Moderator:

- Russell E. Glasgow, PhD

Presentations:

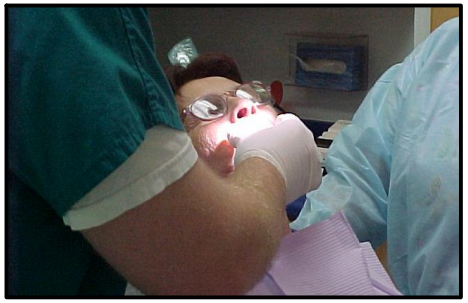
- Gateway Community Health Center
- St. Peter Family Medicine Residency Program
- Department of Family & Community Medicine Marshall University School of Medicine

Gateway Community Health Center, Inc.

community growth support

Empowering Communities for Better Health

Comprehensive System of Care for Patients with Diabetes



Diabetes Initiative Annual Meeting

The Robert Wood Johnson Foundation

October 18-20,2006

Tucson, Arizona

Lourdes Rangel

Demographics

- **Gateway Community Health Center is a Non for profit organization located in Laredo, Texas (along the US-Mexico Border)**
- **Over 75,000 medical, dental, and specialty care patient visits were provided in 2005.**
- **Patient Demographics**
  - **98.5% Hispanic**
  - **98% of patients live below 200% federal poverty level**
  - **63% uninsured**

Census 2000; Kaiser Family Foundation

Demographics

- **In Webb County, one in six adults has type 2 diabetes.** (1999 Texas Department of Health)

- **Webb County also has one of the highest mortality rates for Type 2 diabetes in the state.** (Texas Vital Statistics)

- **Diabetes and Hypertension are the two main diagnosis at Gateway with 2,807 patients with diabetes and 2,303 with hypertension.** (BPHC-Universal Data System)

Partnerships

- **Robert Wood Johnson Foundation-2003**
- National Heart, Lung and Blood Institute-2003
- Human Resources Services Administration
- Pan American Health Organization-2000
- Pfizer Health Solutions Inc-2003
- Methodist Healthcare Ministries-2001

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

Promotora Program

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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 avoiding 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*
- ***Documentation -Progress -Outcomes***

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

Usual 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

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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
- Education on medication use
- How to check feet
- How to identify complications
- Support for lifestyle changes
- Mental health screening

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

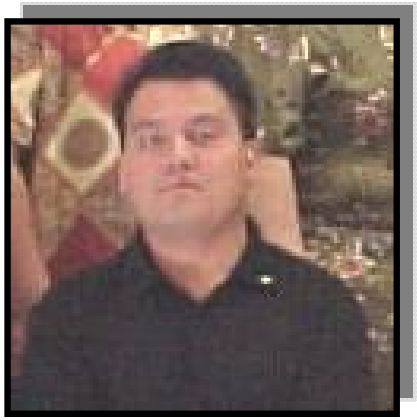
Benefits of Promotora Program

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 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

