- This product was developed by the Robert Wood Johnson Foundation Diabetes Initiative. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.

THE ROBERT WOOD JOHNSON FOUNDATION

Washington University in St. Louis
SCHOOL OF MEDICINE

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

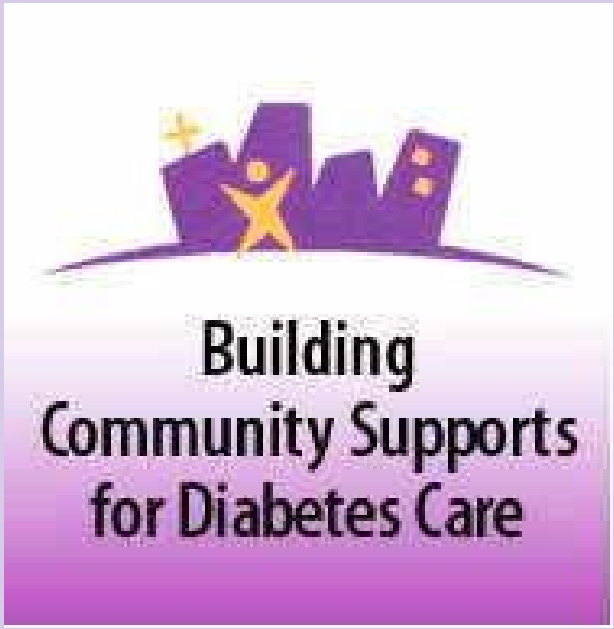
Models for the Use of Community Health Workers in Diabetes Self Management

