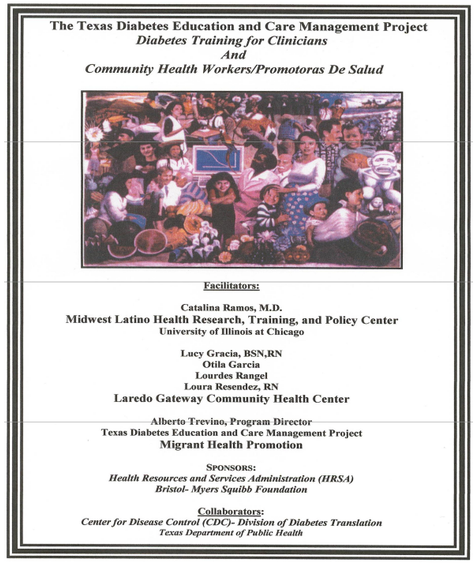
**Maximizes Promotora's work time*
**Removes barriers for patients*
**Depression information is introduced in more patient friendly environment*

7. Promotora Training and Evaluation

- ✓Clinic Site Orientation
- ✓Medical Records
- ✓Diabetes/Cardiovascular Self Management
- ✓Leadership
- ✓Time Management
- ✓Listening Skills
- ✓How To Make a Home Visit and Referrals
- ✓Promotora Safety
- ✓Problem Solving
- ✓Depression Education
- ✓Stress Management
- ✓Support Group Facilitation
- ✓Community Resources

250 Hours of Training

➢Skills List ➢3 Mths Evaluation ➢12 Mths Evaluation ➢Patient Evaluation



The Texas Diabetes Education and Care Management Project
Diabetes Training for Clinicians
And
Community Health Workers/Promotoras De Salud

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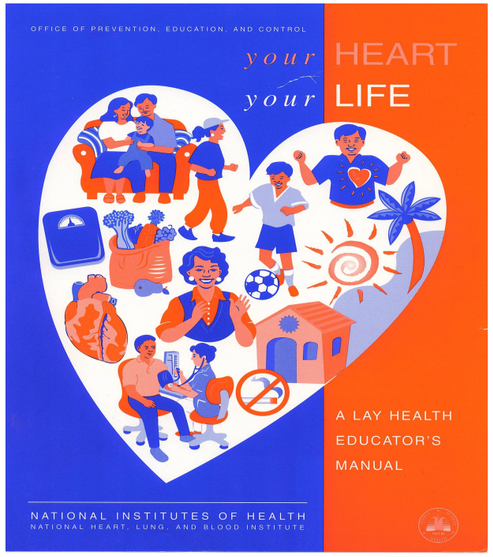
Texas Department of Public Health



5. Role of the Promotora

-Provides informal counseling, social support and culturally sensitive health education;

-Advocates for patient needs;

-Assures that patients receive the health services they need and provides referral and follow-up services;

-Assists and guide the patient in the management of their disease process,

The promotor (a) is considered part of the medical team and plays a key role on the delivery of diabetes self-management.