Success Story

Profile

- Emilio
- Hispanic
- 30 years of age
- Patient since 2003
- Married



Medical History

- Diabetes Type 2
- Hypertension

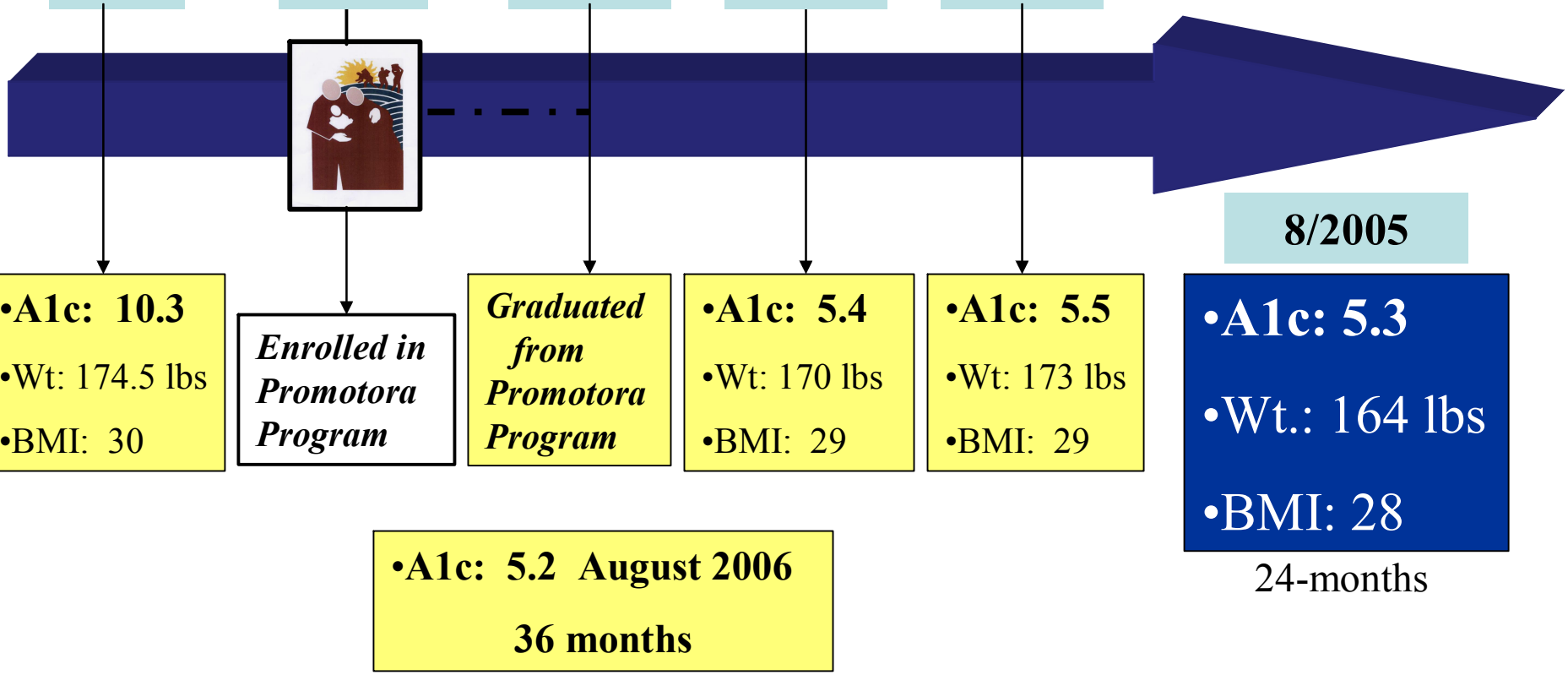
Medications

- Glyburide 1.25 mg
- Enalapril 2.5 mg

Medications (24-months)

- Glyburide 1.25mg (1/2 tablet daily)
- Enalapril 2.5mg (1/2 tablet daily)

Success Story-Progress



Comprehensive System of Care for Patients with Diabetes

Accomplishments

- **Integration of the Promotora Component into the Medical Practice;**
- **Improve the Health Status of the 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** (Diabetes Related)
- **Glaucoma Screening**

Services for Patients with Diabetes.

THE ROBERT WOOD JOHNSON FOUNDATION

Washington University in St. Louis
SCHOOL OF MEDICINE

DIABETES INITIATIVE
A National Program of The Robert Wood Johnson Foundation

Primary Care Re-Designed: Four Steps to Patient Self-Management Support

Devin Sawyer, MD, Family Physician
St Peter Family Medicine Residency Program
RWJF Diabetes Initiative Capstone Meeting
October 20, 2006

The Patient

The Medical Assistant

The Provider

Leaves with scripts, referrals, and instructions

Other Activated Patients

The Patient

The Non-Clinical Staff

Integrated plan
Medical
&
SMG

The Provider

The Medical Assistant

What is different? Four key services

1) Planning and preparation- **MA planned visits** and CDEMS/Centricity registry…includes action planning