AADE Annual Meeting
Los Angeles, August 2006

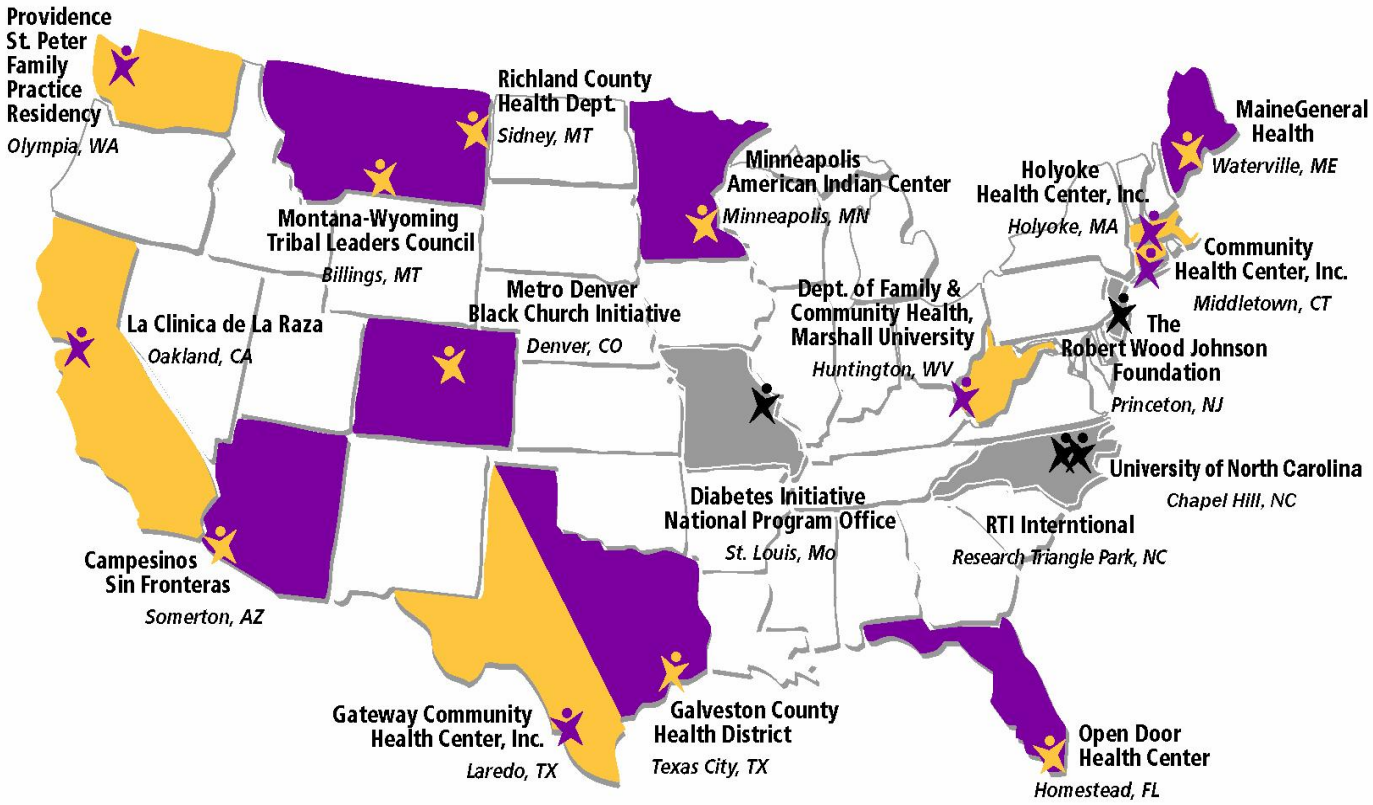
Carol A. Brownson

Diabetes Initiative of the Robert Wood Johnson Foundation

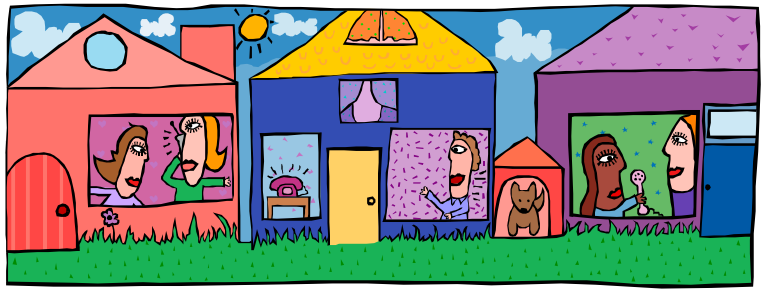
Real world demonstration of self management as part of high quality diabetes care in primary care and community settings



The 14 Sites of the Diabetes Initiative



Community Health Workers (CHWs)



Community Health Workers are trained peer outreach workers who are trusted and respected in their communities who serve as a bridge between their peers and the health care system

- CHWs are key to the interventions in 8 of the 14 sites of the Diabetes Initiative
- 4 are community based; 4 are clinic based

Community Health Workers in the Diabetes Initiative

- "Coaches" in Galveston lead DSM courses in their respective neighborhoods

"Lay Health Educators" in Maine provide support and encouragement for physical activity to co-workers, teach self-management courses and advocate for community trails

- "Community Health Representatives" in MT-WY participate in self management classes and provide follow up support after classes

- Elders who form the Community Council at the Minneapolis American Indian Center guide program direction and teach self management classes to peers

- *Promotoras* are key to the services of 4 DI sites

Focus of CHW contacts in the Diabetes Initiative

80%

- Providing assistance
  - encouragement or motivation
  - helping to set a goal
  - emotional support
  - giving health information (education)
  - personal needs (e.g. transportation, translation, filling out forms, etc.)
- Teaching or practicing diabetes self management skills (e.g., AADE 7) (diet, PA, glucose monitoring)
- Monitoring and follow-up on participant progress
- Recruiting participants, inviting them to participate in programs and services
- Making a referral (health and/or social services)
- Making client aware of rights, services available, etc. (advocacy)

Panelists…

- **Lourdes Rangel**, Director of Special Projects
  Gateway Community Health Center, Laredo TX
  "The Role of the Promotora in a Comprehensive System of Care"

- **Joan Thompson**, Supervisor, Preventive Medicine Department
  La Clinica de la Raza Fruitvale Health Project, Oakland CA
  "Use of Health Promoters for diabetes support in Mexican-Americans"

