Mi Salud Es Primero
(My Health Comes First)

A model for implementing a promotores de salud program for diabetes self-management in a primary care setting
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Alivio Medical Center
National Council of La Raza
Peers for Progress
TransforMED

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ALIVIO MEDICAL CENTER

Alivio Medical Center is a bilingual, bicultural federally qualified health center committed to providing access to quality cost-effective health care to the Latino community, the uninsured and underinsured, and not to the exclusion of other cultures and races. This mission is expressed through the provision of services, advocacy, education and research and evaluation provided in an environment of caring and respect.

NATIONAL COUNCIL OF LA RAZA

The National Council of La Raza (NCLR)—the largest national Hispanic civil rights and advocacy organization in the United States—works to improve opportunities for Hispanic Americans. Through its network of nearly 300 affiliated community-based organizations, NCLR reaches millions of Hispanics each year in 41 states, Puerto Rico, and the District of Columbia. To achieve its mission, NCLR conducts applied research, policy analysis, and advocacy to provide a Latino perspective in five key areas: assets/investments, civil rights/immigration, education, employment and economic status, and health. In addition, NCLR provides capacity-building assistance to its Affiliates who work at the state and local level to advance opportunities for individuals and families. Founded in 1968, NCLR is a private, nonprofit, nonpartisan, tax-exempt organization headquartered in Washington, DC. NCLR serves all Hispanic subgroups in all regions of the country and has regional offices in Chicago, Los Angeles, New York, Phoenix, and San Antonio.

NCLR’s Institute for Hispanic Health (IHH) is dedicated to reducing the incidence, burden, and impact of health problems among Hispanic Americans. IHH works in close partnership with NCLR Affiliates, government partners, private funders, and other Hispanic-serving organizations to deliver the highest quality health interventions. These interventions focus on the improvement of, access to, and utilization of health promotion and disease prevention programs. IHH is committed to providing technical assistance that is culturally competent and linguistically appropriate. To learn more about IHH and other programs of NCLR, visit www.nclr.org.

PEERS FOR PROGRESS

Peers for Progress was founded in 2006 to promote peer support as a key part of health, health care, and prevention in the U.S. and around the world. To accomplish its goals, Peers for Progress began by funding 14 projects in nine countries on six continents to build the evidence base for peer support in diabetes. Other activities include networking for quality improvement, making resources available for program development and evaluation, and providing technical assistance to improve peer support programs across the globe. With NCLR and support from Bristol-Myers Squibb Foundation, Peers for Progress has been active in facilitating advocacy efforts to promote the work of peer supporters at the federal and state levels.

Peers for Progress is dedicated to helping establish peer support as an accepted, core component of health care for all people. If you are interested in using peer support or have been involved with a peer support program, we encourage you to connect with us and colleagues in other peer support initiatives by joining the Peers for Progress global network at www.peersforprogress.org.
**TRANSFORMED**

TransforMED LLC is a nonprofit wholly-owned subsidiary of the American Academy of Family Physicians. It provides ongoing consultation and support to primary care providers looking to transform their practices to a new model of care that is based on the concept of a patient-centered medical home. TransforMED recognizes and supports the unique value that primary care offers to patients and the health care system, and it shares the commitment of primary care to its communities and patients through continuing patient relationships.

**ACKNOWLEDGMENTS**

We would like to sincerely thank the dedicated staff and the *Compañeros en Salud* of Alivio Medical Center for supporting the development and implementation of this project.

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I. INTRODUCTION

i. Background

The human and financial toll of health problems on patients, their families, and society in the United States is enormous. Total health care spending in this country is expected to reach $4.8 trillion, or about 20% of gross domestic product, in 2021, despite the implementation of the Affordable Care Act. As the population ages and more Americans develop chronic health conditions, the need to implement proven, cost-effective strategies that help people lead healthier lives is urgent and growing.

The community health worker (CHW), or peer-support, model has been shown to play a powerful and important role in community health and the health care delivery system. CHWs occupy diverse roles in clinical and community health promotion/disease prevention settings. As trusted members of their communities, CHWs “serve as a liaison, link, or intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.” Depending on their primary responsibilities and the context in which they work, CHWs may be recognized by different names such as promotores de salud (“health promoters”), lay health advisors, or peer coaches. Oftentimes, CHWs share either a disease diagnosis or a demographic resemblance with those they serve, such as a similar linguistic or cultural background or residence in the same neighborhood.

CHWs are particularly effective in reaching special populations, such as racial, ethnic, rural, immigrant, and other underserved populations, and engaging them in health promotion services and programs. With unique insight into their community’s cultural and social mores, CHWs can address specific barriers that prevent individuals from managing their health conditions and accessing health services. They can serve as a bridge between underserved groups and resources in the community as they identify and cater to the specific needs of their population and make appropriate referrals to additional resources.

As more primary care practices aim to transform the delivery of comprehensive primary care, CHWs can play an integral role as a key member of the care team in the Patient-Centered Medical Home (PCMH) model. CHWs can be a source of culturally and linguistically appropriate emotional, social, and practical assistance toward achieving and sustaining complex health behaviors in a whole-person approach. CHWs may provide important feedback and insider knowledge to providers, clinical teams and program administrators about how to tailor integrated and coordinated care for the patient. This linkage is critical because many physicians do not have the time to assess all of the barriers that may hinder an individual’s disease management.

The Mi Salud Es Primero (My Health Comes First) model diabetes-management program discussed in this guide was based on the assumption that the PCMH model, CHW programs, and community outreach activities all play major roles in engaging low-income minority patients to improve self-management behaviors and achieve improved outcomes for their diabetes. The promotores de salud (called compañeros de salud in this program) were part of the extended patient care team. The organizational interactions between the clinical and community resources in this model are depicted below:
ii. Objectives

This guide outlines the design and implementation of *Mi Salud Es Primero*, a population-focused peer support program that targeted the needs of urban, low-income, primarily Latino* adults with type 2 diabetes in Chicago, IL. Specifically, this program integrated *promotores de salud*, referred to as *Compañeros en Salud* (CES), in a Patient-Centered Medical Home (PCMH) model to assist patients with their diabetes self-management.

The purpose of this guide is to serve as a resource for program managers and project coordinators interested in developing a peer support program for a similar population. The guide offers insight into the organizational structure, curriculum, tools and resources that were utilized to coordinate clinical care and community support for this population with type 2 diabetes.

iii. About the *Mi Salud Es Primero* Program

*Mi Salud Es Primero* was a two-year demonstration project implemented by Alivio Medical Center, Peers for Progress, TransforMED, and the National Council of La Raza (NCLR). The project was funded by the Bristol-Myers Squibb Foundation as part of its Together on Diabetes™ program to reduce disparities in diabetes across the United States.

The project involved approximately 3,800 low-income Latino adults (aged 18 and older) living with type 2 diabetes and served by Alivio Medical Center, a federally qualified health center in Chicago, IL. Trained *Compañeros en Salud* (CES) were integrated with primary care clinical teams to help patients improve their diabetes self-management, and they administered peer support according to the “Four Key Functions” identified by Peers for Progress:

1) Assistance in daily management

* The terms “Hispanic” and “Latino” are used interchangeably by the U.S. Census Bureau and throughout this document to refer to persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.
2) Social and emotional support  
3) Linkages to clinical care and community resources  
4) Ongoing support, extended over 24 months

At program initiation, a subset of 471 patients were identified as “high-need” and became part of an intensive intervention that assessed the impact of peer support on diabetes self-management using clinical measures and patient-reported outcomes gathered by surveys. As part of the high-need group, patients received peer support services from a trained CES and were closely monitored and evaluated using pre- and post-clinical measures and measures of diabetes self-management behaviors, as well as depression and quality of life measures. The remaining approximately 3,315 patients with type 2 diabetes received basic peer support or “regular-care” services at Alivio and were assessed using pre- and post-clinical measures.

Another component of this peer-support program was the adoption of the Patient-Centered Medical Home (PCMH) model of care at Alivio Medical Center. In the PCMH model, the primary care physician coordinates patient care across the entire health care system, and continuous provider/patient relationships allow for increased patient engagement, mindful communication, and shared decision-making all within the context of culturally sensitive care.

Intended outcomes of this project included:

- Increased engagement of low-income, disadvantaged, minority adults with diabetes in regular clinical care and self-management of their diabetes.
- Improvement of self-management behaviors (medication adherence, physical activity, healthy diet, glucose monitoring, risk reduction, healthy coping, problem-solving).
- Improvement of clinical indicators (HbA1c, blood pressure, lipids, body mass index, kidney function).

iv. Overview of Program Collaboration

The program partners initiated their collaborative efforts by first exchanging letters of agreement regarding their three-year commitment to designing and implementing the diabetes management program. In these letters, the partners delineated their operational roles and responsibilities for the duration of the project.

Next, the partners identified NCLR Affiliate clinics that might serve as implementation sites for the project and conducted several site visits. They selected Alivio Medical Center in Chicago because of its congruence with the grant’s focus and its possession of an existing promotores de salud program. The project was coordinated across Alivio’s three clinical sites, two in Chicago proper and one in a neighboring suburb.

Over numerous conference calls, the partners created a work plan for integrating all project-related activities, including protocol development, Institutional Review Board applications, and activities such as monitoring and management of program implementation. In addition, they collaborated in developing protocols for the recruitment and training of CES, engagement of patients, provision of peer support and diabetes self-management and education (DSME) classes, and integration with clinical services.

The following organizations worked closely together to coordinate the planning, implementation, and overall management of the project. This collaborative process was one of the strengths of the program and was vital to its success.
Bristol-Myers Squibb Foundation
The Bristol-Myers Squibb Foundation provided program review and contract oversight for the project.

American Academy of Family Physicians (AAFP) Foundation
The AAFP Foundation provided grant management and fiscal oversight and collaborated with partners on program promotion and dissemination of program materials.

Peers for Progress
Peers for Progress managed the overall project, including intervention development, design, research, evaluation, and dissemination. In collaboration with NCLR and TransforMED, Peers for Progress staff coordinated the development of intervention materials, plans, and protocols and managed overall project implementation. Peers for Progress staff also led the development and implementation of evaluation activities in coordination with NCLR and Alivio staff. Other responsibilities included data analysis and management, preparation of reports and publications, and collaboration with NCLR on project dissemination including the development of a toolkit and other materials.

National Council of La Raza (NCLR)
NCLR collaborated with Peers for Progress staff in the design and evaluation of the project, including site selection and site-based survey and interview administration. NCLR also contributed to intervention development (including Compañeros en Salud protocols and training materials) and program implementation (including recruitment and training of peer supporters and linkages with community groups and resources) and managed the implementation of the evaluation protocol. In addition, NCLR focused on the development, dissemination, and promotion of core and tailored program materials, toolkits, and reports in collaboration with Peers for Progress and the AAFP Foundation.

TransforMED
Providing expertise on the Patient-Centered Medical Home (PCMH), TransforMED assisted with site selection and preparation, especially in terms of PCMH characteristics and gap-analysis. TransforMED also assisted in intervention development, including protocols, training materials and PCMH-related practices and policies among local systems and providers. Additionally, TransforMED provided in-kind support by serving as a technology resource, offering expertise in organizational systems, and co-hosting a webinar about peer support and PCMH with Peers for Progress and NCLR.

Alivio Medical Center
As the host organization for the project, Alivio assisted in the development and implementation of initial program set-up in coordination with Peers for Progress and NCLR. Specifically, Alivio hired a Project Manager who oversaw daily activities and program implementation at site level as well as conducted site-based evaluation activities in coordination with Peers for Progress and NCLR. A Project Coordinator was also initially hired to help with the daily coordination, supervision, and support of the Compañeros en Salud.
II. RECRUITMENT OF COMPAÑEROS EN SALUD

Alivio Medical Center has a long history of working with promotores de salud. Their extensive experience helped guide the recruitment and selection of the CES, as well as the decision to pay the CES instead of recruiting volunteers.

i. Recruitment and Selection of CES

The majority of CES were recruited internally from other promotores de salud programs at Alivio. For the remaining open positions, a job posting was circulated at Alivio’s clinic locations and online, and word of mouth was used to spread the news in the community. The Project Manager screened and interviewed the potential candidates in person.