What is different? Four key services

2)The Provider- taught how to negotiate a *medical plan* and integrate with a patient-oriented self-management *action plan* (SMG)

B
B
S
W
A
R

What is different? Four key services

Patients helping patients

3) The MINI-group visit

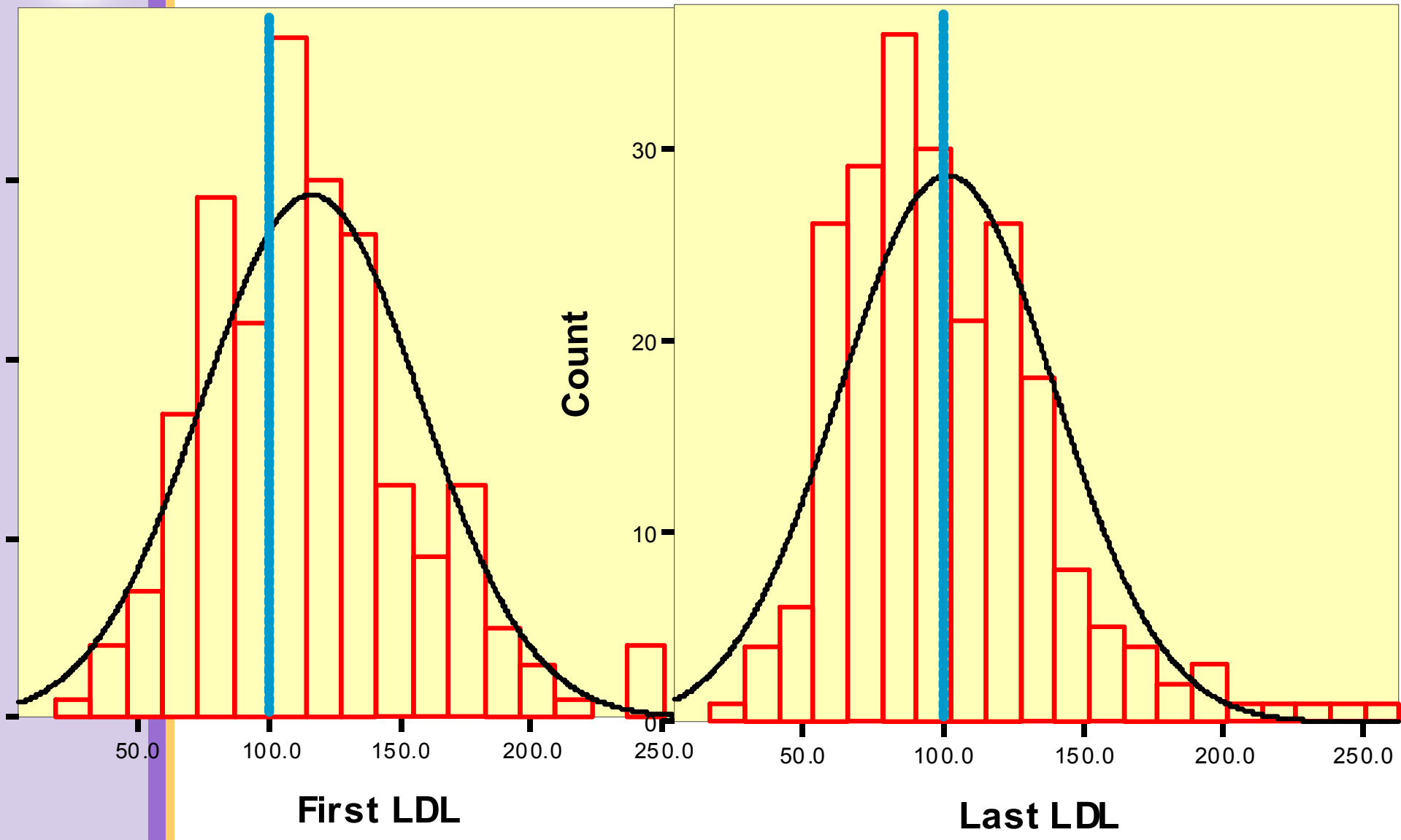
4) The Open-Office Group visit
   - Both involve action planning
   - Stressors, depressed mood, barriers, difficulty coping ALWAYS covered

What changes?