- **Darlene Cass**, Diabetes Educator
  Galveston County Health District, Galveston TX
  "Take Action Galveston"

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The Role of the *Promotora* in a Comprehensive System of Care

AADE Annual Meeting

Los Angeles, August 2006

Lourdes Rangel

Agenda

- Gateway Community Health Center
- Data
- Integration of the *Promotora Model* into the Medical Component
- Results

Demographics

- **Located in Laredo, Texas (along U.S.-Mexico Border)**
- **Began operations in 1963**
- **Center offers a wide array of medical care services provided by physicians and/or mid-level practitioners**
- **Over 75,000 medical, dental, and specialty care patient visits were provided in 2005 (172% increase in 5 years)**
- **Patient Demographics**
  - **98.5% Hispanic**
  - **98% of patients live below 200% federal poverty level**
  - **63% uninsured**

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."

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

- In Webb County, one in six adults has type 2 diabetes.
- Webb County also has one of the highest mortality rates for Type 2 diabetes in the state.
- Diabetes and Hypertension are the two main diagnosis at Gateway with 2,807 patients with diabetes and 2,303 with hypertension.

Collaborative Partnerships

- National Heart, Lung and Blood Institute
- Human Resources Services Administration
- Pan American Health Organization
- Department of State Health Services
- Robert Wood Johnson Foundation
- Pfizer Health Solutions Inc.
- Methodist Healthcare Ministries
- UT Health Science Center San Antonio-Dental School
- Friends of the Congressional Glaucoma Caucus

- Patients
- Family Members
- Medical Providers
- Certified Diabetes Educator
- Medical Support Staff
- Promotoras
- Board of Directors
- Administrators

Services for Patients with Diabetes

- **Drug Assistance Program**
- **Dental Hygiene Services**
- **Medical Services**
- **Podiatry Clinic**
- **Minor Behavior Health**
- **Disease Management Courses**
- **Diabetic Supplies** ($10.00 co-pay)
- **Yearly Eye Exam** ($20.00 co-pay)
- **Assistance with Laser Surgery**
- **Glaucoma Screening** (Free)

Comprehensive System of Care for Diabetes and Cardiovascular Disease Management

Main Components

1. Provider Internalization of Self-management principles;

2. An infrastructure that supports the volume yet provides some consumer choices regarding delivery;

3. A system of referral, follow-up, feedback and documentation that produces integrated and consistent self-management clinical practice;

4. A system that recognizes, manages chronic illness, and related negative emotions.

Washington University in St. Louis School of Medicine

The Robert Wood Johnson Foundation

Promotoras (Community Health Workers) Self-Management Intervention

Diabetes Group Classes

10 week curriculum

Topics Include

- Understanding what diabetes is
- Strategies and benefits of good diabetes control
- Importance of blood sugar monitoring
- Nutrition
- Lifestyle behaviors (physical activity, weight management, smoking cessation)
- Problem solving
- Medication
- Mental health
- Partnership with healthcare team
- Identifying and prevent diabetes complications
- Social support
- Preventive care
- Community resources

