Gateway Community Health Center, Inc.


Empowering Communities for Better Health

# *The Role of Lay Health Workers in Managing Diabetes*

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.

**Presented By:**
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# Demographics



- **Gateway is located in Laredo, Texas (along the 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 84,000 medical, dental, and specialty care patient visits were provided in 2006**

**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."

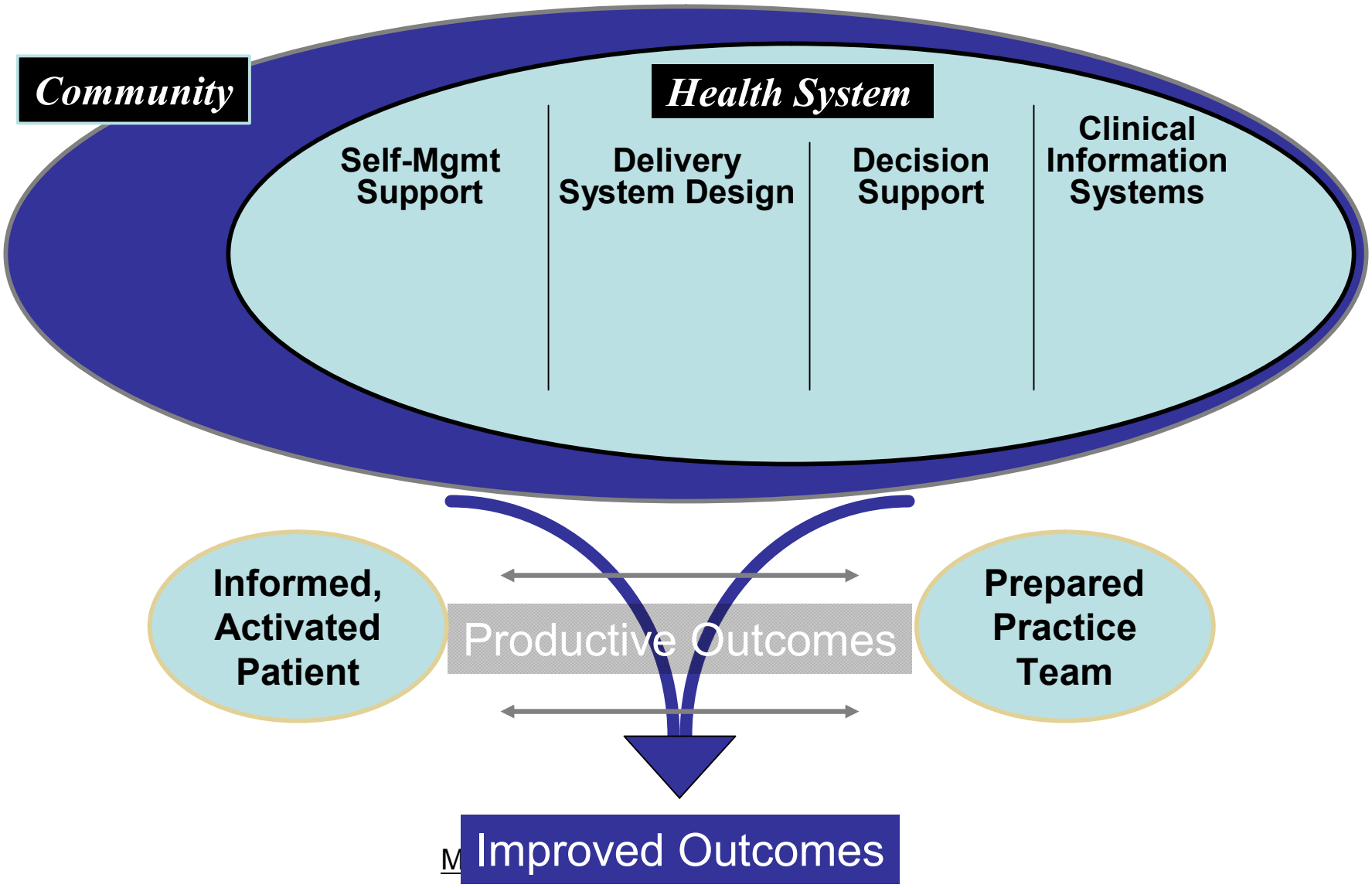
| Gateway | Texas | U.S. |
|---|---|---|
| 99% Hispanic | 32% Hispanic | 13% Hispanic |
| 65% Uninsured | 25% Uninsured | 16% Uninsured |
| 27% of the adult patient population (18+) has diabetes | 8% of Hispanic adults have diabetes | 13.6% of Hispanic adults have diabetes, almost twice that for non-Hispanic whites |