- MA:patient develop a closer relationship that the patient believes is MORE VALUABLE
- MA:provider partner with the patient to effect real behavior change
- Shared responsibilities begin to develop
- Provider perceives they have more time during their visit because of the pre-planning and preparation, and grouping of patients
- PATIENTS SELF-MANAGE

Does it make a difference? Data…

- Phase I: The mean change in HbA1c= -0.42, with a p-value=0.0012
- Patients with greatest participation:
  - 3 or more planned visits showed greatest HBA1c reduction
  - 3 or more group visits showed greatest weight reduction
- Phase I and II: first blush… LDL


Count
30
20
10
0
50.0
100.0
150.0
200.0
250.0
First LDL
Last LDL

Equifinality in Self-Management

Goal Setting	At every visit. With MA and PCP
DM Management Skills	Basics- the MA. Medical- PCP. Comprehensive- Referral to DM Ed
Problem Solving	Begins at Planned visit. Happens primarily at Mini and Open Office group visits. Can happen at PCP visit.
Monitoring & Feedback	MA phone support. CDEMS. PCP
Ongoing support and Encouragement	Connecting each visit to the last.


CDEMS Registry
Group Visit
Follow-up Phone Call
Data Entry
Provider Visit
Data Entry
Planned Visit
Phone Call
Self-Management Goal Cycle (SMG)
A Provider Approach to Quality Goals:
BBSWAR – Big Bad Sugar WAR
Background
Barriers
Success
Willingness-To-Change
Action Plan
Reinforcement

Some of our stories…

Polly and her Dad, Allen

MA planned visit

Lillian- Open Office group visit

Carol - the MINI visit

Dissemination of Regional and Statewide Self-management Resources and Training

Richard Crespo, PhD

Center for Rural Health

Marshall University, Huntington, WV

Co-Authors:
Sally Hurst, BA
Edna Green
Molly Shrewsberry, MPH

RWJF Diabetes Initiative
Final Annual Meeting
Tucson, AZ
Oct. 18-20, 2006

WV Advancing Diabetes Self-Management Program

A partnership of rural health centers and churches in West Virginia working to promote innovative ways to help people experience the benefit of taking control of their diabetes.

