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:
Lourdes Rangel
Director of Special Projects
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 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**
### 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

<table>
<thead>
<tr>
<th>Gateway</th>
<th>Texas</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>99% Hispanic</td>
<td>32% Hispanic</td>
<td>13% Hispanic</td>
</tr>
<tr>
<td>65% Uninsured</td>
<td>25% Uninsured</td>
<td>16% Uninsured</td>
</tr>
<tr>
<td>27% of the adult patient population (18+) has diabetes</td>
<td>8% of Hispanic adults have diabetes</td>
<td>13.6% of Hispanic adults have diabetes, almost twice that for non-Hispanic whites</td>
</tr>
</tbody>
</table>
Chronic Care Model

Community

Health System

Self-Mgmt Support
Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient

Prepared Practice Team

Productive Outcomes

Improved Outcomes
Chronic Care Model – Gateway Approach

**Community**

- Self-Mgmt Support
  - Patient-centered
  - Behavior change
  - Goal-oriented
  - Use of CHWs

**Health System**

- Delivery System Design
  - Team Approach
  - Planned Visits
  - Continuity of Care
  - Group Education/Support Group

- Decision Support
  - Guidelines
  - Provider Education
  - Patient Involvement

- Clinical Information Systems
  - Patient Registry
  - Data Reporting
  - Monitoring

**Informed, Activated Patient**

**Prepared Practice Team**

**Improved Outcomes**

**Productive Outcomes**
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

- 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

Diabetes/CVD Group Classes
10 week curriculum

Support Groups
On-going

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

Promotoras:
Promotora Training - Topics and Evaluation

- 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

- **MD Visit**
- **Assessment**
- **MD Education** (verbal and printed handouts)
- **Treatment Plan**
  - Labs
  - Medication
  - Care Plan
- **Referral to Promotora program**

**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

<table>
<thead>
<tr>
<th>To Providers</th>
<th>To Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>More efficient use of time</td>
<td>More time spent on education</td>
</tr>
<tr>
<td>Improved diabetes control</td>
<td>Improved health outcomes</td>
</tr>
<tr>
<td>Assess of social needs/concerns</td>
<td>Individualized care</td>
</tr>
<tr>
<td>Reinforce treatment plan</td>
<td>Better self management</td>
</tr>
<tr>
<td>Extension of MD services</td>
<td>Improved access to care</td>
</tr>
<tr>
<td>Health advocate / additional clinic services and referrals identified</td>
<td>Specific needs met by appropriate referrals</td>
</tr>
<tr>
<td>Implement clinical protocols</td>
<td>Improved quality of care</td>
</tr>
</tbody>
</table>
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
Effective Promotora Training is critical for the continued growth, respect, credibility and sustainability of this model in the public health field.

**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.
Self Management is the key to good control of diabetes and Promotoras play an important role.

Lourdes Rangel
Director of Special Projects
lulur.gateway@tachc.org
www.gatewaychc.com