**2005-07 Diabetes Risk Assessment Results (20,000):**

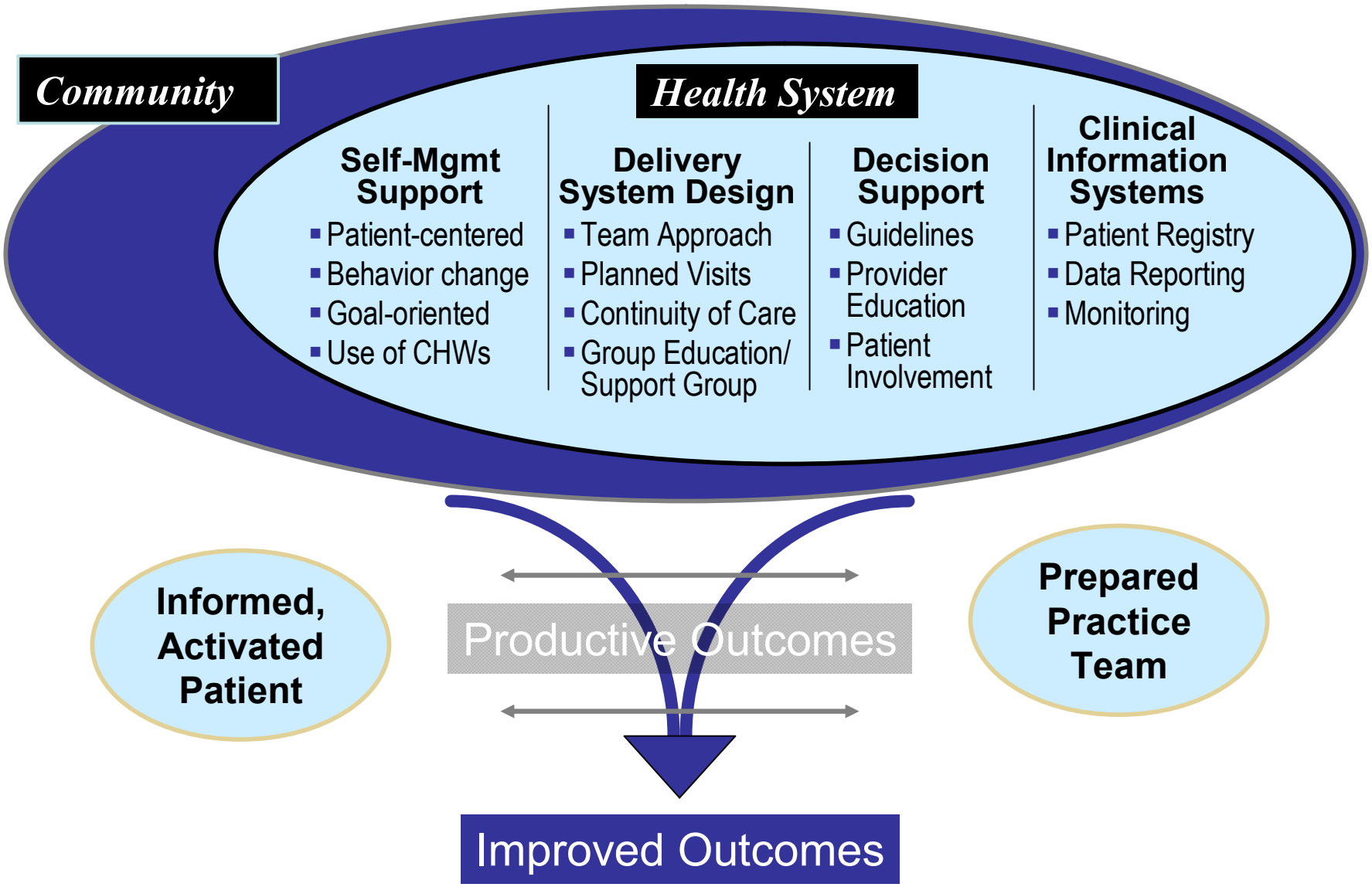
- 42% at risk of developing diabetes due to family history;
- 47% BMI higher than normal;
- 42% do not exercise according to the recommended time and duration;
- 65% were women; 35% were men;
- 17% had diabetes.

Source: UDS Report; Census 2000; Kaiser Family Foundation; American Diabetes Association Assessment Tool

# Chronic Care Model



# Chronic Care Model – Gateway Approach



**Gateway's Diabetes self-management Program is a culturally-relevant program that assists patients and their family members to understand and self-manage diabetes through trained Community Health Workers (Promotoras).**

## Program Goals

- Increase awareness of diabetes
- Improve diabetes clinical care through adherence to national guidelines
- Demonstrate behavioral change and self-management skills
- Achieve high satisfaction with care received

# Promotora Program

## Topics Include

**Diabetes/CVD Group Classes**

***10 week curriculum***

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

**Support Groups**

***On-going***


Promotoras:

- *Assess patient needs*
- *Individual contacts, as needed*
- *Patient advocate*
- *Liaison to healthcare Team*
- *Documentation*
  - *-Progress*
  - *-Outcomes*

# Promotora 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
- ✓Goal Setting
- ✓Problem Solving
- ✓Mental Health Training
- ✓Stress Management
- ✓Support Group Facilitation
- ✓Community Resources
- ✓Communication Skills

**Evaluation**

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

# Routine 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

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
- Medication use
- 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**