Project Goals

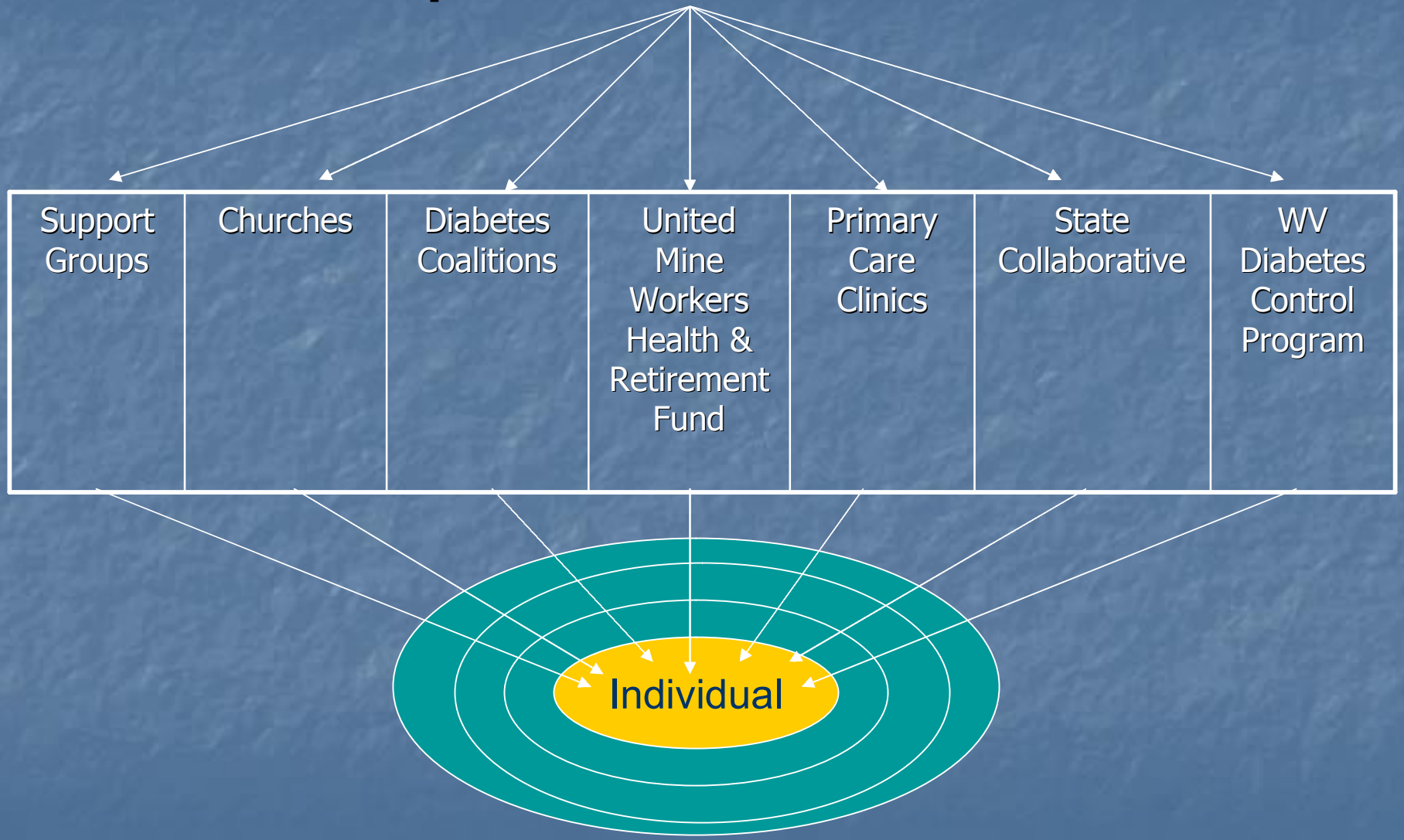
1) Disseminate self-management communication materials using social marketing strategies
2) Equip and support the partner agencies to lead ongoing *Help Yourself* self-management workshops
3) Integrate changes into health care systems that facilitate self-management education and support
4) Promote expansion of medical group visits through mentoring and consultation

Intervention Strategies

- "Help Yourself:" Chronic Disease Self Management Program
- Communication plan and behavior change materials
- Patient self-assessment tools
- Help Yourself toolkit and website

