Mi Salud es Primero: A Dissemination Model for Promotores de Salud in Primary Care Reaching Populations of Patients with Chronic Disease

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Society of Behavioral Medicine
• FQHC in Chicago, IL
• Serving 3,787 Latino adults with Type 2 diabetes

Supported by the Bristol-Myers Squibb Foundation’s *Together on Diabetes*
Program Partners

**Alivio Medical Center** – Implementation partner for Peer Support & PCMH demonstration

**American Academy of Family Physicians Foundation** – program administration, strategic planning, linkage with family medicine and primary care community

**National Council of La Raza** – guidance cultural and linguistic tailoring, resource development and advocacy efforts, co-lead national peer support learning network

**Peers for Progress** – overall program leadership, guidance for program development, program monitoring and evaluation; co-lead national peer support learning network;

**TransforMED** – PCMH enhancement, practice change, performance metrics

**University of North Carolina** – Peers for Progress Program Development Center, program administration
Clinic-Community Collaborations

• Organizational separation but functional integration
  – This ensures peer support is reliably accessible to providers and patients.

• Peer support provides linkages to community resources, DSME classes, and diabetes support groups
Peer Support & Patient-Centered Medical Home

Person With Diabetes

Clinical Resources
- Primary Care – Patient-Centered Medical Home
- Linkage: EMR, Reciprocal Referrals, Case Huddles,
- Extender of DSME, Beh Change Goals
- Ongoing Support for DSM: 4,000 and 400
- Social, Emotional Support

Community
- Compañeros en Salud

www.peersforprogress.org
## Demographics

<table>
<thead>
<tr>
<th></th>
<th>N (%) or Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>54.36 (13.31)</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>2,085 (58.0%)</td>
</tr>
<tr>
<td>Male</td>
<td>1,508 (42.0%)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1,628 (45.3%)</td>
</tr>
<tr>
<td>Single</td>
<td>664 (18.5%)</td>
</tr>
<tr>
<td><strong>Hispanic or Latino</strong></td>
<td>3,323 (96.2%)</td>
</tr>
<tr>
<td><strong>Age at diagnosis</strong></td>
<td>50.11 (13.15)</td>
</tr>
<tr>
<td><strong>Years with diagnosis</strong></td>
<td>3.76 (6.62)</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
</tr>
<tr>
<td>Sliding-scale</td>
<td>1,840 (51.3%)</td>
</tr>
<tr>
<td>Medicare/Medicaid</td>
<td>1,340 (37.4%)</td>
</tr>
<tr>
<td>Private insurance</td>
<td>396 (11.0%)</td>
</tr>
</tbody>
</table>
# 3,787 Patients with Diabetes

### Model of PCMH-PS Integration

**High Need Group**
- HbA1c > 8%, Psychosocial Distress, Physician’s Referral
- 471 of the 3,787
- Bi-weekly contacts for 12 weeks
- Monthly contact for 6 months until no longer meet criteria for High Need or until progress has stabilized
- Quarterly thereafter

**Regular Care Group**
- Quarterly contacts, encourage clinical care and use of resources (e.g., group classes) and self-management
- Transition to High Need as needed
Identification of Patients with T2DM (~3,800)

High Need Patients (471)
- HbA1c ≥ 8
- Psychosocial distress
- PCP referral

Regular Care Patients (3,316)
- Diabetes registry, EMR, daily clinic schedule, info table in waiting area, community events

Patient Assigned to Compañero en Salud (CES)

Patient Engagement with Peer Support

Initial Contact by CES
- Low demand – initial call to describe and offer services, not push to accept
- Build rapport and proceed with program activities once patient is engaged

Tiered, flexible program intensity
- CES and patient decide on frequency of contact based on patient’s needs
- High Need – biweekly contact for 12 weeks, then monthly for 6 months, or until no longer meet criteria for high need
- Regular Care – quarterly contacts, encourage use of clinical care and resources, and self-management; transition to High Need if needed

Assistance with Daily Living
- Individualized goal setting
- AADE 7 Key Behaviors
- Glucometer instruction
- Basic DSM education
- Clinic workshops (e.g., nutrition)

Social and Emotional Support
- 1:1 support by phone or in person
- Support groups

Linkage to Clinical Care and Community Resources
- Appointment assistance
- Rx assistance program
- Referral to provider and/or clinic services
- Linkage to community resources (e.g., legal, educational, social)

Ongoing Support
- 24-month availability
- Proactive and on demand
# CES-CONTACT NOTE

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Patient ID #:</th>
<th>YOB:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**Current group:**
- [ ] 400-group
- [ ] 3600-group

**Patient status:**
- [ ] Active
- [ ] Inactive
- [ ] Unreached

*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
- [ ] In-person
- [ ] Support Group

### Place
- [ ] Clinic
- [ ] Community

### Who initiated the contact
- [ ] Community
- [ ] Provider

### Duration
- [ ] < 5 Min
- [ ] 5 to 30 Min
- [ ] > 30 Min

### Key behaviors
**AADE 7 Self-Care Behaviors**
- Healthy eating
- Physical activity
- Glucose-monitoring
- Medications-adherence
- Reducing risks
- Problem solving
- Healthy coping
- Losing 10 pounds

### Focus of behaviors discussed
- ND = Not-discussed
- GI = General-information discussed
- GD = Goal-discussed

### Status of goal/behaviors discussed
- NC = Not considering
- C = Considering
- P = Planning-to-do it
- D = Doing it
- CSD = Completed and still doing it

### Support Provided
- Emotional support
- Encouragement or motivational support
- Problem-solving
- New goal(s) set
- Goal(s) review
- Glucometer provided
- Discount card provided
- Personal needs:
  - Economic (ex: housing, employment)
  - Legal (ex: citizenship)
  - Social and health services (ex: eligibility)
  - Medication support program
  - Filling forms
  - Other:

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**Note:**
- [ ] 720.0x540.0
<table>
<thead>
<tr>
<th>#1 Date:</th>
<th>Time: AM/PM</th>
<th>Week-day: Mon-Tue-Wed-Thur-Fri-Sat</th>
<th>Able to contact Pt.</th>
<th>Kept in-person</th>
<th>Missed in-person</th>
</tr>
</thead>
<tbody>
<tr>
<td>#2 Date:</td>
<td>Time: AM/PM</td>
<td>Week-day: Mon-Tue-Wed-Thur-Fri-Sat</td>
<td>Able to contact Pt.</td>
<td>Kept in-person</td>
<td>Missed in-person</td>
</tr>
<tr>
<td>#3 Date:</td>
<td>Time: AM/PM</td>
<td>Week-day: Mon-Tue-Wed-Thur-Fri-Sat</td>
<td>Able to contact Pt.</td>
<td>Kept in-person</td>
<td>Missed in-person</td>
</tr>
</tbody>
</table>

- Letter sent: Date letter sent: ____/____/____
- Unable to contact patients after letter and fourth attempt
- Next support contact: date: ____/____/____ Time: _____:_____  
  Patient is willing to participate in UNC evaluation survey

Comments:

CES-Health Educator:
Patient Engagement

During the intervention period August 1, 2012-February 28, 2015:
• Compañeros en Salud (CES) at Alivio provided support to 3,147 (83%) of 3,787 adult patients with diabetes
• CES reached 88% of 471 patients identified for intensive support (i.e., “high need” patients)
• CES reached 82% of 3,316 patients receiving general support (i.e., “regular care” patients)
• On average, each CES managed a case load of 490 patients
• 19,188 documented successful contacts amounting to approximately 5,965 hours of peer support provided
• Number of contacts per patient ranged from 1 contact to 44 contacts with a mean of 5.60 (SD=5.15) contacts
AADE7 Self Care Behaviors

Since August 1, 2012, general information was given and/or goals were discussed for the AADE7 self care behaviors:

<table>
<thead>
<tr>
<th>AADE 7 Self Care Behavior</th>
<th>% of time discussed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Healthy Eating</td>
<td>50%</td>
</tr>
<tr>
<td>2) Physical Activity</td>
<td>44%</td>
</tr>
<tr>
<td>3) Glucose Monitoring</td>
<td>55%</td>
</tr>
<tr>
<td>4) Medication Adherence</td>
<td>48%</td>
</tr>
<tr>
<td>5) Reducing Risks</td>
<td>43%</td>
</tr>
<tr>
<td>6) Problem Solving</td>
<td>35%</td>
</tr>
<tr>
<td>7) Healthy Coping</td>
<td>26%</td>
</tr>
<tr>
<td>* Losing 10 pounds</td>
<td>21%</td>
</tr>
</tbody>
</table>

*While not an AADE7 Self care behavior, losing 10lbs is a clinically significant goal and can improve metabolic control and associated risk factors.¹

¹Trends in the prevalence and ratio of diagnosed to undiagnosed diabetes according to obesity levels in the U.S. Gregg EW, Cadwell BL, Cheng YJ, Cowie CC, Williams DE, Geiss L, Engelgau MM, Vinicor F. Diabetes Care. 2004 Dec;27(12):2806-12
Changes in HbA1c

<table>
<thead>
<tr>
<th>HbA1c %</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td><img src="graph1.png" alt="Graph" /></td>
<td><img src="graph2.png" alt="Graph" /></td>
</tr>
<tr>
<td>High-Needs Patients</td>
<td><img src="graph3.png" alt="Graph" /></td>
<td><img src="graph4.png" alt="Graph" /></td>
</tr>
</tbody>
</table>

*P<0.05

Decrease in mean HbA1c across all patients and those with High-Needs
Increase in Proportion High Need with HbA1c < 8%

*P < 0.05
Finding the Organizational Niche
Three Models of Clinic-Community Linkage

• Separate but linked division of clinical provider organization – Alivio Medical Center, Chicago

• Clinically based program but community based peer supporters – New York-Presbyterian/Columbia University

• Community based program but clinically based peer supporters – Rhode Island Parent Information Network
Hospital-Community Integrated Management: 
*Shanghai Integration Model*

Shanghai Sixth People’s Hospital - Shanghai Jiao Tong University

- Promotion of routine care through Community Health Centers
- Shared electronic information platform
- Training for selected 1° care physicians and nurses at 3° hospital: 3-6 months, follow up 2-3 times per year
- Guidelines for care
- Dual referrals:
  - Referrals to specialty care for those with poor metabolic control or complications
  - Follow up of referrals back to community by hospital staff
- Target HbA1c = 6.5%
  - Percentage achieving increased from 13.3% to 31.8%
- Screening for complications increased from 9.9% to 45.1%
- Referrals to 3° care decreased

Jia, W. American Diabetes Association, Boston, USA, June, 2015
Specialty Care

Primary Care

Peer Supporter

Patient

Ongoing Diabetes Management
Policy Considerations

• Opportunities in ACA
  – Medicaid Health Homes addressing, e.g., support for transitional care
  – Call to Action at: http://goo.gl/w2yzs4

• Workforce Challenge
  – Worldwide, 387 million with diabetes would require: 715,000 full-time workers @ 1 serves 500, or 39 million volunteers, each seeing 10 patients
  – Examples of large-scale programs: Thailand – Village Health Volunteers since 1978
    Pakistan – 96,000 “Lady Health Workers”
Peer Support Around the World

Peer support programs and organizations – from small-budget volunteer programs to official parts of health care systems – exist all around the world.

> FIND PEER SUPPORT PROGRAMS

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