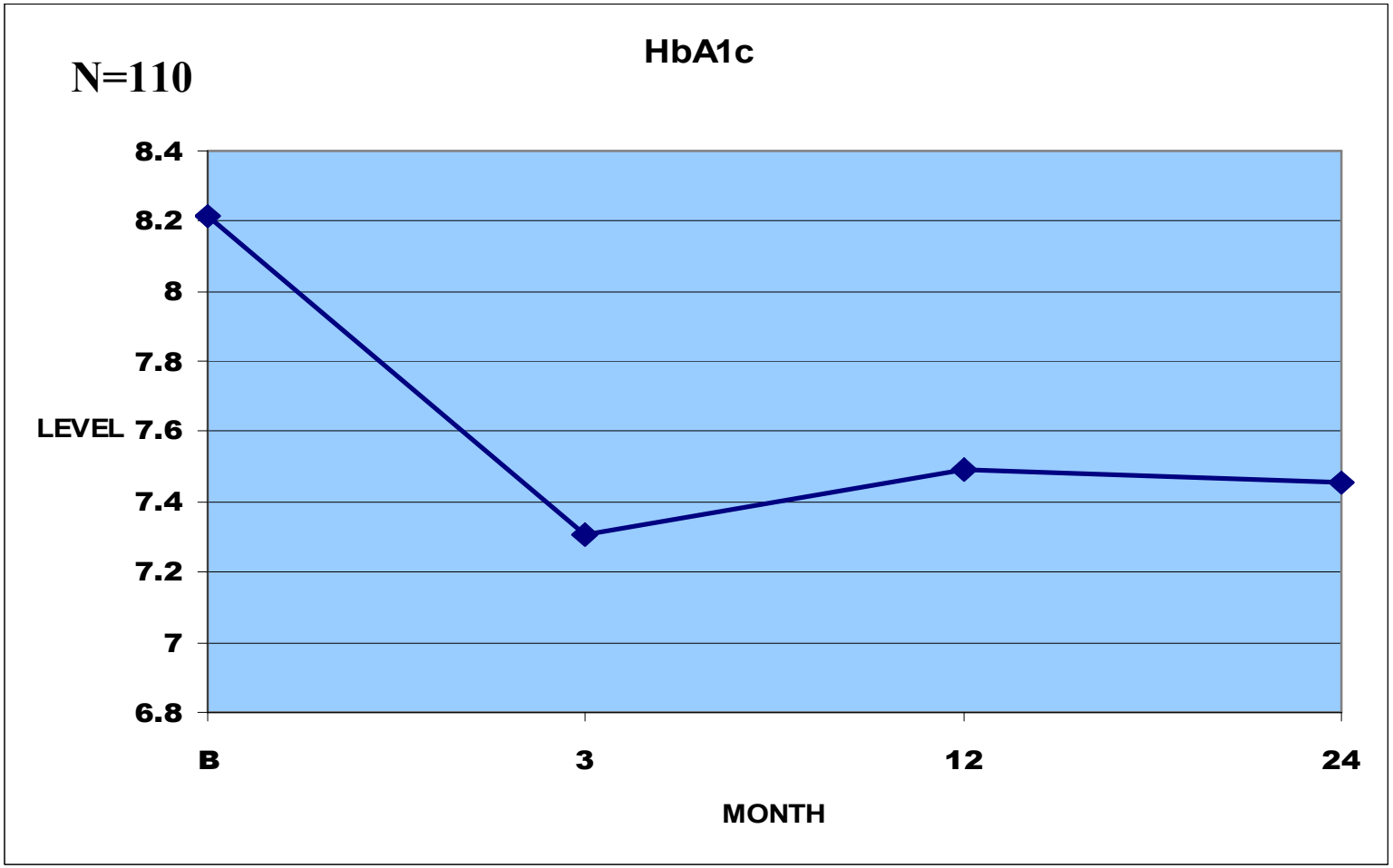
**MD visits are more focused, less follow up required**

# Benefits of the Integration of the Promotora Program

| To Providers | | To Patients |
|---|---|---|
| More efficient use of time | ⟷ | More time spent on education |
| Improved diabetes control | ⟷ | Improved health outcomes |
| Assess of social needs/concerns | ⟷ | Individualized care |
| Reinforce treatment plan | ⟷ | Better self management |
| Extension of MD services | ⟷ | Improved access to care |
| Health advocate / additional clinic services and referrals identified | ⟷ | Specific needs met by appropriate referrals |
| Implement clinical protocols | ⟷ | Improved quality of care |

# Results

***Goal: A1c levels below 7.5 over an extended period of time***




**65% of the patients maintain their A1c at or below 7.5 over an extended period of time**

# Sustainability Strategies

***Proposed Changes within the Organization***

- Explore the possibility to increase the cost per office visit;
- Expand services to the private sector;
- Offer services to worksites.

***Training Program***

- **Promotora training to facilitate self-management classes;**
- **Self-management curriculum;**
- **Bilingual training;**
- **Train-the-trainer sessions for local sustainability.**

***Effective Promotora Training is critical for the continued growth, respect, credibility and sustainability of this model in the public health field.***

# Thank You!

**Self Management is the key to good control of diabetes and**

**Promotoras play an important role.**

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