Strong emphasis was placed on the following skills:
1. Clear understanding and knowledge of service-area population and community.
2. Strong commitment to serve the targeted community areas.
3. Specific communication skills (i.e., engage clients in ways that establish trust and rapport with them and their families, provide a non-judgmental atmosphere during interactions, acknowledge the dignity of cultural traditions).
4. Ability to adapt outreach strategies based on the population, venue, behavior, or identified risks.
5. Skill in helping patients identify their own strengths and problem-solving abilities through motivational interviewing techniques (open-ended questions, reflective listening, positive reinforcement, etc.).
7. Ability to manage time, set priorities, and work both independently and as part of a team.

ii. Job Description and Payment

The Project Manager developed the job description for the CES (see Appendix A for a copy of the job description). After accepting the position, each CES signed a contract in accordance with Alivio’s standard hiring procedures. CES were paid $13 per hour, including full benefits and paid vacation days. They paid the CES to reduce turnover and to help fully integrate them with the clinical staff. The Project Manager hired a Project Coordinator, six full-time CES to work directly with the patients at Alivio’s three main clinics, and one full-time and two part-time CES for community outreach efforts.
III. TRAINING OF *COMPAÑEROS EN SALUD*

Alivio led the development of CES training materials and curriculum with support from NCLR, an organization with expertise in developing *promotores de salud* programs.

i. Initial Training

The initial CES training occurred at Alivio Medical Center over a period of six hours per day for eight days, a total of 48 hours of training. The training was conducted in Spanish and covered the following content:

| DAY 1 | 1. Human Resources  
2. Alivio Medical Center intro and welcome (remarks from Executive Director)  
   Alivio history, mission, values, and vision  
   Video  
   Development Department: Plans for the future, key events  
3. Objectives of training  
4. *Compañeros en Salud* welcome  
5. Introduction to Project Coordinator  
6. Introduction to CES program  
   Mission of CES program  
   Overview of how team works  
   Overview of CES program  
   Meeting the rest of the CES staff  
   Tour of workspace  
7. Peers for Progress  
   Overview  
   Goals and Purpose  
8. Patient-Centered Medical Home model  
   Standards of PCMH  
   Background on Affordable Care Act |
|---|---|
| DAY 2 | 1. Diabetes  
   Impact  
   Prevalence of diabetes and obesity among children and adults in 6 community areas in greater Chicago area  
   Percentage of adults who have been advised about weight (overweight or obese), have completed adequate physical activity, have watched television vs. participated in physical activity  
   Healthy People 2020 Diabetes Goals and Objectives  
   Qualitative data (information about local community)  
2. CHWs  
   History of the role of *promotores* in the U.S.  
   History of *promotores* within Alivio  
3. Peers for Progress project organizational model  
4. Role of *promotores* within Peers for Progress project  
   Job description  
   Navigation of health care system at Alivio  
   Interaction with the rest of the health care team  
   Patient case load  
   Internal organizational structure  
   Supervision, meeting schedules, etc.  
   Self-determination |
<table>
<thead>
<tr>
<th>Support of patient autonomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empowerment</td>
</tr>
<tr>
<td>6. Team-building Activity: Sharing experiences providing peer support to community members</td>
</tr>
</tbody>
</table>

**DAY 3**
1. **Diabetes self-management (part 1 of 3)**
   - Objectives of training
   - What can CES address and what should be addressed by provider/CDE (Certified Diabetes Educator)
   - Role-playing after each session topic
   - Nutrition
   - Physical activity
   - Others
2. **Communication/support skills**
   - Speaking with community members (variation of motivational interviewing)
   - Introduction to motivational interviewing
   - Active listening
   - Guiding problem-solving
   - Role play

**DAY 4**
1. **Diabetes self-management (part 2 of 3)**
   - Objectives of training
   - What can CES address and what should be addressed by provider/CDE
   - Role-playing after each session topic
   - Nutrition
   - Physical activity
   - Others
2. **Join Peers for Progress Organization Team Call for one hour**

**DAY 5**
1. **Diabetes self-management (part 3 of 3)**
   - Objectives of training
   - What can CES address and what should be addressed by provider/CDE
   - Role-playing after each session topic
   - Nutrition
   - Physical activity
   - Others
2. **Case management**
   - What it is and what it isn’t
   - Principles
   - Process
3. **Team-building activity**

**DAY 6**
1. **Electronic Medical Records**
2. **Documentation**
   - Charting provides the data needed for effective interdisciplinary care to ensure the continuity of that care
   - Charting must serve as a legal record that can be used to protect the patient, the health care facility, and the health team professionals who provide care
3. **Other Institutional Records**
   - Diabetes Care Plan
   - Progress Notes
   - Review Alivio Medical Center policies/procedures and sign confidentiality statement
   - Medical Records procedures
3. **Project documents**
   - Intake Form
   - Patient Demographics
   - Health Indicators: BMI, labs, BP, etc.
   - Diabetes Management Plan
   - Encounters (including patient attendance in diabetes classes)
   - Referrals
4. **Emergency codes and procedures**
### DAY 7

1. Referrals—Internal
   - Chicago Family Case Management
   - WIC
   - Behavioral Health
   - Other CES programs
   - Senior Services
   - CDE/RD

2. Medication assistance

3. Key messages
   - Program branding, name, motto, logo, etc.

### DAY 8

1. Goal setting techniques (to be facilitated once *promotores* have acquired knowledge of resources available for this project)

2. Glucometer: Diabetes Health Trainer
   - Patient Blood Glucose log

3. Teaching check list

4. Patient check list

5. Freestyle Card—cost savings on test strips

6. Teach back/demonstration

7. Closing discussion: What’s your vision for the project?

### ii. Ongoing Training

CES participated in different types of trainings that were made available by various outside organizations throughout the project period: the National Council for Community Behavioral Healthcare conducted a training session on mental health; the National Eye Institute gave a workshop on promoting healthy eyes in patients with diabetes; the Illinois Kidney Foundation facilitated a discussion on kidney disease prevention; the Chicago Hispanic Health Coalition gave a training session on the Affordable Care Act; and finally, NCLR and TransforMED conducted additional trainings focusing on how *promotores de salud* can be a voice for change for the Latino community, how to develop and incorporate a care plan, and how to improve motivational interviewing skills.
IV. PATIENT ENGAGEMENT

The entire population of adults (18 years old or older) with type 2 diabetes who were registered patients of Alivio Medical Center automatically became eligible for the *Mi Salud Es Primero* program. From this population, individuals that met the criteria listed below were categorized into two main groups: “high-need” and “regular-care.” Within these groups, patients received services based on their needs according to a flexible, tiered system described in Section V: CES Protocols.

i. **Identification of High-Need Patients**

Individuals who were at high risk and in most need of intensive one-on-one peer support were classified as “high-need” patients at program initiation.

High-need patients met the following criteria:

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alivio patient</td>
<td>Gestational diabetes</td>
</tr>
<tr>
<td>Diagnosis of type 2 diabetes</td>
<td>Severe medical conditions that might preclude frequent visits to the clinic</td>
</tr>
<tr>
<td>Medical visit in the last year</td>
<td>Poor short-term prognosis (expected death in &lt;2 years)</td>
</tr>
<tr>
<td>Prescribed type 2 diabetes medication</td>
<td>Serum creatinine level &gt;3.5 mg.dl</td>
</tr>
<tr>
<td>HbA1c ≥ 8</td>
<td>Dialysis</td>
</tr>
<tr>
<td>Minimum age of 18 years old</td>
<td>Chronic kidney disease: Stage 3, 4</td>
</tr>
<tr>
<td>Barriers to diabetes self-management:</td>
<td>Active alcohol or drug abuse</td>
</tr>
<tr>
<td>Low socio-economic status</td>
<td>Lack of permanent residency in the near geographic area</td>
</tr>
<tr>
<td>Personal/social barriers</td>
<td>Individuals age &gt;75</td>
</tr>
<tr>
<td>Lack of family support</td>
<td>Lack of permanent residency</td>
</tr>
<tr>
<td>Low comprehension of diabetes self-management</td>
<td>Current diagnosis of schizophrenia, other psychotic disorders, or bipolar disorder</td>
</tr>
<tr>
<td>Frequent visits to the emergency room</td>
<td></td>
</tr>
</tbody>
</table>

ii. **Identification of Regular-Care Patients**

The remaining adult patients with type 2 diabetes were classified as “regular-care” patients.

Exclusion criteria for regular-care patients included:
- Gestational diabetes
- Type 1 diabetes

Regular-care patients received quarterly contacts in person or via telephone from their CES and were encouraged to utilize resources in the clinic (e.g., DSME classes) and in the community. If regular-care patients needed more intensive services, the patient and the CES would decide on a frequency of peer support contacts that met his or her needs, as described in Section V.

iii. **Methods for Engaging Patients**

Program staff, clinicians, and administrative staff reached and engaged patients using these methods:
<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PECS/Centricity Database</td>
<td>This internal database at Alivio generated a report of all adult patients with type 2 diabetes, which was cross-checked with the list of patients who had already been contacted via the internal referral system every two months.</td>
</tr>
</tbody>
</table>
| Internal Referral System       | An existing referral system was utilized for referring patients to their CES. Providers completed the “Diabetes Management Provider Referral form” (see Appendix B for a copy of this referral form) and submitted it to the clinic’s Certified Diabetes Educator (CDE). Referrals were screened by the CDE. Before the implementation of the project, the CDE would refer the patient to:  
  - CDE for 1:1 services  
  - Registered Dietician for 1:1 services  
  - Group diabetes self-management classes  
  As the project was implemented, the CDE continued to collect the provider referrals and referred all adult patients with type 2 diabetes to the Project Coordinator. A letter was then sent to the patient informing them of this free program. See Appendix C for a copy of the Patient Engagement Letter in English and Spanish.  
  The CDE was then able to focus on patients with gestational diabetes, type 1 diabetes, and those who didn’t know how to properly use insulin.  
  Once the Electronic Medical Records (EMR) system was put into place in the second year of the project, the provider referral system became implemented electronically. See Appendix D for a graphic representation of the EMR referral form. |
| Appointment with provider      | By 9:00 a.m. daily, the CES Project Coordinator received the schedule of provider (MD, NP, and CDE) appointments. CES ensured that they made in-person contact with every adult patient with type 2 diabetes before or after their provider appointment.                                                                                                                                   |
| Self-referral                  | Patients were able to contact the program directly by telephone. They could also talk to their doctor or MA about the program if they had any questions.                                                                                                                                                                                                 |
| Clinic outreach                | Patients received information about the program via other clinic staff, support groups, self-diabetes management education classes, or program flyers and posters found throughout Alivio’s clinics.                                                                                                                                                                       |
| Community outreach activities  | During community outreach activities, staff provided health information and free glucose screenings. Individuals with abnormally high glucose levels were asked if they had a medical home. If they did not have a medical home, they were asked if they wished to become patients of Alivio Medical Center. If they wished to become patients of Alivio, program staff filled out a Pre-Registration form and gave the form to the appropriate Patients Support Staff member, who made an appointment for the patient and reported the appointment date back to program staff. Once these individuals became established patients, were seen by a primary care provider, and were diagnosed with type 2 diabetes, they became part of the regular-care group. |
iv. Assignment of Patients to CES

The Project Coordinator was responsible for assigning patients to their CES and aimed for an even distribution of patients among all of the CES. Patients with major complications were assigned to the more experienced CES. Patients were also assigned to one of the clinical sites based on geographic proximity. Ultimately, about 600 patients were assigned to each CES.