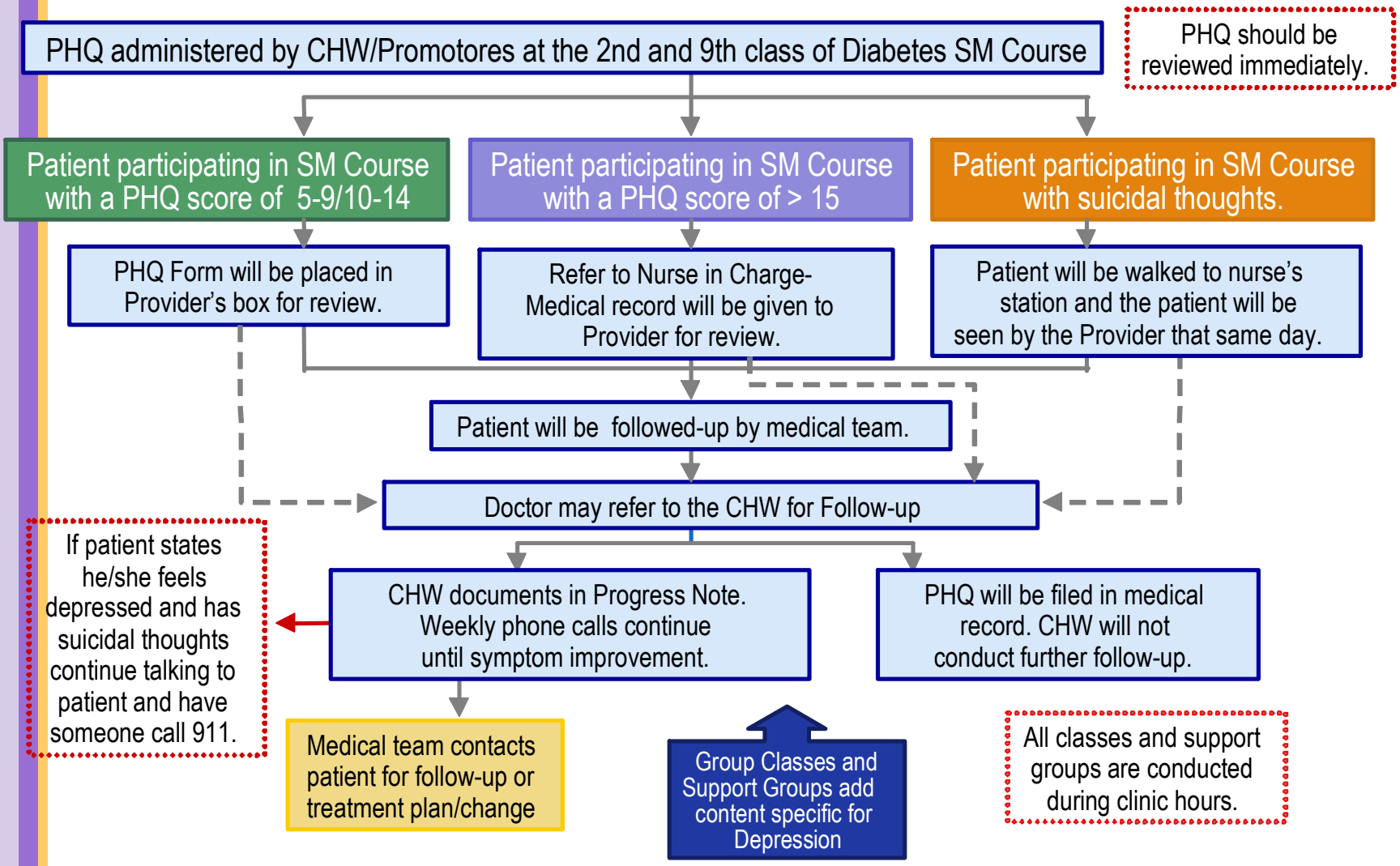
Support Groups

Reinforces topics from classes

Promotoras:

- ***Assess patient needs***
- ***Individual contacts, as needed***
- ***Patient advocate***
- ***Liaison to healthcare Team***
- ***Document-ation***

CHW Protocol for Depression



CHW TRAINING TOPICS AND EVALUATION

300 Hours of Training

- ✓Clinic Site Orientation
- ✓Medical Records
- ✓Diabetes Self Management
- ✓Leadership
- ✓Time Management
- ✓Listening Skills
- ✓How To Make a Home Visit and Referrals
- ✓Advocacy
- ✓Promotora Safety
- ✓Problem Solving
- ✓Mental Health Training
- ✓Stress Management
- ✓Support Group Facilitation
- ✓Community Resources
- ✓Communication Skills

Evaluation

- ➢Skills List
- ➢3-month
- ➢12-month
- ➢Patient

Standard Care

Appt scheduled

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

↓

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

↓

MD Follow up x 3 months, as needed

Care that Includes Promotoras (CHW)

