OBJECTIVES

- Overview of Alivio Medical Center
- Overview of “My Health Comes First / Mi Salud es Primero” Diabetes Program at Alivio Medical Center
- CHWs:
  - Roles and responsibilities
    - Patient-centered medical home model
- Patient case study
In the mid-1980s, Carmen Velásquez, Alivio’s founder and only Exec. Dir. Troubled by the medical needs of local residents living in Pilsen, Little Village and Back of the Yards.

1989: 1st clinic opens

2000: 2nd clinic opens

2007: dental clinic and 1st school-based health center
ALIVIO MEDICAL CENTER

- 98% pts fall at or below 200% fed’l poverty level
- 97% are Latino, predominately Mexican
- 70% prefer to be served in a language other than English
- 71% pts have not completed high school
- 2011: 26,466 pts; over 99,000 pt visits
DIABETES IMPACT

- 23.6 million people in the United States
- 7th leading cause of death
- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times
- Leading cause of kidney failure, lower limb amputations, and adult-onset blindness
- In addition to these human costs, the estimated total financial cost of DM in the US in 2007 was $174 billion, which includes the costs of medical care, disability, and premature death.
In the U.S., Latinos, American Indians and African Americans are disproportionately impacted. Due to the steady rise in the number of persons with DM, and possibly earlier onset of type 2 DM, there is growing concern about:

- Substantial increases in diabetes-related complications
- Increase in the number of persons with DM and the complexity of their care might overwhelm existing health care systems
- The need to take advantage of recent discoveries on the individual and societal benefits of improved diabetes management and prevention by bringing life-saving discoveries into wider practice
- The clear need to complement improved diabetes management strategies with efforts in primary prevention among those at risk for developing DM
Healthy People 2020 Goal

- 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.
CHWs-Capacities AND CONTRIBUTIONS

- CHWs unique ability to serve as “bridges” between community members and health care services
- Connectors: b/c live in the communities, understand what is meaningful for that community, communicate, and recognize and incorporate cultural (cultural identity, spiritual coping, traditional health practices)
- Provide social support that complements health care services
- Educate providers about community’s needs and cultural relevancy of interventions (cultural competency)
FROM DSME TO DSMS

Diabetes education has changed a great deal in recent years. DSME are more patient-centered with greater emphasis on ongoing support to sustain self-management gains made by pts as a result of education.
By developing self-mgmt skills in the context of the challenges that they encounter daily, patients derive direct benefits from these learning experiences and thereby increase their motivation for sustained self-care behaviors.
Diabetes Self-Management through Peer Support and Community Outreach with the Patient Centered Medical Home

Funded by Bristol Myers Squibb for 3 years

- **Planning Phase:** December through June 2012
- **Implementation Phase:** June 2012 – June 2014
- **Evaluation Phase:** June 2014 – October 2012
Together on Diabetes® of the Bristol-Myers Squibb Foundation

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Peers For Progress

↓

Alivio←←NCLR
Objective: to demonstrate and evaluate the contributions of peer support as a strategy for

- Support of individuals’ diabetes mgmt and
- Community outreach from the PCMH
- Thereby, to demonstrate and evaluate the contributions of such PCMH and peer support for diabetes mgmt leading to improved health outcomes
OUTCOMES

- Aim to improve health outcomes of the target population
- This will include:
  - Engagement in regular clinical care and self-management
  - Improvement in self-management behaviors (e.g., prescription adherence, physical activity, healthy diet, etc.)
  - Improved clinical indicators (e.g., HbA1c, BP, BMI, etc.)
  - Improved quality of life.
Population:

+ 4000 patients: measure clinical indicators
+ 400: intensive, longitudinal study
  - Clinical measures and patient reported outcomes
  - Engagement in regular clinical care
  - Improvement in diabetes self management behaviors (adherence to medication regimes, physical activity, diet)
  - Improvement in clinical indicators (glucose, A1c, Blood pressure, cholesterol, BMI)
  - Improvement in Quality of Life
PATIENT ENGAGEMENT/SUPPORT CONTACTS

- 400/High Need Group:
  - Biweekly contacts for 12 weeks, then monthly for 6 months until no longer meet criteria for High Need or until progress has stabilized

- 36 Group:
  - Regular Care (balance of approx. 3,600 patients w/ diabetes)
  - Quarterly contacts, encourage clinical care and use of resources (e.g., group classes) and self management, transition to High Need prn
Flexible, nondirective strategies to engage patients in peer support include:

- Low demand – initial call to describe and offer services, not push to accept
- Repeat calls in 2-4 weeks (according to judgment of Compañero/a) to “check in with” not “check up on” patient
- Two-year availability to patient
- After patient is engaged, begin working on individually chosen goal from set of key (AADE 7) behaviors, health eating, etc.
ORGANIZATIONAL INTERACTIONS

- Linking to clinic & community resources
- Delivering consistent, integrated DSME
- Providing ongoing Peer Support for DSM
- Enhancing clinical care

Clinical Resources  | Primary Care  | Compañeros en Salud  | Community

Patient
WHAT DOES DSMS LOOK LIKE FOR THIS PROJECT?

- Assist with enrollment in medical home
  - Help pt navigate systems (health, community)

- Part of health team and help with care coordination

- Provide pre and post medical visit prep and debriefing
  - Help pts understand medical advice
WHAT DOES SUPPORT LOOK LIKE FOR THIS PROJECT?