Protocol for Patient Assignment

The following steps were taken to assign patients:
1. The Project Coordinator sorted and assigned patients to CES.
2. Each CES had a caseload of about 78 patients that met the criteria for intensive diabetes self-management support (78.5 patients X 6 Educators = 471 patients).
3. CES were assigned to provide support to patients at one of the clinic’s three main clinical sites (not school-based health centers). The Project Coordinator distributed the patients identified for the high-need group among the CES working at each specific site.
4. In the case that a CES was assigned a patient who was a family member, friend, or someone who might cause conflict or violation of the patient’s right to privacy, the Project Coordinator assigned the patient to another CES.
5. In the case of time off (vacations, sick days, and personal days), CES responsibilities were covered by another CES, the Project Coordinator, or the Community Outreach CES, who had been cross-trained to effectively offer patient support.
6. All patients received information on how to contact his/her CES and the Project Coordinator. They were also informed from the first encounter on that they should feel free to contact the Project Coordinator with any comments or concerns (e.g., to request a change of CES).

Additional Factors for Patient Assignment

In the beginning of the program, there was a conscious effort to assign male patients to the two male CES. This decision was made to avoid any potential conflict or misunderstanding surrounding a male peer supporter frequently calling a female patient. Because more female patients were engaged in the program than male patients, gender-based matching occurred naturally due to the greater number of female CES. Furthermore, more complex patients (i.e., patients with co-morbidities) were assigned to more senior CES for their expertise with high-needs patients.
V. CES PROTOCOLS

Program partners developed protocols for the CES to follow during each contact with patients.

i. Flowchart of Protocol for High-Need and Regular-Care Patients

This flowchart illustrates the movement of patients through the program and the fluidity between high-need and regular-care groups. See Appendix E for a detailed description of this protocol.

Identification of Patients with T2DM (~3,800)
- High-Need Patients (471)
- Regular-Care Patients (~3,316)

Patient Assigned to CES

Initial Contact by CES
- Before each contact, CES checks EMR for all phone numbers on file, next scheduled appointment with PCP, and the date and level of last HbA1c
- CES calls to describe and offer services and builds rapport with patient
- CES identifies areas in which patient needs assistance via Assessment Form (see Appendix F) and completes Contact Note form (see Appendix G)
- CES makes an appointment to schedule the second contact, by phone or in person

CES Protocol for High-Need Patients
- Flexible tiered program with contacts by phone or in clinic
- High Intensity: Contact every 2 weeks for at least 6 contacts (~12 weeks)
- Moderate Intensity: Once a month for 3 months
- Low Intensity: Quarterly, or every 3 months

CES Protocol for Regular-Care Patients
- Quarterly contacts by phone or in clinic
- Encourage use of clinical care and resources (e.g. DSME classes and support groups)

CES and patient decide on tier/frequency of contact based on patient’s needs
Ex: Patients can move from Low to High Intensity when problems arise and then back to Low Intensity when stabilized.

Patient can initiate contact with CES at any time
CES completes Contact Note after every successful contact*

*CES completes Contact Note for all call attempts, letters mailed, and discussions lasting longer than 5 min.
ii. Flowchart of CES Protocol—Patient Engagement via Telephone

Initial Contact by CES: Was patient reached by telephone?

Patient is reached

Patient engages with CES program (Active Status)

Follow protocol for initial contact and subsequent contacts for High-Need or Regular-Care

Patient does not engage with CES program (Inactive Status)

CES explains his/her availability to the patient, briefly reviews how they can help the patient, and says that they will call back in a month or so to “check in with” (IMPORTANT: not “check up on”) the patient

Patient is not reached

Wait three days after first attempt and call again (Inactive Status)

If unreached, wait another three days and call again

If still unreached, a letter will be mailed on the same day as the third attempt informing the patient of the program and asking the patient to contact the program as soon as possible

Patient explicitly states he/she does not want to be contacted again

If patient does not contact program, call patient one week after letter is mailed

If still unreached, wait one month and call again

If still unreached, wait one month and call again

Continue to call monthly for six months, and if patient is still unreached…

Patient is placed on DO NOT CONTACT list*

*See next page for information about the “Do Not Contact List”
iii. Do Not Contact (DNC) List

Every patient who met the following criteria was placed on the “DO NOT CONTACT” list:

- Patient explicitly requested not to be contacted by program
- Patient could not be reached by CES after 6 months
- Patient did not have a clinical appointment in the last 12 months or no longer receives clinical services from Alivio (e.g., moves away, changes insurance policies, etc.)
- Telephone numbers in system were incorrect, disconnected, or no one answered
- No response by patient after letter was mailed out asking patient to call the program
- Patient no longer met inclusion criteria
- Patient died during the course of the program

The “DO NOT CONTACT” list was given to the CES staff in charge of outreach. Staff checked quarterly in the system for updates on the patient (clinical appointment and/or contact information). If there were no updates since last checking in the system, an attempt to contact the patient was NOT made. If there were updates in the system, the patient was removed from the “DO NOT CONTACT” list, and this information was given to the CES initially assigned to the patient in order to reinstate the Support Services protocol for the regular-care patient group.

How patients could get moved from DNC list back to CES

- A patient who previously opted out could change his or her mind and become reintroduced to the program at any time
- A patient could make an appointment at Alivio after not having been seen for 12+ months. The CES reviewed the EMR regularly for new appointments and would retrieve the patient’s contact information and call the patient.

iv. Ongoing Peer Support Activities by CES

Through telephone contact and meetings in the clinic, CES provided peer support to patients according to these “Four Key Functions” identified by Peers for Progress:

<table>
<thead>
<tr>
<th>Assistance with Daily Living</th>
<th>Linkage to Clinical Care and Community Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized goal setting</td>
<td>Appointment assistance</td>
</tr>
<tr>
<td><strong>AADE 7 Key Behaviors</strong></td>
<td>Registration for DSME group classes</td>
</tr>
<tr>
<td>Glucometer checklist (See Appendix G for a copy of the glucometer checklist)</td>
<td>Rx assistance program</td>
</tr>
<tr>
<td>Basic DSME</td>
<td>Referral to provider and/or clinic services</td>
</tr>
<tr>
<td>Clinic workshops (e.g., nutrition)</td>
<td>Engagement in Alivio clinic activities (e.g., health fairs, weekly info table in lobbies) or health services outside of Alivio</td>
</tr>
<tr>
<td></td>
<td>Linkage to community resources (e.g., legal, educational, food banks, economic, childcare)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social and Emotional Support</th>
<th>Ongoing Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encouragement and motivational support</td>
<td>24-month availability</td>
</tr>
<tr>
<td>1:1 support by phone or in person</td>
<td>Phone-based and in-person at clinic</td>
</tr>
<tr>
<td>Support groups</td>
<td>Proactive and on demand</td>
</tr>
</tbody>
</table>

In addition, CES led the following clinic-based and community-based activities throughout the duration of the program:

1) Diabetes Self-Management Education (DSME) Classes
- DSME classes were offered during the entire program implementation period.
- The classes were offered in four separate sessions, each lasting approximately two hours, once a week for four weeks. The toolkit can be accessed through the following links:
• High-need and regular-care patients were encouraged to participate in these classes.
• For patients who did not want to or could not participate in the four DSME classes, CES held one-on-one sessions, provided the patients with written educational materials, or invited them to clinic events for diabetes patients.

2) Diabetes Self-Management Support (DSMS) Groups
• DSMS groups were offered weekly, with each session lasting no more than two hours.
• Both high-need and regular-care patients were encouraged to participate in these groups.
• Prior participation in DSME classes was not required.
• Participation in support group sessions was counted as an individual support contact and documented as such.
• Click this [link](#) to access the DSMS guide in Spanish and this [link](#) to access the DSMS guide English.

3) Clinic Events for Diabetes Patients
• Program staff implemented two events annually that were open to all adult patients with type 2 diabetes and their guests.
• One event took place in November in recognition of Diabetes Awareness Month.
• These events were designed to offer a variety of workshops related to diabetes self-management, health screenings, and resources.
• Participation in these events counted as a support contact and were documented as such.

To ensure program quality and fidelity, the Program Coordinator observed classes and one-on-one sessions to ensure that correct information was given during each. The CDE or Clinical Director was also available as a resource if diabetes-related questions arose that the CES could not answer.
TransforMED worked closely with Alivio Medical Center to assist in their transformation into a Patient-Centered Medical Home (PCMH), while simultaneously supporting the development and testing of linkages between CES and providers and the integration of peer support with clinic services. TransforMED and Peers for Progress hosted a webinar, titled “Diabetes Management: Success with Peer Support and Population Health”, describing in detail the transformation that occurred at Alivio. Click this link for a copy of the slides and this link to watch the webinar. The following addresses complementarity of PCMH and peer support services; the development of the extended care team model; and lessons learned from implementation of the Mi Salud Es Primero program.

i. Complementarity of PCMH and Peer Support Services

The PCMH is an approach to providing comprehensive primary care for children, youth, and adults that is person-focused. It is a health care setting that facilitates partnerships between individual patients and their personal physicians, as well as, when appropriate, the patient’s family.10 The goal is to coordinate roles between the clinical team, the CES, and the patient around a shared care plan to improve health outcomes, as depicted here:

![Coordinating Role of Shared Care Plan](image)

Within the context of the PCMH, peer support can be a powerful strategy for community engagement, linkages to care, and health and disease management, which are endeavors central to the PCMH but not always easily accomplished within clinical care.

Both peer support and the PCMH share a focus on enhanced access to and team-based health care, coaching patients to assume more active roles in health care, enhanced communication between patients and providers, culturally-sensitive outreach and follow-up, partnerships between people and organizations, and, through all of these, reducing health care disparities.11,12 This kind of combined strategy can serve not only to maximize effects on behavior change and self-management but also to build systems for enhanced care for sustained improvements. See the figure below.
Key considerations in the development of the *Mi Salud Es Primero* program were the role of primary care in chronic disease management, the evolution of the PCMH, and the role of peer support in ongoing encouragement and support of chronic disease management. These three forces coalesce in the following ways:

I. There is broad consensus that primary care and the PCMH are central to comprehensive approaches to diabetes management and chronic disease management in general.

II. A central tenet of the PCMH and community-oriented primary care (using community organization strategies staged from primary care settings) is outreach to communities to harness the social influences of individuals’ daily lives to support improved health behaviors.

III. From the community perspective, organizations poised to develop and sustain community-based promotion are often difficult to identify. Primary care will endure and is often interwoven with the community that surrounds it. Accordingly, effective models of staging community organization from primary care would have strong advantages in sustainability.

IV. Community outreach is difficult. Community-based classes and activities often reach only a small number of those intended and may fail to reach those most in need.

V. Peer support is an excellent vehicle for community organization and outreach from the PCMH. Peer supporters can provide diverse linkages to communities. They also can reach and engage those most in need.

VI. At the same time, peer supporters can link patients and the PCMH with other community resources to promote healthier lifestyles.

**ii. Development of the CES-PCMH Integration Model**

*Pre-program implementation*

Central to the success of the program was the appointment of a Project Manager at Alivio Medical Center. The responsibilities of the Project Manager included 1) coordinating the development and implementation of the CES peer support program for diabetes patients; 2) leading efforts to develop pathways for integration of CES services with providers and clinical services at Alivio and community resources outside the clinic; 3) identifying relevant community resources and establishing linkages for referrals; and 4) identifying clinic champions and marketing the program throughout the clinic setting.

Program partners met monthly with the Alivio Project Manager and key staff at Alivio Medical Center to develop plans for the program, conduct assessments and trainings, and ensure open communication among all stakeholders.
During the eight months prior to initiation of the program, partners worked together to develop the peer support protocol implemented by the CES. This protocol is explained in detail in Section V and in Appendix E. During this time, the Alivio program staff revised and updated their in-house DSME curriculum and developed the patient binder and other program resources.

