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The Role of Lay Health Workers in Managing Depression and Diabetes

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Enhancing access to and promoting self management as part of quality diabetes care through primary care and community settings
Resources and Supports for Self-Management

- Individualized assessment
- Collaborative goal setting
- Assistance in learning self-management skills, including healthy coping
- Follow-up and support
- Access to resources for healthy lifestyles
- Access to high quality clinical care
- Continuity of care
Where we started: We have to treat depression and emotional disorders before we can address self-management.

- Prevalence of depression is doubled among persons with diabetes.
- Depression is associated with worse glycemic control, more severe diabetes symptoms, disability, added complications, and higher health care use.
- Self-management is less adequate among diabetes patients with depression (e.g., non-adherence to diabetes medications, physical inactivity, poor nutrition, and smoking are correlated with depression).
- 40% of patients with diabetes have anxiety symptoms; generalized anxiety disorder (GAD) is present in 14%.
- Independent of depression, panic is associated with higher HbA1c values, more diabetic complications, greater disability, and lower social functioning.
Next step in our evolving model: Addressing depression is part of self-management

Self Management is the Use of Skills to:

- Deal with your illness
- Continue your normal daily activities
- Manage the changing emotions brought about by dealing with a chronic condition

The goal of self-management is to achieve the highest possible functioning and quality of life....no matter where along the path a person starts.
Types of Emotional Disorders

Examples of Clinical and Subclinical Emotional Disorders

**Clinical**
- Mood Disorders
  - Major depression
  - Dysthymia
  - Bipolar
- Anxiety disorders
  - Panic disorder
  - Phobia
  - Trauma related
- Substance abuse

**Subclinical**
- Anger
- Fear
- Frustration
- Anxiety
- Stress
- Guilt
- Worry
- Irritability
Where we are now: Normalizing attention to negative emotionality and promoting healthy coping

- No one is immune to negative emotions!
- Like other risk factors, mental health can be viewed along a continuum of risk. Consider a “stepped care” approach in intervention, beginning with healthy coping and moving to therapy and medications as needed.
- Skills for healthy coping can be taught, and should be included in routine health promotion interventions as well as diabetes self management skills training.
- Of note: The American Association of Diabetes Educators has included "Healthy Coping" among its AADE7 Self Care Behaviors™
Emotional Health - Defined

The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity.
Addressing These Issues...

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

And CHWs play an important role...
Key Roles of CHWs in Addressing Emotional Health

- Provide education and address myths and stigmas
- Teach coping skills
- Conduct assessments/screen
- Encourage and assist with problem solving and goal setting
- Connect clients with resources/encourage access to care
- Provide informal counseling and support
- Support treatment plan
- Monitor and follow up
- Prepare for dealing with emergencies
- Bridge cultural beliefs and language issues
Gateway Community Health Center
Program Overview

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 involved all stakeholders within the Center to integrate the implementation of the self management intervention into the Center’s medical practice.

Stakeholders

• Patients
• Promotores
• Medical Providers
• Certified Diabetes Educator
• Medical Support Staff
• Administrators
• Board of Directors
Promotor(a) Roles and Responsibilities

- Provide informal counseling, social support and culturally sensitive health education;
- Advocate for patient needs;
- Assure that patients receive the health services they need and provide referral and follow-up services.
- Assist 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.
**Gateway Diabetes Self Management Intervention Flow Chart**

**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)

**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

**Intervention Ends**

**Voluntary Biweekly Support Group**

**6 & 12-month Data**
- HbA1c, Lipid Profile, BP, BMI, Foot Exam, Eye Exam, Flu vaccine, Pneumovax, Hospitalizations, ER visits, Knowledge and Health Belief PHQ
**CHW Protocol for Depression – Gateway Community Health Center**

PHQ administered by CHW/Promotores at the 2nd and 9th class of Diabetes SM Course

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

- **Patient participating in SM Course with a PHQ score of > 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 CHW for Follow-up

- **YES**
  - CHW documents in Progress Note. Weekly phone calls continue until symptom improvement.
  - Group Classes and Support Groups add content specific for Depression

- **NO**
  - PHQ will be filed in medical record. CHW will not conduct further follow-up.
  - All classes and support groups are conducted during clinic hours.

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

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

PHQ should be reviewed immediately.
Depression: Role of the Promotor(a)

Assists Medical Provider in the process of;

- Screening
- Referral
- Education
- Support
Depression Assessment Tool: Patient Health Questionnaire (PHQ-9)

- Screens for and assess depressive symptoms
- Brief, 9-item validated tool
- Provides a severity score and a preliminary diagnostic criteria
- Available in English and Spanish*

www.depression-primarycare.org

*The PHQ-9 is adapted from PRIMEMDTODAY™, developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. The names PRIME-MD® and PRIMEMDTODAY™ are trademarks of Pfizer Inc.
# Demographics - Phase I

## Gender
- Male: 28% (55)
- Female: 72% (148)

## Age Categories
- 20-39: 7% (14)
- 40-59: 37% (75)
- 60-79: 35% (71)
- 80-100: 2% (4)

## 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)
Results
Phase 1 HbA1c per Course

Phase I-HbA1c by Course

Phase I-HbA1c

Average HbA1c Values
N= 109

Baseline 3mths 6 mths 12 mths
Results

Phase I

- Not Clinically Depressed: 66%
- Mild Depression: 23%
- Moderate Depression: 5%
- Severe Depression: 6%

N=78

Phase 2

- Initial Not Clinically Depressed: 59%
- Initial Mild Depression: 8%
- Initial Moderate Depression: 6%
- Initial Severe Depression: 6%
- Exit Not Clinically Depressed: 29%
- Exit Mild Depression: 8%
- Exit Moderate Depression: 6%
- Exit Severe Depression: 6%

N=78

Initial vs Exit
**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 in phase I had both diseases.

**Benefits of integration:**
- Maximizes Promotora’s work time
- Removes barriers for patients
- Depression information is introduced in more patient friendly environment
Involving the health care team in developing protocols/roles for CHWs is key to program success (e.g., only clinicians can diagnose mental disorders)

It is essential to establish clear roles and procedures for handling emergencies (e.g., suicidality)

Educational materials and activities should be culturally and linguistically appropriate

The unique relationship between the CHW and the client lends itself to addressing emotional health

CHWs can serve as role models for healthy coping by taking care of themselves