- Liason between PCP and pt
  - Access to PCP, CDE, RN for F/U and concerns re: pts

- Ongoing support (practical, social, emotional)
  - Assess needs, ID and address barriers to diabetes mgmt
  - Available by phone and in clinic
<table>
<thead>
<tr>
<th>Diabetes Self-Management (DSM) Services at Alivio</th>
<th>Regular Care</th>
<th>High Needs (~400)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall DSM program/services at Alivio - Everybody receiving same services and messages about diabetes</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Compañeros en Salud (CES) Community Events – to increase diabetes awareness, promote appropriate screening, diagnosis, and referral for/access to reg. clinical care</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Primary care PCMH clinical health services (quarterly visits, care plan)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CES as a resource – CES programs &amp; encourage use of community resources such as affordable healthy food, physical activity, etc.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Open events/drop-in activities at Alivio to reach and engage patients into clinic services and diabetes support (health fairs, weekly info table is lobbies)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Diabetes self-management education (group or individual)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Support groups (bi-weekly, monthly)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individual, intensive support for DSM</td>
<td>X</td>
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### PATIENT ENCOUNTERS

<table>
<thead>
<tr>
<th><strong>1:1</strong></th>
<th><strong>GROUPS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone calls: CES contact pts following protocol schedule</td>
<td>Diabetes Self-Management Education groups: series of 4 two-hour workshops</td>
</tr>
<tr>
<td>Clinic: previously scheduled encounter w/CES</td>
<td>Diabetes Self-Management Support groups: weekly, ongoing 1 ½-2 hour, semi-structured sessions. No limit on # of sessions. To begin in June 2013</td>
</tr>
<tr>
<td>Clinic: not previously scheduled encounter w/CES. ID pt when pt comes in for PCP appt</td>
<td>WIC: 4 times/month CES present to WIC clients, 30-45 minutes, on diabetes and the program</td>
</tr>
<tr>
<td>Info table: in lobby of clinics. Pts approach table and CES approach pts in waiting area</td>
<td>Biannual Diabetes Health and Resource Fairs</td>
</tr>
</tbody>
</table>
RESULTS TO DATE

- 1976 pts have been reached by a CES
- 401/468 (86%) of HIGH NEEDS (research cohort) have been reached
- 6,323 successful 1:1 peer support pt contacts
The patient-centered medical home—one of modern health care’s most important innovations—is a model of care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.”

Clinicians, insurers, purchasers, consumer groups and others know the patient-centered medical home is a proven alternative to the nation’s costly, fragmented delivery system. Research confirms that medical homes can lead to higher quality and lower costs, and can improve patient and provider experiences of care.
PATIENT-CENTERED MEDICAL HOME

- Care Management
- Care Coordination
- Practice-Based Care Team
- Quality and Safety
DSME & DSMS Team at Alivio

- 10 Primary Care Providers
- Certified Diabetes Educator
- Diabetes Trainer
- 4 RNs
- Medical Assistants
- Mi Salud es Primero Manager and Coordinator
- 9 Compañeros en Salud (CHWs)
- Patients
Training
- For the first two weeks (June 11 – June 22, 2012),
- Overview of Peers for Progress
- Overview of Patient-Centered Medical Home (PCMH)
- Diabetes impact: nationally, city and community level
- Diabetes Self-Management Education versus Support
- Roles and responsibilities
- Diabetes Self-Management (nutrition, risk factors, pathophysiology, complications, 7 self-management key behaviors, blood glucose self-monitoring, treatment, and goal setting)
- Communication skills/motivational interviewing
- Case management; community resources
- Problem solving techniques
- Role playing exercises
The weeks that followed consisted of training and/or reinforcement of the following:

- Diabetes Self-Management
- Glucometer/blood glucose self-monitoring
- Goal setting techniques
- Problem solving
- Introduction to anxiety and depression
- Prescription Assistance Program
- Documentation and data tracking; database
- Diabetes Self-Management Education patient classes
- Curriculum; documentation and evaluation
MORE TRAININGS

- Mental Health First Aid
- ACA
- Diabetes and Eye Health
- ONGOING SUPPORT AND SUPERVISION OF CHWS
PATIENT CASE STUDY

Pt X: 62 y/o female. Dx Type 2 diabetes +10 yrs ago
- Others: Depression, Hx of breast cancer, high cholesterol
- Recently employed PT
- Lives alone, sister visits her a lot
- Tx: oral meds and insulin

1\textsuperscript{st} contact 12/15/2012: appeared quiet and reserved at first
- The first recommendations: check glucose daily and establish a regular eating pattern (small meals every 3 hours).
- After several contacts pt established goal: walk 30 min daily
- 5/17/13 pt increased walk to 75 min every other day.
- 6/11/13 Pt concerned about low blood glucose especially at night.
- Pt feels very accomplished and engaged in her self-management; encouraged by her improved health and demeanor
- A1c level improved to 6.7% from 10%
COMPENSATION AND SUSTAINABILITY

- FULL-TIME WITH FULL BENEFITS
- $13/HOUR
- Partnering with
  - MCOs
  - ACOs
  - Reimbursement mechanisms
THANK YOU

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