After the peer support protocol was established, partners began planning for integration with clinic services and the care team. As a starting point to identify potential linkages and opportunities for two-way communication between the CES and providers, the program partners organized a series of case reviews. The case reviews were held by conference call or in person and were organized and led by the Alivio Project Manager. The framework for the case reviews involved:

• Key staff members at Alivio attended, including clinicians, nurses, CDE, CES, as well as any other clinic staff members who were interested.
• Providers took turns presenting information about a diabetes patient with whom they were working and indicated specific problem areas where they had not been able to help the patient and/or where the patient needed improvement or assistance with initiating self-management behaviors.
• Participants in the case review took turns providing feedback and suggestions on how the provider might help the patient and how the CES might be able to help the patient.
• The Project Manager led a follow-up discussion summarizing and exploring possibilities for establishing new integration protocols.

Several possible pathways for linkages between CES and providers were recognized as a result of these discussions, which included:

- Seeking out a provider in-person before and/or after a patient visit
- Sending messages and alerts via EMR (theoretical at the time as the EMR was not yet functional)
- Developing a referral system for providers to link patients to CES for peer support services
- Others

**Implementation Period**

**Integration of CES in clinical area**

In practice, every morning before clinical operations began, the CES reviewed daily primary care provider schedules to identify adult patients with type 2 diabetes who had appointments that day. Then the CES pulled those patients’ files and engaged with the patient in the waiting area. In addition, at least one other CES was stationed in the waiting area to engage patients who came in for same-day appointments.

The roles and responsibilities of the CES, the Medical Assistant, and the Primary Care Provider were coordinated to work from a shared care plan for the patient. Once the CES made the initial contact with the patient in the clinical area on the day of their provider appointment, the following steps were implemented:

**Step 1: Before provider appointment—CES**

• Review with patient at-home blood glucose levels
• Review patient’s previous diabetes self-management goals
• Remind the patient to ask the provider for necessary referrals
• Remind the patient to write down levels of clinical indicators

**Step 2: Before provider appointment—Medical Assistant**

• Check vital signs
• Record vital signs in patient’s binder
Step 3: During provider appointment—Primary Care Provider
- Review labs with patient
- Review diabetes self-management goals
- Give instructions to patient
- Give verbal orders to CES on how to improve the health of the patient

Step 4: After provider appointment—CES
- Record labs in patient’s binder
- Provide basic DSME based on goals/needs
- Review goals developed with provider
- Develop short-term objectives based on goals
- Invite and sign patient up for DSME classes
- Invite and sign patient up for DSMS groups
- Sign patient up to receive a free glucose monitor, if needed
- Document the education conducted with the patient and any other relevant notes in the EMR

iii. Lessons Learned from the *Mi Salud Es Primero* Program

Although the path toward integrating CHWs into the PCMH model will vary depending on the program and context, this project has provided some lessons learned about the critical elements that will be essential for organizations to consider.

**Infrastructure**

While infrastructure and organizational change are challenging, a well-integrated team has first and foremost established buy-in from leadership. At Alivio, both the CEO and the Medical Director were committed to this program and believed in the unique contribution and increased effectiveness that the CES could provide to the clinical team. Leaders should take mindful actions to carve out ways to build camaraderie among the team and consistently communicate that the CHWs are essential to the team.

Another key component of successfully integrating CES into the clinical team was providing them with access to the electronic medical records. This helped increase coordination of service delivery and communication between the CES and the provider. For example, the CES were able to review patient test results and write notes to the provider about the progress of the patient.

Initially, there was a lack of trust between the providers and the CES. Because the providers did not fully understand the role of the CES, there was hesitancy in referring their patients to the CES. Once they realized that the CES were providing vital information about patients that may otherwise remain unknown to the provider, there was an increase in referrals to the CES. When the patient saw the provider and the CES working together, it increased respect between the patient and the CES.

**Workflow**

The definition of staff roles and responsibilities for all members of the team is integral to harmony and efficiency. This includes establishing a clear workflow for CES within clinical settings, ensuring that all members of the team are aware of specific roles and responsibilities through meetings and organizational communication, and having the CES spend as much time as possible in the clinical area prior to the full integration. Ultimately, CES were seen as professional colleagues by team members.
Furthermore, including CES in the planning and implementation process greatly helped to overcome barriers to serving the target population, thereby facilitating and reducing the overall workload of the rest of the clinical care team.

**Supervisor and support of CES**
It was essential to have a supervisor for the CES. This person oversaw the day-to-day work of the CES, was a champion for them with the leadership team, and provided them with necessary back-up support including team-building activities, therapy sessions, and one-on-one meetings.

**Sustainability**
Without a payment model to fund these services, the CES at Alivio were not sustained beyond the grant period. Only two of the nine CES were able to subsequently get jobs as care coordinators at Alivio. The remaining CES, unfortunately, have had to look for another job. To make the business case that this type of program saves money, improves health outcomes, and increases quality of health care, it is critical that evaluation results be presented back to the clinical team throughout the project period as well as at the end.
VII. MANAGEMENT OF COMPAÑEROS EN SALUD

i. Supervision, backup, and ongoing support

The Project Manager and Project Coordinator were responsible for direct oversight of the peer support program at Alivio. While the Project Manager was responsible for the program as a whole, the Project Coordinator was responsible for managing and supervising the CES.

The Project Manager and Project Coordinator held weekly meetings with all CES in order to:

- Ensure the program was being implemented as planned
- Be updated on how the CES were providing support to the patients
- Address any concerns the CES had in providing support, including decision-making around when to engage backup providers such as the CDE, a nurse, or a physician
- Reinforce and practice skills for providing support
- Identify areas for program improvement
- Provide the opportunity for CES to offer support to one another

In addition to the weekly group meetings, the Project Coordinator met 1:1 with each CES weekly during the first six months and then monthly for the remainder of the project period. These meetings lasted for about one hour and included role-playing, goal setting, and identification of community resources that were available and pertinent to the needs of their patients. The CES were responsible for submitting a summary report of their monthly patient contacts to the Project Coordinator. The Project Coordinator reviewed these reports and reconciled them with the information entered in the CES Access Database. Then, during the 1:1 meetings, the CES and Project Coordinator discussed progress made, addressed any challenges the CES was facing, and identified strategies for problem-solving and areas for improvement.

The Project Manager’s and Project Coordinator’s offices were co-located in the same general area as the desks for the CES. Both the Project Manager and Project Coordinator maintained an open door policy and the CES were encouraged to seek them out if they needed assistance in any way. Appreciation dinners and regular outings for the CES were held to boost morale and to team-build. In addition, the CES received back-up support via therapy sessions, stress management workshops, group support meetings, and a walking group during lunch.

As a result, the retention rate among the CES was relatively high. Only two CES left during the implementation period of the project.

ii. Personnel Evaluation

The CES participate in annual performance reviews as per Alivio Medical Center’s human resources policy. Each CES completed a self-evaluation, and then their supervisor, the Project Coordinator, provided a written evaluation. Then, the CES and Project Coordinator met to discuss both of the evaluations, address any discrepancies, and identify areas for improvement.
VIII. EVALUATION OF PROGRAM

The *Mi Salud Es Primero* program was a closely monitored demonstration project designed to develop best practices and effective tools and resources for the integration of peer support and community outreach with primary care PCMH resources. During implementation, the program team engaged in continuous quality improvement measures to assess patient engagement and changes introduced by the program. An evaluation to assess program outcomes and organizational success factors was conducted by Peers for Progress and NCLR at the conclusion of the program.

i. **Continuous quality improvement**

The program utilized rapid cycle quality improvement methods such as the **PDSA cycle** or Plan-Do-Study-Act, to test changes and make program improvements during the implementation period. In addition, the program team developed project-specific tools in order to effectively perform quality improvement efforts.

ii. **Patient Engagement**

In order to manage the population of patients being engaged by the CES, program partners from Peers for Progress, NCLR, and TransforMED worked with Alivio program staff to develop tools for documenting, tracking, and monitoring peer support encounters. The Assessment Form (see Appendix F) and the Contact Note (see Appendix G) were developed collaboratively by the program team with substantial input from the CES. The program team developed a database in MS Access which mirrored the Contact Note. The Project Manager and Project Coordinator trained the CES to enter the information they recorded on the Contact Note into the program database. With feedback from the CES, the program team designed a Program Monitoring Report (see Appendix I) which summarized data from the program database. The report was reviewed monthly by the *Mi Salud Es Primero* program team and program partners.

The Program Monitoring Report served as a “dashboard” and enabled the *Mi Salud Es Primero* program team to look at a visual representation of the population being reached out to by the CES and categorized them as **active** (reached by CES and engaged with program), **inactive** (reached by CES but not yet actively engaged with the program) or **unreached** (not yet reached by CES). The report also showed the numbers of patients engaged by level of intensity (biweekly, monthly, and quarterly) as well as the number of successful peer support contacts completed and the corresponding number of patients to which that applied. This information helped the *Mi Salud Es Primero* Project Manager and Project Coordinator to fine-tune the program and focus the CES’ efforts where they were most needed.

iii. **CES–Care Team Integration Model**

The program staff tested linkages to the care team model by: 1) defining what a successful change would look like, 2) performing the tasks needed to establish the linkages, 3) reviewing those changes with the program team and obtaining feedback from providers and others as needed, and 4) making adjustments as necessary to improve the linkage or communication. This PDSA cycle approach was utilized in weekly *Mi Salud Es Primero* staff meetings with the Project Manager, the Project Coordinator, and the CES. The Project Manager also met regularly (biweekly, monthly, or as
needed) with providers such as the CDE, lead diabetes physicians, and, when needed, the Medical Director. These ongoing quality improvement meetings provided ample opportunity for problem-solving and addressed any other concerns that arose about integration.

iv. Program Evaluation

Program staff at Peers for Progress and NCLR developed an evaluation plan to assess improvements in patient outcomes, increased access to and utilization of routine care, and organizational success factors for integration of peer support and community outreach with primary care services. The evaluation plan consisted of an integration of information from various sources including program records, Alivio’s electronic medical records (EMR), structured telephone interviews with patients in the High-Need group, semi-structured interviews with Alivio administration, staff, providers, and CES, and data from the CES Contact Note database. Below is an outline of the evaluation plan including the source or instrument used to obtain the information.

a. Program implementation—documentation of development and implementation of key program features [Source: program records]

b. Engagement of target population—documentation of engagement in key program features (CES contacts, DSME classes, support groups, etc.) [Source: Mi Salud Es Primero program database, program records, and EMR reports]

c. Clinical status indicators—glycated hemoglobin (HbA1c), blood pressure, cholesterol, body weight, recommended tests (eye examinations, foot examinations) [Source: EMR reports]

d. Diabetes self-management—medication adherence, physical activity, healthy diet, tobacco use, glucose testing, foot care, dental care, and sleep quality [Source: patient telephone interviews conducted during both years of program]

e. Quality of Life—general and diabetes-specific quality of life, depression [Source: patient telephone interviews conducted during both years of program]

f. Mediators and Moderators of Peer Support—assessment of utility of peer support program by participants; health literacy; availability and satisfaction with diabetes support from family and friends and health care team; and non-directive vs. directive support from peer supporters [Source: patient telephone interviews conducted during both years of program]

g. Organizational Success Factors—identification of factors within and among PCMHs, community, and organizations that are critical to the successful deployment of peer supporters, integration of their work with clinical care, feasibility, and sustainability. [Source: key informant telephone interviews with Alivio administration, providers, staff, and CES]

v. Organizational Success Factors

Program staff at Peers for Progress developed survey instruments to assess organizational success factors for integration of peer support services with the following goals:

1) Understand how Alivio integrated peer support resources with clinical services and qualified for PCMH status (e.g., resources needed, leadership/persons involved, feasibility)

2) Identify key organizational success factors that influenced integration of peer support resources and PCMH qualification—as well as factors that hindered change.
3) Identify the value as well as downsides of a) peer support integration, b) PCMH (for patients, providers, and organizations) and c) peer support integration AND PCMH (for patients, providers, and organizations)

Program staff developed four separate guides to tailor the interviews to non-clinical staff/administration, clinical providers, program staff (Project Manager, Project Coordinator), and CES. See Appendix J for the Guide for Key Informant Interviews for the clinical providers and the CES.
IX. REFERENCES


Appendix A: Job Description

Compañero/a en Salud Job Description

Reports to: Mi Salud es Primero Coord.          Program: Peers for Progress
Classification: Exempt                         Date: July 2013

SUMMARY: In an effort to meet the Healthy People 2020 diabetes-related goal to reduce the disease and economic burden of diabetes mellitus (DM) and improve the quality of life for all persons who have, or are at risk for, DM, the Peers for Progress Compañero/a en Salud position requires someone who can work independently and as part of a multidisciplinary team to help patients with diabetes manage complicated health issues. This position involves providing practical, social and emotional support. Help patients manage diabetes through individual and group diabetes education; manage a caseload of patients; encourage the use of and linking to other clinic and community resources; coordination of services and referrals; provide ongoing follow-up and support; participating in community education and outreach events, and completing data reports. An ideal candidate must have strong bilingual (Spanish and English) oral communication skills and could communicate effectively with patients, health care providers and community members. The Peers for Progress Compañero/a en Salud works closely with other Compañero/as en Salud, Peers for Progress Coordinator, Peers for Progress Manager clinical staff and other members of the health center to implement a variety of diabetes education and services with the goal of making Alivio Medical Center a Patient Centered Medical Home.