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 glucose meter
- Education on medication
- How to check feet
- How to identify complications
- Support for lifestyle changes

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 Promotora Program

To Providers		To Patients
More efficient use of time	⟷	More time received on education
Improved diabetes control	⟷	Improved health outcomes
Assessment of social needs/concerns	⟷	Individualized care
Reinforce treatment plan	⟷	Greater adherence
Extension of Providers services	⟷	Improved access to care
Health advocate / additional clinic services and referrals	⟷	Specific needs met by appropriate referrals
Implement clinical protocols	⟷	Improved quality of care

Success Story

Profile

- **Mr. Emilio Resendiz**
- **Hispanic**
- **30 years of age**
- **Patient since 2003**
- **Married**

Medical History

- **Diabetes Type 2**
- **Hypertension**

Medications

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

Medications

- **Glyburide 1.25mg (½ tab daily)**
- **Enalapril 2.5mg (½ tab daily)**

Success Story-Progress

6-months

12-months

8/2003

- **A1c: 10.3**
- Wt: 174.5 lbs
- BMI: 29.95

8/2003

Enrolled in Promotora Program

10/2003

Graduated from Promotora Program

4/2004

- **A1c: 5.4**
- Wt: 170 lbs
- BMI: 29.18

10/2004

- **A1c: 5.5**
- Wt: 169 lbs
- BMI: 29.01

8/2005

- **A1c: 5.3**
- **Wt.: 164 lbs**
- **BMI: 28.15**

24-months

Thank You!

Self Management is the key to good control of diabetes and emotional health…

Promotoras play an important role.

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Use of Health Promoters for diabetes support in Mexican-Americans

2006 AADE Annual Meeting

Los Angeles, August 9-12, 2006

Joan Thompson, PhD, MPH, RD, CDE

La Clinica de la Raza - Profile

Serves over 40,000 patients a year

- 84% Latino
- 85% <200 % federal poverty level

Insurance coverage

- 50% no insurance
- 40% Medicaid or Medicare
- 10% private insurance

Project Description

Goal:

Provide diabetes self management support by initiating a health promoter program

Target Population:

Patients with A1c>8 and/or inadequate social support

Patient Recruitment:

Provider referral

Enrollment:

Period varies from 6 mo to 3 years

Implementation

Promoters provide one on one counseling and facilitate group activities. All patients receive usual care (RD visits, access to classes, provider visits)

Description of Promoters

Recruitment:

- Provider referral
- Must have diabetes or a family member with diabetes.
- Ten active promoters at any one time

Status:

- Volunteer with stipend
- Undocumented

Language and literacy

- Monolingual Spanish speaking
- Wide range of literacy level (0 – 18 yrs formal education)

Characteristics:

- All are women, most with young children
- A desire to help others
- Good interpersonal skills
- Accessibility at the patient's convenience
- Willingness to be accepted as part of a patient's family
- All are seen as leaders in their community/neighborhood

Initial Training

Training

- Diabetes self management – initially 10 sessions (2 hr each)
- Collaborative goal setting, action plans and problem solving
- Group facilitation
- Confidentiality
- Stages of change and processes of change

On-going Training

Some topics are:

- Glucose meter training
- Medications
- Depression and stress management - 18 hours
- Cardiovascular disease
- Benefits of physical activity
- Carbohydrate counting, meal planning, alcohol
- Stages of change model updates
- Smoking cessation
- Food stamps and food bank
- How to use emergency services
- Medicare
- Complications of diabetes
- Asthma

Promoter Activities

Individual

- Stage patient for readiness to change
- Counsel 1 on 1 according to stage of change

Group

- Teach diabetes classes (2 x/wk)
- Lead Circle of Friends group (3 x/wk)
- Help with depression group (1x/wk)
- Lead walking club (3x/wk)
- Home visits to work with the families

Community

- Make presentations in the community
- Tabling at Farmers Market
- Help at health fair

Stages of Change

Steps:

- Determine readiness to change
- Use "Guide to Stages of Change Interventions" to facilitate behavior change in the following areas:
  - Following a meal plan
  - Doing physical activity
  - Taking medicines as indicated
  - Monitoring blood sugar
- Set a goal if the patient is in the Preparation stage.

