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.
Improving Diabetes Self Management Education in Community Health Centers by Incorporating Promotores in the Health Care Team
Gateway Community Health Center, Inc.

- 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
**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.
Roles and Responsibilities

Medical Providers and Support Staff

• 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.

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.

Reinforce DSM process by:
• Offering health education;
• Highlighting patients attendance to DSM classes;
• Celebrating patients accomplishments or supporting them to meet their goals.

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)

**Intervention Ends**

- 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)

**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.

Voluntary Biweekly Support Group Sessions
Note: These forms are part of the patient’s medical record and are completed by the promotoras.
Depression Screening and Follow-up Protocol

- **PHQ administered by Promotoras at the 2\textsuperscript{nd} and 9\textsuperscript{th} class of Diabetes SM Course**

  - **Patient participating in SM Course with a PHQ-9 score of 5-9/10-14**
    - PHQ-9 Form will be placed in Provider’s box for review.

  - **Patient participating in SM Course with a PHQ-9 score of higher than 15**
    - Refer to Nurse in Charge
    - Medical record will be given to Provider for review.

  - **Patient participating in SM Course with suicidal thoughts.**
    - 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**
      - Promotora documents in Progress Note.
      - Weekly phone calls continue until symptom improvement.

    - **If No**
      - 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.**

- **Note: PHQ-9 should be reviewed immediately.**
Note: PHQ-9 and Mental Health Progress Report are completed by the promotoras for screening and follow up, are part of the medical records.
• 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.
Comprehensive Disease Management Intervention

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.
• 88% Retention Rate in SM Courses
• 49% of clients return to the support groups
Gateway Diabetes Self Management Project

Phase I - Cholesterol Outcomes

High & Low Density Levels

Baseline 12 Mths

HDL

LDL

N = 78

0 20 40 60 80 100 120

Preliminary Results
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

- **08/2003**: Enrolled in Promotora Program
  - A1c: 10.3
  - Wt: 174.5 lbs
  - BMI: 30

- **10/2003**: Graduated from Promotora Program
  - A1c: 5.4
  - Wt: 170 lbs
  - BMI: 29

- **04/2004 (6 mts.)**: Graduated from Promotora Program
  - A1c: 5.5
  - Wt: 170 lbs
  - BMI: 29

- **10/2004 (12 mts.)**: Graduated from Promotora Program
  - A1c: 5.5
  - Wt: 173 lbs
  - BMI: 29
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