TO PERFORM THIS JOB SUCCESSFULLY, AN INDIVIDUAL MUST BE ABLE TO PERFORM EACH ESSENTIAL DUTY SATISFACTORY. THE REQUIREMENTS LISTED BELOW ARE REPRESENTATIVE OF THE KNOWLEDGE, SKILL, AND/ORABILITY REQUIRED. REASONABLE ACCOMMODATIONS MAY BE MADE TO ENABLE INDIVIDUALS WITH DISABILITIES TO PERFORM THE ESSENTIAL FUNCTIONS.

ESSENTIAL DUTIES AND RESPONSIBILITIES:

1. Team member:
   • Active member of a multi-disciplinary team that takes a holistic approach at improving the health outcomes of patients with diabetes.
   • Works with other members of Alivio Medical Center staff to plan and implement individualized care and services to patients with diabetes.
   • Act as liaison between patients and Providers to obtain glucose meters and testing strips, medications, referrals for lab tests, eye exams, mental health and other relevant services.
   • Participates in internal and community meetings as assigned.
   • Communicate regularly with Peers for Progress Coordinator on progress and barriers to effective services.

2. Case management:
   • Manage a caseload of patients with diabetes through the provision of ongoing follow-up and support through proactive contact provided on a routine basis and as needed as much as possible at the convenience of the patients.
   • Work with these patients to improve health outcomes, reduce barriers to diabetes self-management, completion of referrals, medication adherence and appointment compliance.
   • Able to motivate patients to develop individualized diabetes self-management plans with realistic goals, engage in behavior change and take a proactive role in their health by accessing needed services and/or advocating for themselves.
• Able to regularly assess progress on the goals and motivate patients to meet those goals through a system of referrals, follow-up and individual support.
• Implement effective monitoring of individual and family behavioral changes.

3. **Systems navigation:**
• Help patients effectively engage in clinical services through the navigation of the clinic/health care system, informing them of diabetes standards of medical care and preparing for and debriefing after medical visits.
• Encourage use of, provide referrals to, and ensure effective access to a broad array of local community resources to ensure barriers to diabetes management are addressed.
• Advocate effectively so that clients receive needed services in a timely fashion, while understanding reasonable limits.

4. **Record Keeping and Reporting:**
• Maintain documentation in order to prepare monthly reports and track productivity.

5. **Diabetes Self-Management Education and Support:**
• Provision of social and emotional support through encouragement, nurturing social/family networks; support with coping skills, stress, and depression.
• Assist patients with identifying barriers to effective diabetes self-management and the development of personal problem-solving skills.
• Speak and present information effectively. Conduct culturally appropriate group and one-on-one education with patients related to diabetes management, nutrition, and physical activity, psychosocial adjustment, following the medical care plan, and enhancing communication with medical provider. Select and recommend appropriate educational materials. Promotes and provide approved, culturally appropriate interventions.

6. **Community Outreach:**
• Participate in community outreach, education and diabetes screening at events including health fairs and community presentations.

7. **Additional Responsibilities**
• Complete full orientation/training program and participate in continuing education
• Other duties as assigned.

**SPECIAL SKILLS AND ABILITIES REQUIRED:**
8. Able to strongly embrace and personify the mission of Alivio.
9. Able to contribute to and support the Patient Centered Medical Home model at Alivio Medical Center.
10. Able to manage time, set priorities, work independently as well as an effectively in a team.
11. Have understanding and knowledge of population and community of service area. Strong commitment to serve the targeted community areas
12. Adapt outreach strategies based on population, venue, behavior or identified risks that are appropriate to a given population and its self-determined concerns
13. Strong communication and organizational skills. Engage clients in ways that establish trust and rapport with them and their families, including providing a non-judgmental atmosphere during interactions.
14. Use communication strategies and direct service methods that acknowledge the dignity of cultural traditions, even if some changes are suggested.
15. Provide information about indicators of risky behavior and signs of possible health/behavioral problems in a manner that allows clients and families to face current or potential problems with minimal fear and avoidance.

16. Able to help clients identify their own strengths and problem-solving abilities through motivational interviewing techniques (open-ended questions, reflective listening, positive reinforcement, etc.)

17. Describe and document community needs and assets so that clients and service providers can make use of the full range of information necessary to evaluate community issues and to plan for appropriate effective responses at collective as well as individual levels

18. Must be highly motivated, self-initiated, and flexible.

19. Computer knowledge necessary: Microsoft Office suites and internet navigation

20. Willing to do home visits

21. Prepare to work evenings, Saturdays & Sundays.

SUPERVISORY RESPONSIBILITIES:
Manages and supervises staff listed below, including hiring, training, evaluating and managing performance to meet departmental efficiency and performance measures in keeping with the Union Collective Bargaining Agreement (CBA), Personnel Policies and Procedures and prevailing employment laws as appropriate.

• None

KEY INTERRELATIONSHIPS:
Senior Health Promoter, Compañeros en Salud Manager, Peers for Progress Coordinator, Diabetes Data Specialist, Certified Diabetes Educator, Medical Providers, Registered Dietitian and community partners

WORKING CONDITIONS:
OSHA Category 2 – Involves no regular exposure to blood, body fluids, or tissues, but may require unplanned tasks that involve exposure to blood, body fluids, or tissues.

QUALIFICATIONS:
Education: H.S. Diploma or GED
Licensure: N/A
Experience: One year minimum of community involvement work. Experience working with people with diabetes
Special Training: Knowledge of or experience working in the Latino community. Completion of the Compañeros en Salud training, Electronic Medical Records, Motivational Interviewing and other trainings as necessary
Demonstrated Competencies: Proficient in Spanish and English. Excellent communication skills, especially written and public speaking. Excellent team member. Able to manage time and set priorities. Strong communication & organizational skill. Computer knowledge necessary: Microsoft Office suites and internet. Must be highly motivated, self-initiated, and flexible; prepare to work evenings, Saturdays & Sundays.

Prepared by: Juana Ballesteros, Peers for Progress Coordinator

EXECUTIVE MANAGEMENT REVIEW:
Appendix B: Diabetes Management Provider Referral Form

Diabetes Management Provider Referral Form

Patient Name: _________ DOB: _____ MR# _________ Date: _______

Provider Required-
Diabetes Diagnosis:
□ Type one  □ Type 2  □ Gestational  □ Pre-existing Diabetes/Pregnancy  □ Pre-Diabetes

◊ Does patient have clearance to exercise?  □ YES  □ NO
◊ Exercise restrictions: _______________________

Management Training Recommended:
□ Comprehensive Diabetes Management Skills Group Class
□ Comprehensive Diabetes Management 1:1 for Type 1, Type 2 or GDM
□ Insulin Instruction, 1:1
□ Self Blood Glucose Monitoring, 1:1
□ Nutritional Counseling for Pre-Diabetes, 1:1

Reasons for Referral:
□ New Dx, Type 2 or GDM  □ Persistently Elevated Blood Sugars/HbA1c
□ Recurrent Hypoglycemia  □ Weight Loss in Diabetes/Pre-Diabetes

Existing Barriers that challenge patient’s diabetes management:
□ History of non-adherence to medical regimen
□ Visual/Hearing impairment
□ Impaired Mobility/Dexterity
□ Low Literacy
□ Mental Health
□ Other: _______________________

Provider Signature: ______________________________

Other Data:

Labs/Date: __________
FBS, 1 hr. or 3 hr. GTT: ______________________
HbA1c: ______
Cholesterol: ______
Triglycerides: ______
LDL: ______
HDL: ______
Urine Microalbumin: ______

Medications: ____________________________________________________
Appendix C: Patient Engagement Letter in English and Spanish

Dear: _______________________________  Date: ____/____/_____

At Alivio Medical Center, we are dedicated to your health and wellness.

Your medical provider referred you to the diabetes program “My Health Comes First”. The program offers completely free services for the care and control of diabetes so that you may have a better quality of life.

Below you will find the reason for why this letter was mailed to you. Please respond as soon as possible, and please remember that your health is very important to us.

☐ I have not been able to contact you at the following phone number: _______________
☐ You need to attend group classes on Diabetes Control.
☐ You missed your appointment to receive a glucose monitor and instructions how to use it.
☐ _______________________________

Please call as soon as possible the following telephone number: _____________

Sincerely,
_________________________________
Your Partner in Health and Diabetes Educator

Estimado (a): _______________________________  Fecha: ____/____/_____

En el Centro Medico Alivio, estamos comprometidos con su salud y bienestar. Su médico lo refirió al Programa ¡Mi Salud es Primero! En donde usted recibirá sin costo alguno los servicios necesarios para el cuidado y control de la diabetes para que usted tenga una mejor calidad de vida.

En la parte de abajo aparece el motivo por el cual se le ha enviado esta carta. Por favor conteste lo más pronto posible y recuerde, su salud es muy importante para nosotros.

☐ No me ha sido posible contactarlo en este teléfono: _______________
☐ Necesita asistir a las Clases de Control de Diabetes.
☐ Faltó a la entrega e instrucción del monitor de glucosa.
☐ _______________________________

Por favor comuníquese lo más pronto posible al teléfono:______________________________

Sinceramente,
_________________________________
Su Compañero en Salud y Educador de Diabetes
Appendix E: Descriptive Protocols for High-Need and Regular-Care Patients

A. Protocol for High-Need Group

Support services for patients in the high-need group are broken up into three levels of intensity: high, moderate, and low intensity.

- **High Intensity**: Contacts with patients are every two weeks for at least six contacts (12 weeks).

- **Moderate Intensity**: Contacts with patients are once a month for three months. Patients will be moved into Low Intensity after at least three months of being in Moderate Intensity and after at least three support contacts.

- **Low Intensity**: Contacts with patients are quarterly, or every three months. Patients will remain in Low Intensity as long as the patient is not experiencing emotional, social, or economic difficulties that caused the patient to call the CES for support.

a. High-Need—High Intensity

Contacts with patients are every two weeks for at least six contacts (12 weeks). Patients will move into the Moderate Intensity level at the discretion of the CES and in consultation with the Program Coordinator.

*Before the initial contact with a patient, the CES should do the following:*
1. Check the EMR for all the phone numbers on file for that patient.
2. Check EMR for next appointment with Primary Care Provider.
3. Check date and level of last HbA1c.

*At the first substantive contact with a patient, the CES should do the following:*
1. Build general rapport by getting to know each other and informing the patient about the program.
   CES were advised not to push the patient to accept participating in the program.