Circle of Friends (Support Group)

Activities

- Relaxation techniques
- Arts and crafts
- English as a second language
- Discussion and mutual support

Integration of promoters into clinic

- Related to the Diabetes project Previously cited group activities
  - Case conferencing quarterly with the doctors
  - Provide weekly relaxation class
- Spread beyond the diabetes project
  - Assist in classes for parents of overweight children on parenting around feeding issues
  - Help design structured learning activities to do in child care (while their parents are attending the class)
  - Attended the pilot series of parenting classes and provided feedback for revising curriculum
  - Became members of our Parent Advisory Council for providing self management support for parents of overweight children

What contributes to our success?

- Full acceptance by the medical providers
- Good inter-personal skills of the promoters
- Adequate on-going training and support
- Accessibility to the patients

Pamphlets on Stages of Change (Diabetes)

Available on http://lumetra.com

Guide to Stages of Change Interventions:
Using the trans-theoretical model for your patients with diabetes.

- Monitoring blood sugar
- Using a meal plan
- Taking medicine
- Exercise

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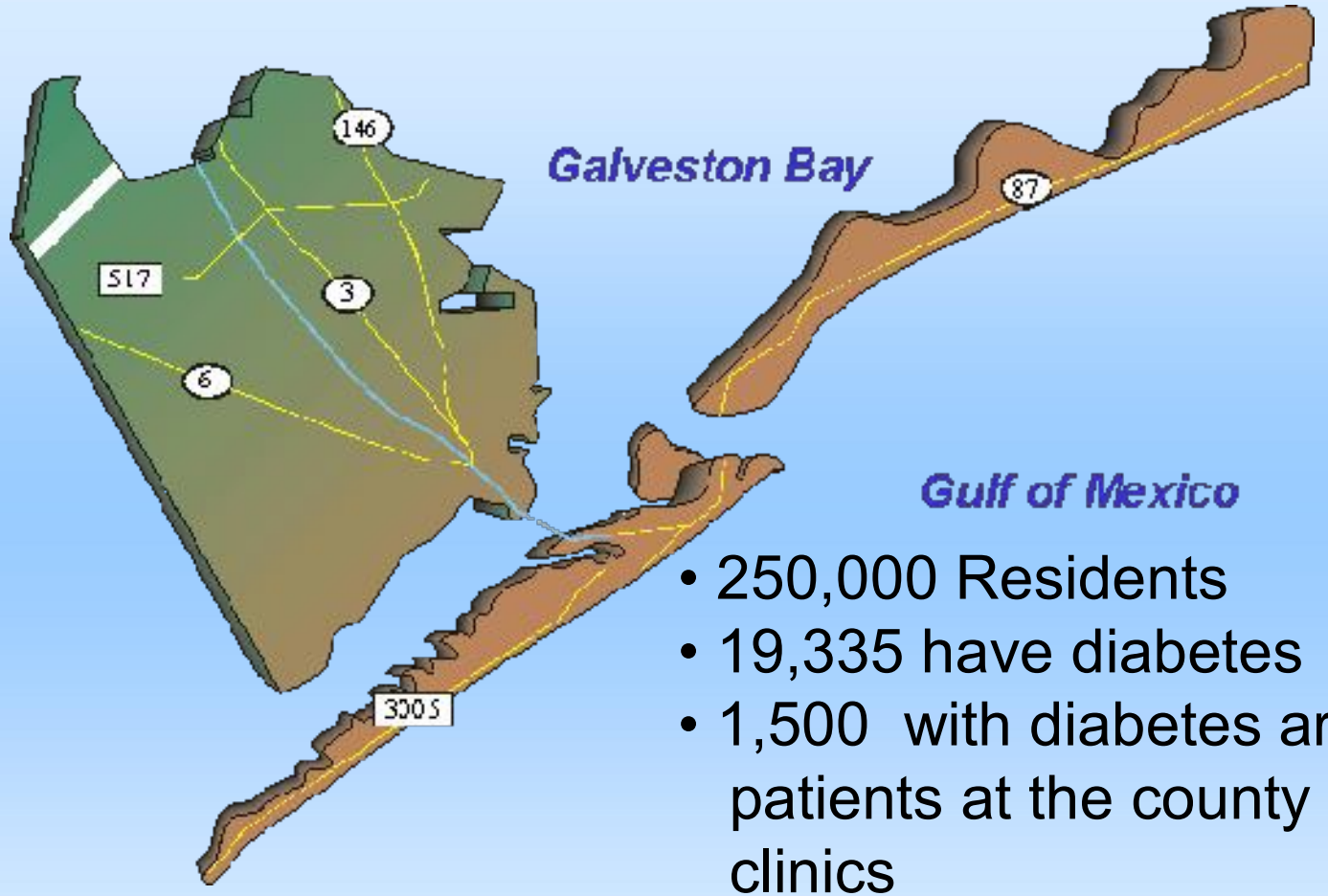
Take Action Galveston

