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
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
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

**Diabetes Group Classes**
- 10 week curriculum
- Understand 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

**Support Groups**
- Medication
- Mental health
- Partnership with healthcare team
- Identifying and avoiding diabetes complications
- Social support
- Preventive care
- Community resources

**Topics Include**

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

300 Hours of Training

- 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

1. MD Visit
2. Assessment
3. MD Education (verbal and printed handouts)
4. Treatment Plan
   - Labs
   - Medication
   - Care Plan

MD Follow up
- 1 month: Review labs & initial treatment plan
- 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

- Appt scheduled
- 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

Extensive Education
- Using glucometer
- Education on medication use
- How to check feet
- How to identify complications
- Support for lifestyle changes
- Mental health screening
## Benefits of Promotora Program

**To Providers**
- More efficient use of time
- Improved diabetes control
- Assessment of social needs/concerns
- Reinforce treatment plan
- Extension of MD services
- Health advocate / additional clinic services and referrals identified
- Implement clinical protocols

**To Patients**
- More time received on education
- Improved health outcomes
- Individualized care
- Greater adherence
- Improved access to care
- Specific needs met by appropriate referrals
- Improved quality of care

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*Image: Gateway Community Health Center, Inc.*

*Empowering Communities for Better Health*
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)
A1c: 10.3
Wt: 174.5 lbs
BMI: 30

Enrolled in Promotora Program

8/2003

A1c: 5.4
Wt: 170 lbs
BMI: 29

Graduated from Promotora Program

10/2003

A1c: 5.5
Wt: 173 lbs
BMI: 29

4/2004

A1c: 5.3
Wt.: 164 lbs
BMI: 28

12/2004

A1c: 5.2 August 2006
36 months

8/2005

8/2003

6-months
12-months
24-months
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
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
Leaves with scripts, referrals, and instructions
Integrated plan
Medical & SMG

The Patient

Other Activated Patients

The Non-Clinical Staff

The Provider

The Medical Assistant

 diabetes initiative
A National Program of the Robert Wood Johnson Foundation
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)
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
## Equifinality in Self-Management

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

Lillian - Open Office group visit

MA planned 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
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

- 51 Coalitions
- 9 States

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!