*Once the patient is engaged and has gained confidence with the CES, the CES should do the following:*
1. Check in with the patient regarding challenges posed by diabetes such as family stress, difficulties staying motivated, feeling discouraged, etc.
2. Identify areas in which the patient would like assistance from the CES.
3. Fill out the 1) Assessment Form and 2) Contact Note Form.
4. CES will make an appointment to schedule the 2nd contact, by phone or in-person, with the patient.
5. See Appendix F for a copy of the Assessment Form

*After the first substantive contact, every time a patient is contacted, the CES will try to cover the following:*
1. Check in with patient regarding challenges posed by diabetes such as family stress, difficulties staying motivated, feeling discouraged, new developments in their life, new concerns or questions, etc.
2. Provide general support (emotional support, encouragement, motivational support).
3. Identify personal needs. These are areas in which the patient would like assistance from the CES. They may include: glucose monitor instruction and discount card, prescription assistance program, employment, childcare, legal, economic and referrals to services as needed.
4. Discuss self-management tips:
   a. Explain or review the 7 diabetes self-management key behaviors; patient will receive diabetes basic information, healthy eating for diabetes patients.
   b. Support the patient in identifying the self-management key behavior they are most interested in working on.
   c. Set a new goal and review previous goals set by patient.
5. Ideally each patient participates in the DSME classes. If patients are not able to participate in the DSME classes they will still receive the information during individual support contacts.
6. CES, per their training, will notify the Project Coordinator of any cases that they may not be able to handle and that might need the attention of a provider.
7. A Contact Note form will be filled out after:
   a. Every contact attempt
   b. If a patient is not reached after an initial attempt, all future attempts for a total of three, are noted in the same Contact Note. If after three attempts the patient is not reached a letter is mailed. This is also noted in the Contact Note.
   c. Every successful support-related contact with a patient. This means that the CES reached the patient and had a substantive discussion (support, information, referral) with her or him that lasts longer than 5 minutes.
      7. CES should NOT fill out a Contact Note for calls for reminders for classes or appointments with providers.
   8. See Appendix G for a copy of the Contact Note form.

b. High-Need—Moderate Intensity

Contacts with patients are once a month for three months. Additional contacts are at the option of the patient or at the CES’s discretion.

CES will attempt to cover the following during support contacts:

I. Review the 7 diabetes self-management key behaviors
II. Support patient in identifying the next self-management key behavior they will develop self-management goals for
III. The CES will review with patient previous goals that were set and/or assist patient in setting new goals.
IV. Support can be provided in any of the following methods:
   a. Problem solving
   b. Emotional support
   c. Encouragement and motivational support
   d. Referrals as needed (housing, food pantry, behavioral health, medical care appointment, etc.)
V. Ensure that the patient has a glucometer, testing strips, all the medications prescribed to the patient by his/her medical provider(s), and the next appointment with primary care provider scheduled
VI. Further discussion of areas in which patient would like assistance from CES
VII. If patient has not attended DSME group classes, the CES will encourage patient to attend.
VIII. If patients require more than the minimum monthly support contacts, more will be conducted as needed.

Patients will be moved out of Moderate Intensity into Low Intensity as long as:
- There are NO pressing psychosocial problems currently present AND
- Their depression assessment (PHQ-9) is not elevated
NOTE: The PHQ-9 is a brief and useful instrument for screening, diagnosing, monitoring and measuring the severity of depression. A protocol was developed for CES to administer the PHQ-9 with diabetes patients who needed to be assessed. Click this link to access the PHQ-9 Manual in English. Click this link for a copy of the script in English and Spanish. If the CES determined that a patient might be depressed, they made a referral to Behavioral Health.

c. High-Need—Low Intensity

Contacts with patients are quarterly, every three months. Patients will remain in Low Intensity as long as patient is not experiencing:

- the PHQ-9 is NOT elevated AND
- there are NO pressing psychosocial problems currently present

If a patient is experiencing any of these then the patient will be moved to either Moderate or High Intensity. This decision will be made in consultation with the Program Coordinator.

CES will attempt to cover the following during support contacts:

I. Review the 7 diabetes self-management key behaviors
II. Support patient in identifying the next self-management key behavior they will develop self-management goals for
III. The CES will review with patient previous goals that were set and/or assist patient in setting new goals.
IV. Support can be provided in any of the following methods:
   a. Problem solving
   b. Emotional support
   c. Encouragement and motivational support
   d. Referrals as needed (housing, food pantry, behavioral health, medical care appointment, etc.)
V. Ensure that the patient has a glucometer, testing strips, all the medications prescribed to the patient by his/her medical provider(s), and the next appointment with primary care provider scheduled
VI. Further discussion of areas in which patient would like assistance from CES
VII. If patient has not attended DSME group classes, the CES will encourage patient to attend.
VIII. If more than quarterly support contacts are necessary, the CES will inform the patient when the project concludes.

IX. Approximately 4-6 months before the project concludes, the CES will inform the patient when the project concludes.
   o Before the project concludes, CES must ensure the patient has the following:
     - Glucometer
     - Testing strips
     - All the medications prescribed to the patient by his/her medical provider(s)
     - Next appointment with primary care provider scheduled

B. Protocol for Regular-Care Patients

Patients will be contacted within two weeks after referral is received or they have been identified for the regular-care group by the Program Coordinator.

Before calling a patient for the first time, the CES will:

- Check the EMR for all the phone numbers on file for that patient
- Check EMR for next appointment with Primary Care Provider
- Check date and level of last HbA1c
CES will attempt to cover the following during support contacts:
1. Patient will be informed about the purpose of the phone call. If patient was referred directly by a provider then contact will address the patient needs identified in the referral.
2. All patients will be invited to attend the DSME group classes.
3. All patients will be informed about other clinic services.
4. A Contact Note will be filled out after every attempt to contact and actual contact with a patient.
5. Services for the regular-care group will be the same during all phases until the end of the program.
6. All patients will be contacted quarterly by CES to discuss progress, status, need for services, and invite them to DSME and DSMS groups. More frequent contacts can be made based on support needs of patient. A patient can initiate contacts at any time.
<table>
<thead>
<tr>
<th><strong>EVALUACION INICIAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INFORMACION DEL PACIENTE</strong></td>
</tr>
<tr>
<td>Nombre:</td>
</tr>
<tr>
<td>Fecha de Nacimiento:</td>
</tr>
<tr>
<td>Direccion:</td>
</tr>
<tr>
<td>Seguro Médico: ☐SI ☐NO Tipo:</td>
</tr>
</tbody>
</table>

1. Nombre de Contacto de Emergencia y Relación: Teléfono:
2. Nombre de Contacto de Emergencia y Relación: Teléfono:

1. Proveedor de Salud: Clínica:
2. Proveedor de Salud:

### ANTECEDENTES SOCIOECONOMICOS Y CULTURALES

<table>
<thead>
<tr>
<th><strong>Nivel</strong></th>
<th><strong>Descripción</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Origen Étnico:</td>
<td>☐Hispano ☐Caucásico ☐Africano-Americano ☐Americano ☐Indígena Nativo ☐Asiático ☐Otro</td>
</tr>
<tr>
<td>Estado Civil:</td>
<td>☐Soltero ☐Casado ☐Divorciado ☐Unión Libre ☐Viudo ☐Otro</td>
</tr>
<tr>
<td>Lenguaje que prefiere:</td>
<td>☐No lee-escribe ☐Lee y escribe ☐Primaria ☐Secundaria ☐Preparatoria ☐Universidad</td>
</tr>
<tr>
<td>Educación:</td>
<td>☐No</td>
</tr>
<tr>
<td>Ocupación Actual:</td>
<td>☐Empleado ☐Desempleado ☐Deshabilitado ☐Retirado</td>
</tr>
<tr>
<td>Vivienda:</td>
<td>☐Propia ☐Hipoteca ☐Rentada ☐Con familia ☐Albergue ☐NO</td>
</tr>
</tbody>
</table>

# Personas que viven con usted: ______ # De Personas que trabajan: ☐Nadie

¿Está de acuerdo en compartir información con sus familiares: ☐Sí ☐No ☐Solo con: ____________

### ANTECEDENTES PERSONALES

¿Alguien más en su familia tiene diabetes? ☐NO ☐Sí ¿Quién?: ____________

¿A usted cuando lo diagnosticado con Diabetes? ☐_____Años ☐Recién diagnosticado < 3 meses

Tratamiento Actual: ☐Con Tx Médico pero no lo toma ☐Medicamentos orales
☐MO + Insulina ☐Solo Insulina ☐Otro

¿Le ha dicho su Doctor si tiene o tuvo alguno de los siguientes Problemas?

<table>
<thead>
<tr>
<th><strong>Problema</strong></th>
<th><strong>Descripción</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Presión Arterial Elevada</td>
<td>☐NO ☐Sí ☐Colesterol Elevado ☐NO ☐Sí</td>
</tr>
<tr>
<td>Problemas en la visión</td>
<td>☐NO ☐Sí ☐Problemas en el oído ☐NO ☐Sí</td>
</tr>
<tr>
<td>Diabetes Gestacional</td>
<td>☐NO ☐Sí ☐Infarto o Derrame cerebral ☐NO ☐Sí</td>
</tr>
<tr>
<td>Complicaciones por la Diabetes</td>
<td>☐NO ☐Sí ☐¿Cuál?</td>
</tr>
</tbody>
</table>

### NIVELES DE CONTROL

Conoce sus últimos niveles de: ☐NO ☐Sí ¿Cuál es? Le han realizado algún examen de:

<table>
<thead>
<tr>
<th><strong>Nivel</strong></th>
<th><strong>Descripción</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucosa</td>
<td>☐NO ☐Sí ☐Visual</td>
</tr>
<tr>
<td>Hemoglobina A1c</td>
<td>☐NO ☐Sí ☐Pies</td>
</tr>
<tr>
<td>Presión Arterial</td>
<td>☐NO ☐Sí ☐Riñón</td>
</tr>
<tr>
<td>Colesterol</td>
<td>☐NO ☐Sí ☐Dental</td>
</tr>
<tr>
<td>Triglicéridos</td>
<td>☐NO ☐Sí ☐Mental:</td>
</tr>
<tr>
<td>Otros</td>
<td>☐NO ☐Sí</td>
</tr>
</tbody>
</table>

Fuma ☐Sí ☐YA NO ☐Nunca Tipo /día /semana /mes Desde cuando:

Alcohol ☐Sí ☐YA NO ☐Nunca Tipo /día /semana /mes Desde cuando:
### ACTIVIDAD FÍSICA

<table>
<thead>
<tr>
<th>Realiza Actividad Física</th>
<th>NO</th>
<th>SI</th>
<th>Cuanto: _____ minutos/día o _____ días / semana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tipo:</td>
<td>Caminar</td>
<td>Correr</td>
<td>Bicicleta</td>
</tr>
<tr>
<td>Necesita algún equipo especial:</td>
<td>NO</td>
<td>SI</td>
<td>Calzado Especial</td>
</tr>
</tbody>
</table>

### HISTORIA DE EDUCACION EN DIABETES

<table>
<thead>
<tr>
<th>Ha recibido educación en diabetes antes:</th>
<th>NO</th>
<th>SI</th>
<th>Cuando:</th>
<th>Donde:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ha recibido educación nutricional antes:</td>
<td>NO</td>
<td>SI</td>
<td>Cuando:</td>
<td>Donde:</td>
</tr>
<tr>
<td>Tiene Monitor de Glucosa en casa:</td>
<td>NO</td>
<td>SI</td>
<td>Tipo:</td>
<td></td>
</tr>
<tr>
<td>Checa su Glucosa:</td>
<td>SI</td>
<td>_____/día</td>
<td>_____/semana</td>
<td>NO</td>
</tr>
</tbody>
</table>