A Diabetes Self-Management Program

AADE Annual Meeting
Los Angeles, August 2006

Darlene Cass, RN

Galveston County Texas



- 250,000 Residents
- 19,335 have diabetes
- 1,500 with diabetes are patients at the county clinics
- ~ 5,000 with diabetes have no health insurance

Take Action
A Diabetes Self-Management Program

- Take Action curriculum is an interactive program that includes the AADE 7
- Goal setting at each class, a Goal Tracker and follow up reporting
- Individual Medical Record
- Workbook of worksheets to assist participants in understanding their current diabetes management and where they are ready to make changes

Take Action Galveston

Our Project:

- Provide diabetes education in the community in non-traditional settings
- Recruit and train Community Health Coaches using the Train the Trainer Model and the Take Action, A Diabetes Self-Management Program.

Community Health Coach Classes

Community Health Coaches – 53

Number of class locations - 20

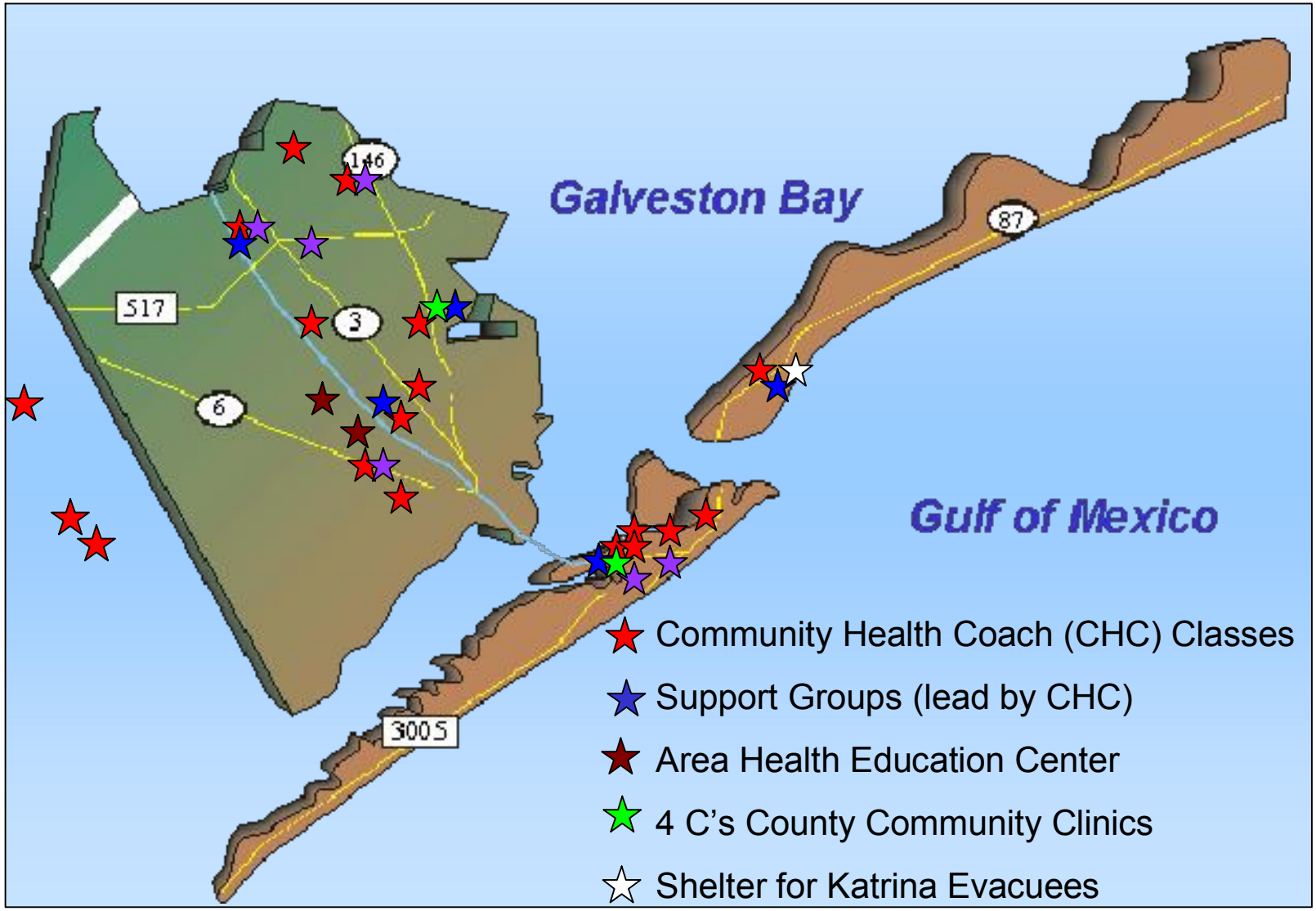
Community classes – 5 are on going

- 328 individuals

Community Support Groups

- 105 individuals

Take Action Class Locations



Class Sites

Coach "Recruitment"

- Participants in the Take Action Classes
- Community Health Nurses
- Parish Nurses
- Area Health Education Center staff
- Texas Cooperative Extension agent
- Local pharmacists
- Interested community members
- Medical students and nursing students

Training and Support

Training

- Coach manual
- Tool Box
- Power Point presentation
- 12 hours of training

Support

- Monthly phone contact