  (in development)
- Medical Group Visits
- Integration of self-management support

Spread Partners



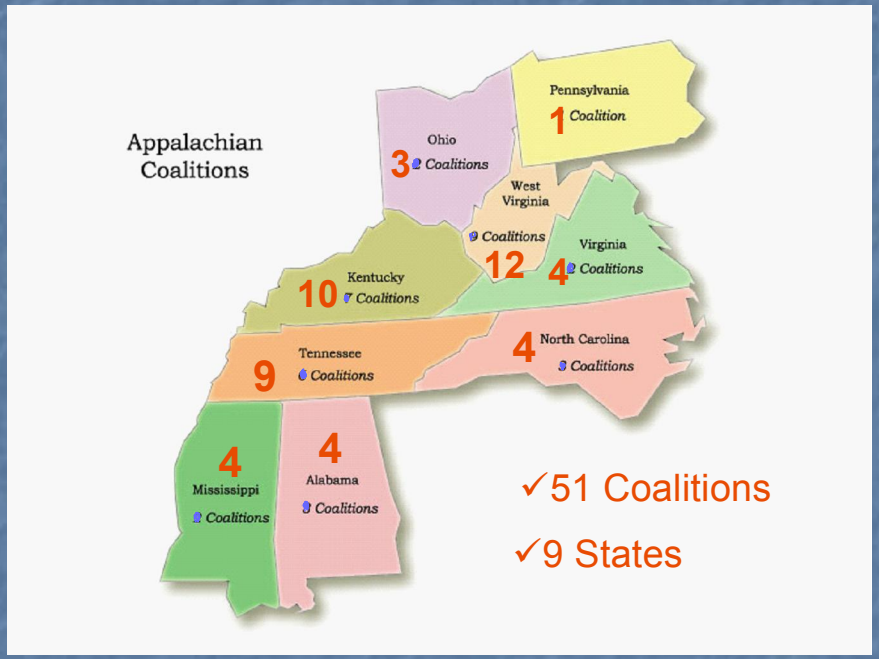
Whole Environment Approach

Commitment to Self Management - Ongoing TA and Support

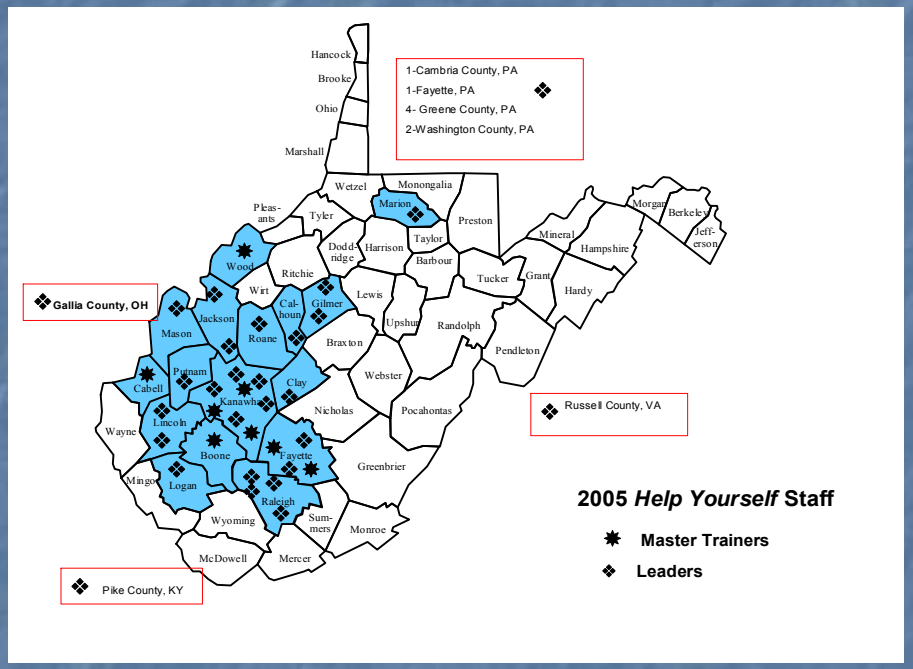
- Training and support for WV State Collaborative effort
- Assistance with data collection and evaluation
- Develop of new SM materials
- Toolkit development
- Help Yourself webpage
- Major focus of WV Diabetes Control Program

Dissemination

Regional Spread



West Virginia Spread



Over 150 leaders trained in 12 states
Over 100 leaders trained from WV

Key Lessons Learned

- Social marketing approach: a strategic tool for successful integration of self management
- Overcoming barriers to self management requires system changes in primary care practice and community
- Medical group visits have a positive impact on self management and clinical outcomes
- Replication through leader training promotes sustainability

The Importance of OFUS

- Facilitate communication and link to clinical providers
- Provide a range of methods for ongoing reinforcement
- Train community leaders and peers in key roles
- Groups promote personal connections
- Use common language to reinforce key messages
- Variety of interventions…something for everyone
- Take programs to the people where they are
- Everyone can benefit from and promote self management

Thank You!