KNOW DIABETES BY HEART

CHWs Providing Diabetes Support in Health Disparate Communities

March 28, 2022
Hot Off The Press

Know Diabetes by Heart™ Awards $900,000 for Community Education

Ten grants from the American Diabetes Association and the American Heart Association's joint initiative aim to decrease heart disease and stroke among people with type 2 diabetes.
COMMUNITY GRANTEES

Scripps
NACHW
Jefferson Health
Esperanza
COOPERATIVE EXTENSION
JOHNS HOPKINS UNIVERSITY
Feinstein Institutes for Medical Research
GATEWAY COMMUNITY Health Center, Inc.
inquisith health
NM State
Chicago Hispanic Health Coalition
Know Diabetes by Heart
OVERVIEW

• The KDBH community grantees integrated KDBH health lesson and patient education resources into the ADA approved diabetes support program activities

OBJECTIVES:

Among KDBH Community Grantee participants with type 2 diabetes, assess for change in:

• Proportion of participants who are aware that people with type 2 diabetes are at an increased risk for heart attack and stroke

• Proportion of participants who are aware that cardiovascular disease is the leading cause of death for people with type 2 diabetes

• Proportion of participants who have discussed their risk for heart disease with their healthcare provider

• Proportion of participants who have engaged in at least one health action or behavior to better manage their condition and risk for cardiovascular disease
METHODOLOGY

DIABETES SUPPORT PROGRAM INTEGRATION OF KDBH HEALTH LESSON INTO THE PROGRAM SERIES

• Pre/post data collection: data was collected at baseline prior to the beginning and/or on the first day of the support program and at follow-up, immediately post-program

KDBH HEALTH LESSON HELD AS A SINGLE SESSION

• Post data collection: follow-up only survey was disseminated via a survey link to all participants who attended the single session
WHAT IS KNOW DIABETES BY HEART?

The American Heart Association and the American Diabetes Association’s initiative, Know Diabetes by Heart™, aims to empower people living with type 2 diabetes to lower their risk for cardiovascular disease.

Visit KnowDiabetesbyHeart.org to learn more.
# Diabetes & Heart Disease: The Numbers You Need to Know

Knowing five numbers can give you a more accurate picture of your health. At your next appointment, talk to your doctor about how to keep them in target range to lower your risk of heart disease and stroke.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>What Is It?</th>
<th>How Is It Done?</th>
<th>How Often?</th>
<th>Target Range</th>
<th>My Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C (Blood)</td>
<td>Your average blood glucose levels over 3 months</td>
<td>Blood test</td>
<td>Every 3 months</td>
<td>A1C &lt; 7%</td>
<td>Recent A1C:</td>
</tr>
<tr>
<td>BMI (Body Mass Index) &amp; Waist Circumference</td>
<td>A body shape index that compares your weight to your height</td>
<td>Height and weight</td>
<td>Regularly</td>
<td>BMI: 18.5-24.9</td>
<td>Waist: 32 inches or less for women; 40 inches or less for men</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>The force of blood moving through your arteries when your heart beats</td>
<td>Self-measured at home</td>
<td>Daily at home if possible</td>
<td>Systolic: 120/80 mmHg</td>
<td>Recent BP Reading:</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>A very unhealthy fat molecule that is carried in your blood</td>
<td>Blood test</td>
<td>Every 1-2 years</td>
<td>Total cholesterol &lt; 200 mg/dL</td>
<td>Recent total cholesterol:</td>
</tr>
<tr>
<td>Kidney Function</td>
<td>Tests how well your kidneys filter blood</td>
<td>Urine &amp; Blood Tests</td>
<td>Every 1-2 years</td>
<td>GFR ≥ 60 mL/min/1.73 m²</td>
<td>Recent GFR:</td>
</tr>
</tbody>
</table>

**7 Consejos para cuidar el corazón cuando tienes diabetes tipo 2**

1. Visite a su doctor con regularidad. Pregunte sobre su salud cardíaca.
2. Controle los hábitos de comer saludablemente. Para empezar, ate menos y verduras. Comer mejor le ayudará a sentirse mejor.
4. El cuidado de su misma puede ayudarlo a cuidar su corazón. Reduzca el estrés, el estrés es bueno para la mente y el cuerpo.
5. Deje de fumar.
6. Mantenga la glucemia, presión sanguínea, colesterol y peso.
7. Toma medicamentos siguiendo las indicaciones.