### ¿Sabe identificar un episodio de HIPOGLUCEMIA e HIPERGLUCEMIA? | SI | NO

### ¿Sabe qué hacer para controlar estos episodios? | NO | SI

### HISTORIA DE ALIMENTACION

<table>
<thead>
<tr>
<th>¿Ha cambiado su peso en los últimos 6 meses?</th>
<th>NO</th>
<th>SI</th>
<th>_____/mes</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Ha recibido algún plan de alimentación por un RD-CDE?</td>
<td>NO</td>
<td>SI</td>
<td>Cuando:</td>
</tr>
<tr>
<td>¿Sigue alguna dieta especial?</td>
<td>NO</td>
<td>SI</td>
<td></td>
</tr>
<tr>
<td>¿Además de sus medicamentos toma algún suplemento alimenticio?</td>
<td>NO</td>
<td>SI</td>
<td>Vitaminas</td>
</tr>
<tr>
<td>¿Es usted quien prepara la comida en su hogar?</td>
<td>NO</td>
<td>SI</td>
<td>Esposa</td>
</tr>
<tr>
<td>¿Es usted quien decide qué alimentos llevar a casa?</td>
<td>NO</td>
<td>SI</td>
<td>Esposa</td>
</tr>
<tr>
<td>¿Come fuera de casa?</td>
<td>NO</td>
<td>SI</td>
<td>_____/semana</td>
</tr>
</tbody>
</table>

### VIVIENDO CON DIABETES

<table>
<thead>
<tr>
<th>¿Cómo se siente al vivir con diabetes?</th>
<th>Indiferente</th>
<th>Enojado</th>
<th>Cansado</th>
<th>Culpable</th>
<th>Ansioso - Preocupado</th>
<th>Frustrado</th>
<th>Deprimido</th>
<th>En Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Cómo lo hace sentir el esfuerzo constante que hace para controlar la diabetes?</td>
<td>Indiferente</td>
<td>Enojado</td>
<td>Cansado</td>
<td>Culpable</td>
<td>Ansioso - Preocupado</td>
<td>Frustrado</td>
<td>Deprimido</td>
<td>En Control</td>
</tr>
</tbody>
</table>

### BARRERAS PARA EL CONTROL DE LA DIABETES

<table>
<thead>
<tr>
<th>¿Qué tan interesado esta en recibir información y apoyo para mejorar el manejo y control de la diabetes?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>MUY Interesado</th>
</tr>
</thead>
<tbody>
<tr>
<td>¿Qué le gustaría cambiar para comenzar a controlar la diabetes?</td>
<td>Alimentación</td>
<td>Actividad física</td>
<td>Medicamentos</td>
<td>Recibir información</td>
<td>Constancia en citas medicas</td>
<td>Otro:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Cuáles son algunas de las barreras qué le dificultan controlar la diabetes?</td>
<td>Falta de información</td>
<td>Idioma</td>
<td>Finanzas</td>
<td>Alimentación</td>
<td>Cultura</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dificultad para ver</td>
<td>Dificultad para oír</td>
<td>Dificultad para leer</td>
<td>Horarios de clínica</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No hay buena comunicación con Médico</td>
<td>No tiene apoyo de la familia</td>
<td>Otro:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¿Qué tan motivado se siente para hacer cambios?</td>
<td>SIN Motivación</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>¿Qué tan confiado se siente para hacer esos cambios?</td>
<td>SIN Confianza</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>
## Appendix G: Contact Note

### CES-CONTACT NOTE

<table>
<thead>
<tr>
<th>Patient Name: 2)</th>
<th>Patient ID #: 3)</th>
<th>Date: 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of contact: 1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Current group:
- [ ] high-need group 6)
- [ ] regular-care group 7)

### Patient status:
- [ ] Active 8)
- [ ] Inactive 9)
- [ ] Unreached 10)

*Active: Patient is engaged in support activities
Inactive: Patient is being contacted but not actively engaged in support activities
Unreached: Attempts are being made but patient has not been contacted

### Type of contact
- [ ] Phone call 11)
- [ ] In person 12)
- [ ] Support
  - [ ] Group 13)

### Place
- [ ] Clinic 14)
- [ ] Community 15)
- Specify: ____________

### Who initiated the contact
- [ ] Compañero 16)
- [ ] Provider 17)
- [ ] Patient 18)
- [ ] Other 19)
- Specify other: ____________

### Duration
- [ ] < 5 Min 20)
- [ ] 5 to 30 Min 21)
- [ ] >30 Min 22)

### Key behaviors

#### AADE 7 Self-Care Behaviors

<table>
<thead>
<tr>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Glucose monitoring</th>
<th>Medications</th>
<th>adherence</th>
<th>Reducing risks</th>
<th>Problem solving</th>
<th>Healthy coping</th>
<th>Losing 10 pounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>ND= Not discussed 23)</td>
<td>NC= Not considering 26)</td>
<td>C= Considering 27)</td>
<td>P= Planning to do it 28)</td>
<td>DI= Doing it 29)</td>
<td>CSD= Completed and still doing it 30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI= General information discussed 24)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GD= Goal discussed 25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Focus of behaviors discussed

<table>
<thead>
<tr>
<th>Healthy eating</th>
<th>Physical activity</th>
<th>Glucose monitoring</th>
<th>Medications</th>
<th>adherence</th>
<th>Reducing risks</th>
<th>Problem solving</th>
<th>Healthy coping</th>
<th>Losing 10 pounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>ND= Not discussed 23)</td>
<td>NC= Not considering 26)</td>
<td>C= Considering 27)</td>
<td>P= Planning to do it 28)</td>
<td>DI= Doing it 29)</td>
<td>CSD= Completed and still doing it 30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI= General information discussed 24)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>GD= Goal discussed 25)</td>
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### Status of goal/behaviors discussed

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<th>Glucose monitoring</th>
<th>Medications</th>
<th>adherence</th>
<th>Reducing risks</th>
<th>Problem solving</th>
<th>Healthy coping</th>
<th>Losing 10 pounds</th>
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<tbody>
<tr>
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<td>NC= Not considering 26)</td>
<td>NC= Not considering 26)</td>
<td>NC= Not considering 26)</td>
<td>NC= Not considering 26)</td>
<td>NC= Not considering 26)</td>
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<tr>
<td>DI= Doing it 29)</td>
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<td>DI= Doing it 29)</td>
<td>DI= Doing it 29)</td>
<td>DI= Doing it 29)</td>
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</tr>
<tr>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
<td>CSD= Completed and still doing it 30)</td>
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### Support Provided

- [ ] Emotional support 31)
- [ ] Encouragement or motivational support 32)
- [ ] Problem solving 33)
- [ ] New goal(s) set 34)
- [ ] Goal(s) review 35)
- [ ] Glucometer provided 36)
- [ ] Discount card provided 37)
- [ ] Personal needs: 38)
- [ ] Economic (ex: housing, employment) 39)
- [ ] Legal (ex: citizenship) 40)
- [ ] Social and health services (ex: eligibility) 41)
- [ ] Medication support program 42)
- [ ] Filling forms 43)
- [ ] Other: ____________ 44)

### Assistance and Diabetes Self-Management Next Steps

- [ ] To obtain an appointment: ____________ 45)
- [ ] Referral to social services: ____________ 46)
- [ ] Referral to other Alivio programs: ____________ 47)
- [ ] Registered or invited patient to DSME classes 48)
- [ ] Registered or invited patient to DSM Continuing education classes 49)
- [ ] Registered or invited patient to support group 50)

### Contact Attempts

<table>
<thead>
<tr>
<th>#1 Date: 51)</th>
<th>Time: 52) AM/PM</th>
<th>Week day: 53) Mon Tue Wed Thu Fri Sat</th>
<th>Able to contact Pt: 54)</th>
<th>NO 55)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| #2 Date: 60 | Time: AM/PM | Week day: Mon Tue Wed Thu Fri Sat | ☐ Able to contact Pt. ☐ NO
If no: ☐ ☐ No working #
☐ Kept in person ☐ Missed in person |
| #3 Date: 61 | Time: AM/PM | Week day: Mon Tue Wed Thu Fri Sat | ☐ Able to contact Pt. ☐ NO
If no: ☐ ☐ No working #
☐ Kept in person ☐ Missed in person |
| ☐ Letter sent 62 | Date letter sent: ____/____/____ |
| ☐ Unable to contact patients after letter and fourth attempt 64 | |
| ☐ Next support contact 65 | date: ____/____/____ |
| Time: ____:____ | ☐ Patient is willing to participate in UNC evaluation survey 66 |
| Comments: 67 | }

### CES Health Educator:

1. **Number of contact**: Subsequent number of contact
2. **Patient Name**
3. **Patient ID #:** Number provided to patient for program purpose
4. **YOB**: Year of birth
5. **Date**: Date when peer complete the contact form
6. **High-need group**: patient is in high-needs group
7. **Regular-care group**: patient is in regular-care group
8. **Active**: Patient is engaged in support activities
9. **Inactive**: Patient is being contacted but not actively engaged in support activities
10. **Unreached**: Attempts are being made but patient has not been contacted
11. **Phone call**: contact completed by phone
12. **In person**: contact completed in person
13. **Support Group**: contact completed in support group
14. **Clinic**: contact completed in the clinic
15. **Community**: contact completed in the community: health fairs, events, super markets, street, etc.
16. **Compañero**: Peer initiate the contact form
17. **Provider**: PCP initiate the contact form, call directly for peer intervention
18. **Patient**: Patient initiate the contact form
19. **Other**: MA, RN, other staff, patient family member
20. **< 5 min**: call duration less than 5 minutes
21. **5 – 30 min**: call duration between 5 to 30 minutes
22. **> 30 minutes**: call or contact in person duration more than 30 minutes
23) **ND**: Behavior not discussed for information or for goal discussed purpose. Any change in status of behavior discussed

24) **GI**: General information-education provides. Any change in status of behavior discussed

25) **GD**: Goal-behavior change discussed. Based on patient answer status of behavior has to indicated.

Sometimes still has NC: Not considering

26) **NC**: Patient doesn’t consider has a behavior change or goal

27) **C**: Patient is or will consider has a behavior change or goal

28) **P**: Patient is planning a behavior change. * New goal set has to be mark If is the first time

29) **DI**: Patient is doing is goal, but did not completed  * Goal review has to be mark

30) **CSD**: Patient completes his goal and will continue doing. * Goal review has to be mark

31) **Emotional support**: peer provide emotional support to the patient

32) **Encouragement or motivational support**: peer provide encouragement or motivation to continue with Diabetes self-management education and support.

33) **Problem solving**: Peer support or assist patient to solve a problem or barrier. Providing different options or ideas to resolve the problem.

34) **New goal set**: has to be mark when a new goal was planning

35) **Goal review**: Has to be mark when has the patient about the results obtained with his goal

36) **Glucometer provided**: patient received glucometer instruction and a glucose meter

37) **Discount card provided**: patient received discount card to obtain discount in glucose strips

38) **Personal Needs**: Patient asks for help or assistance in some need, question, issue, etc.

39) **Economic needs**: patient need information or assistance in economic situations: housing, employment, bill payments, etc.

40) **Legal**: patient needs information or assistance in legal situation: immigration, foreclosure, bankruptcy...

41) **Social and health services**: Medicare, Medicaid, county care eligibility or status, referral information, referral follow up, specialist services information.

42) **Medication support program**: Patient need information or assistance with Medication Assistance Program application

43) **Filling forms**: patient needs assistance to complete a form or to complete a process, to read a letter, etc.

44) **Other**: patient needs schedule a medical appointment, a medication refill, a glucometer and discount card, etc.

45) **To obtain and apt**: Peer help patient to obtain an appointment with his PCP

46) **Referral to social services**: Peer provides to the patient information about resources in the community, which could help him with his specific situation. Legal services, Nonprofit organizations info, etc.

47) **Referral to other available programs**: Peer helps patient to obtain an appointment or a referral to other available programs: CDE, Behavior health, Domestic Violence, WIC, Financial Department, OYE program.