- Assist with setting up classes and delivering supplies and certificates
- Quarterly coach luncheons
- Quarterly TAG (Take Action Galveston) Newsletter

Shining Stars

Common Characteristics of a Community Health Coach

- Eager and willing to learn new things
- Flexible
- Positive and encouraging
- Committed
- Strong desire to help others

Coach's with diabetes want to share their experiences and show you can take control of diabetes

Whisking Your Way to Health

- Series of five classes
- Hands on
- Topics
  - Reducing sugar, fat and salt in recipes
  - Meal planning
  - Adding flavor with herbs, spices, citrus and vegetables
  - Portion sizes
  - Grocery Store Tour

Spreading the word

Take Action participants

- Student manuals
- Participants take the information to family members and friends
- Trained health professionals in 2 other counties to teach Take Action in their communities
- Area Health Education Center (AHEC)
  - Trained 19 AHEC staff to train members of their local community to teach Take Action and Whisking Your Way to Health

Take Action

- Support Groups
- 4 C's Clinics
- Take Action
- Whisking Your Way to Health
- Shelter (Katrina)
- AHEC Centers

What makes CHWs effective?

- CHWs have access to the population they serve
- They have passion and commitment
- The unique relationship they have with clients provides social support that is critical to self management
- This trusting relationship lays the foundation for good self management
- CHW's have greater flexibility to meet clients needs, e.g., time, place, scope
- They have the training and support to fulfill their various roles

Thank You!