48) **Registered or invited to DSME Classes**: patient was invited or registered to the DSME classes

49) **Registered or invited to DSME Continuing education classes**: patient was invited or registered to these classes or to some other events.

50) **Registered or invited to DSM Support Groups.**

51) **#1 Date**: date for the first attempt to contact patient

52) **Time**: time for each attempt to contact patient

53) **Week day**: for each attempt to contact patient

54) **Able to contact**: Patient or peer was able to contact by phone, depends in whom initiated the contact.

55) **NO Able to contact**: Patient or peer was not able to contact by phone.
56) **IF NO, Say:** patient or peer leave a voicemail or leave a message with family member or with other peer.

57) **No working:** phone number is disconnected, phone number doesn’t received calls, phone number is temporarily out of the area service.

58) **Kept in person:** patient received support contact in person. Patient show for his support contact in person or patient was reach in person in clinic area.

59) **Missed in person:** patient did not come to his support contact in person.

60) **#2 Date:** Date for the 2nd Attempt

61) **#3 Date:** Date for the 3rd Attempt

62) **Letter sent:** letter was send after 3 attempts, only in the first contact form or when an active patient has phone # disconnect and need receive some information.

63) **#4 Date:** date for the 4th Attempt

64) **Unable to contact patient after 4 attempts:** patient was unable to contacted, sometime is in the #1, #2, #3 attempt that the contact note form is completed, if other person answer the phone and let us know that patient is out of country, no longer live in Chicago, wrong number.

65) **Next support contact:** Date for the next time that peer will attempt to contact patient.

66) **UNC survey:** patient is willing to participate in UNC evaluation

67) **Comments:**
   a. Any peer comment about patient: no longer patient, not interested in program, etc.
   b. other dates that patient was contacted but not necessary long to fill a “contact note form”
   c. remain medical appointment
   d. ask for some information
   e. provided some information that patient ask early same day or other day
   f. Patient Intensity Status: 2) Moderate intensity
   g. Place where patient was reach: Clinic area, INFO TABLE, Health Fair.
Appendix H: Glucometer Checklist

ENTREGA DE GLUCOMETRO

<table>
<thead>
<tr>
<th>Nombre:</th>
<th>Pt ID#:</th>
<th>Fecha:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fecha de Nacimiento:</td>
<td>Edad:</td>
<td>Teléfono:</td>
</tr>
<tr>
<td>Lugar:</td>
<td>Grupo</td>
<td>Feria de Salud</td>
</tr>
</tbody>
</table>

Marque la casilla al terminar cada punto

☐ Entrega de Monitor ☐ Nuevo ☐ Usado Tipo:

☐ Monitor: programación de fecha, hora, etc.

☐ Almacenamiento del monitor

☐ Baterías

☐ Códigos

☐ Dispositivo para lancetas

☐ Lancetas

☐ Tiras de prueba Se entregaron tiras: NO SI Cantidad: ______

☐ Memoria del monitor

☐ Prueba de control de calidad

☐ Limpieza del monitor

☐ Desecho de Lancetas: contenedor apropiado

☐ Demostración de cómo obtener una gota de sangre “poster de los 18 pasos”

☐ Demostración por parte del paciente

☐ Limpieza del área donde se va a pinchar

☐ Preparación de dispositivo de lancetas con la lanceta

☐ Preparación de la tira de prueba en el glucómetro

☐ Obtención de gota de sangre

Aplicación de muestra de sangre en la tira de prueba

Registro de resultados

☐ Tarjeta de descuento Se entregó tarjeta: NO SI

☐ Que hacer en caso que el monitor no funcione, numero de la compañía

☐ Importancia de monitorear los niveles de glucosa en casa

Entregar herramienta “Registro de Niveles en Casa”

Explicación de cómo registrar los niveles que obtenga de los chequeos en casa

☐ Repasar los niveles de control para personas con Diabetes

En ayuno de 70 a 110 mg/dl

☐ Dos horas después de comer Menos de 140 mg/dl

Revisar los niveles que el Proveedor de salud le indicó:
<p>| | |</p>
<table>
<thead>
<tr>
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<td><strong>Herramienta de signos de hipoglucemia</strong></td>
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<td></td>
<td><strong>Que hacer en caso de hipoglucemia.</strong></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td><strong>Hiperglucemia</strong></td>
<td><strong>Herramienta de signos de hipoglucemia</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Que hacer en caso de hipoglucemia.</strong></td>
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**Comentarios del resultado de la demostración del paciente:**

<table>
<thead>
<tr>
<th><strong>Firma del Paciente que recibió las instrucciones y el glucometro</strong></th>
<th><strong>Fecha:</strong></th>
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Appendix I: Progress Monitoring Report

[Bar graphs and pie charts showing data on patient monitoring and contact intensity]
### Monthly Total Number of Successful Contacts

<table>
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<th>Date</th>
<th>400 Group</th>
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<th>Total</th>
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Appendix J: Guide for Key Informant Interviews

Interview Guide for Providers
Integration of clinical services with peer support resources

1. Can you describe how Alivio made the decision to integrate peer support and clinical care?
   a. Can you describe who was involved in this decision?
   b. Can you describe when Alivio began integrating peer support and clinical care?

2. Can you describe the process of integrating clinical services with peer supporters at Alivio?
   a. How was the change communicated throughout the practice setting?
   b. Who led the change effort?
   c. What challenges, if any, did you experience?
      i. Did you anticipate these challenges?
      ii. How have you confronted these challenges?
   d. Were there any strategies or approaches that helped make the transition successful?

3. Can you describe how you work with peer supporters?
   a. Can you walk me through a typical interaction?
   b. Do these interactions occur routinely? What typically prompts the communication?
      i. Is there something that works especially well for facilitating communication?
      ii. Is there anything that can be done differently for facilitating communication?
   c. Do peer supporters use the EMR? What type of information do they access or document in the EMR?
   d. Can you describe the information that you receive from peer supporters?

4. What resources are needed for clinical staff and peer supporters to work together successfully?
   a. What resources do peer supporters need to work successfully in collaboration with clinical staff? (e.g., preparation, training, orientation, etc.)
   b. What resources do you and other clinical staff need to work successfully in collaboration with peer supporters? (e.g., preparation, training, orientation, etc.)

5. How would you describe the value of integrating peer supporters and primary care?
   a. For clinical staff?
      i. Have there been any shifts in workload because of peer supporters?
   b. For patients?
   c. For Alivio?

6. How would you describe any problems, if any, caused by having peer supporters integrated with primary care?
   a. For clinical staff?
   b. For patients?
   c. For Alivio?

7. If another organization were thinking about integrating clinical staff and peer support resources, what advice would you give them?
   **PCMH change process**

8. Can you describe how Alivio made the decision to apply for PCMH?
   a. Can you describe who was involved in this decision?
b. Can you describe when Alivio began applying for PCMH?

10. Can you tell me more about the process of changing into a PCMH?
   a. What challenges, if any, did you experience?
   i. Did you anticipate these challenges?
   ii. How have you confronted these challenges?
   b. Were there any strategies or approaches that helped make the transition successful?
   c. Were there any wins/successes that you noticed while Alivio was changing into a PCMH?

11. How would you describe the value of qualifying for PCMH status?
   a. What is the value for clinical staff?
   b. What is the value for the organization?
   c. What is the value for patients?

12. How would you describe any problems, if any, caused by Alivio being a PCMH?
   a. For clinical staff?
   b. For patients?
   c. For Alivio?

13. What advice would you give to the other Alivio sites that are applying for PCMH status?

Peer Support and PCMH change process
14. Were there any challenges of trying to integrate peer supporters and PCMH at the same time?
   a. If so, can you describe those challenges?
   b. Were there any useful strategies that you can think that helped overcome those challenges?

15. How would you describe the value of integrating peer supporters and PCMH at the same time?
   a. How do peer supporters help PCMH achieve its goals?
   b. Does PCMH help peer supporters be more effective?
   a. Does PCMH help patients discuss diabetes management goals with peer supporters?
   b. Can you describe the value of integrating peer supporters and PCMH at the same time for Alivio?

16. Can you describe what downsides, if any, result from having peer supporters and PCMH integrated?
   a. For staff?
   b. For patients?
   c. For Alivio?

17. What advice would you give to other clinics that are trying to integrate peer supporters and PCMH at the same time?

Interview Guide for CES
Integration of clinical services with peer support resources
1. How do you work with clinical staff, such as doctors and nurses?
   a. Can you walk me through a typical interaction?
   b. Do these interactions occur routinely? What typically prompts the communication?
   i. Is there something that works especially well for facilitating communication?
   ii. Is there anything that can be done differently for facilitating communication?
   c. Do you use the EMR? What type of information do they use or document in the EMR?
   d. Can you describe the type of information that you give to clinical staff?
2. How has the way you work with clinical staff, such as doctors and nurses, changed over the 2 years that you’ve been a CES?
   a. What do you think caused these changes to happen?

3. What resources are needed for peer supporters and clinical staff to work successfully together?
   a. What resources do you need to work successfully in collaboration with clinical staff? (e.g.,
      preparation, training, orientation, etc.)
   b. What resources do clinical staff need to work successfully in collaboration with peer supporters?
      (e.g., preparation, training, orientation, etc.)

4. How would you describe the value of integrating peer supporters and primary care?
   a. For clinical staff?
   b. For patients?
   c. For Alivio?

5. How would you describe any problems, if any, caused by having peer supporters integrated with primary care?
   a. For clinical staff?
   b. For patients?
   c. For Alivio?

6. If another organization were thinking about integrating clinical staff and peer support resources, what advice would you give them?

   **PCMH**

7. What do you know about PCMH?
   a. How did you learn about it?

8. How would you describe the value of PCMH?
   a. What is the value for you as a CES?
   b. What is the value for Alivio?
   c. What is the value for patients?

9. How would you describe any problems, if any, caused by Alivio being a PCMH?
   a. What is the value for you as a CES?
   b. What is the value for Alivio?
   c. What is the value for patients?

   **Four Key Functions**

10. Did you help patients with the day-to-day tasks of managing their diabetes, things like adhering to their medications, eating a healthy diet, getting physical activity? If so…
   a. Would you say this was a small part, a moderate part or a great part of your work with patients?
   b. Can you please describe how you did this?

11. Did you help people stay motivated to do the things they need to do to take care of their diabetes? If so…
   a. Would you say this was a small part, a moderate part or a great part of your work with patients?
   b. Can you please describe how you did this?
12. Did you help people cope with stress related to their diabetes or with feeling blue or anxious or other negative moods? If so…
   a. Would you say this was a small part, a moderate part or a great part of your work with patients?
   b. Can you please describe how you did this?

13. Did you help people recognize when and how they can talk to clinical staff, such as doctors and nurses, and help them get the care they should? If so…
   a. Would you say this was a small part, a moderate part or a great part of your work with patients?
   b. Can you please describe how you did this?

14. After initial contacts to help people understand their diabetes and what they need to do to take care of it, did you continue to stay in contact with people and continue to provide them support and encouragement? If so…
   a. Would you say this was a small part, a moderate part or a great part of your work with patients?
   b. Can you please describe how you did this?

   Additional Questions
15. What did patients need the most help with?
   a. How did you help them with this (these) issue(s)?

16. Can you describe an example of a challenge or problem that you encountered when providing support to a patient?
   a. How did you resolve this issue?
   b. Did you ask for help from anyone?

17. Was there anyone at Alivio that provided you with support as a CES?
   a. If so, can you describe how they supported you?
   b. What was the protocol for who you should go to when you needed help?
   c. What did you think of this protocol?
   i. Was it useful? Not useful?
   ii. Would you want to change it anyway?

18. How were you trained to be a CES?
   a. What parts of this training did you like?
   b. What parts of this training would you change?
   c. Did you receive any ongoing training during your time as a CES? If so, could you please describe it?

19. Can you describe a success or positive story that you experienced while being a CES?