La gente con diabetes PUEDE vivir vidas más saludables.
RESOURCES
12 community partners in 21 states across the country

DIABETES SUPPORT PROGRAM INTEGRATION
• 6,087 enrolled

KDBH HEALTH LESSON SINGLE SESSION
• 8,943 participants

• TOTAL: 15,030 participants
<table>
<thead>
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<th>Grantee</th>
<th>Number of States Served</th>
<th>List of States Served</th>
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<tbody>
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<td>Clemson University</td>
<td>13</td>
<td>AZ, CA, CO, FL, GA, MD, MI, MO, NJ, NY, NC, SC, TX</td>
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<tr>
<td>National Association of Community Health Workers</td>
<td>8</td>
<td>CA, CT, FL, GA, HI, LA, OR, TX</td>
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<tr>
<td>Texas A&amp;M Health Science Center</td>
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<td>AZ, GA, TX</td>
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<tr>
<td>InquisitHealth</td>
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<td>NV, NY</td>
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<tr>
<td>New Mexico State University</td>
<td>1</td>
<td>NM</td>
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<tr>
<td>Scripps Whittier Diabetes Institute</td>
<td>1</td>
<td>CA</td>
</tr>
<tr>
<td>Gateway Community Health Center</td>
<td>1</td>
<td>TX</td>
</tr>
<tr>
<td>Esperanza</td>
<td>1</td>
<td>PA</td>
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<tr>
<td>Johns Hopkins University / Feinstein Institutes for Medical Research</td>
<td>1</td>
<td>MD</td>
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<tr>
<td>Chicago Hispanic Health Coalition - UIC</td>
<td>1</td>
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<tr>
<td>Thomas Jefferson University</td>
<td>1</td>
<td>PA</td>
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WHO DELIVERED THE PROGRAM

OTHER INCLUDED:

- Non-certified educator
- Champions from local community churches
- Extension Agents
- College professor
- Internal Medicine doctor
- Exercise Physiologists and LPN
- Pharmacist
**KDBH Materials Used**

- **KDBH HEALTH LESSON...**: 100%
- **4 QUESTIONS TO ASK YOUR...**: 100%
- **KDBH SPANISH RESOURCES**: 80%
- **KNOW YOUR NUMBERS, LOWER...**: 80%
- **YOUR MEDICINE CHART**: 60%
- **CARE TEAM BOOKLET**: 30%
- **TIPS FOR BUILDING A SUPPORT...**: 30%
- **OTHER KDBH PATIENT EDUCATION...**: 80%

**How Materials Were Integrated**

- **Used as part of existing programming**: 36%
- **Distributed as part of community outreach**: 9%
- **Shared during conferences**: 83%

26,950 people received KDBH information through community outreach, e-newsletters, radio, etc.
DEMOGRAPHICS

AGE*
- 33% ≤ 45 years old
- 51% 46-65 years old
- 17% ≥ 66 years old

GENDER
- 69% Female
- 31% Male

ETHNICITY

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<tr>
<th>Ethnicity</th>
<th>Percentage</th>
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<tr>
<td>White</td>
<td>31%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>24%</td>
</tr>
<tr>
<td>Hispanic, Latinx, or Spanish Origin</td>
<td>39%</td>
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<tr>
<td>American Indian or Alaskan Native</td>
<td>1%</td>
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<tr>
<td>Asian or Asian American</td>
<td>1%</td>
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<tr>
<td>Middle Eastern or North African</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
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</tbody>
</table>

Education*
- Some high school or less: 35%
- High school graduate: 38%
- Some college or trade school: 14%
- College or trade school graduate: 11%
- Graduate school: 3%

*Data from the post program survey only
PROGRESS TOWARD GOALS AND OBJECTIVES

PROGRESS MADE

• Increased program enrollment and participation
• Building new or maintaining existing partnerships
• Positive participant outcomes

ACTIVITIES UTILIZED

• Consistently promoting program to recruit new participants
• Building and maintaining partnerships
• Utilizing partners to expand the program to new sites
• Offering virtual sessions
• Training new presenters/lifestyle coaches
OUTCOMES

AFTER RECEIVING THE KDBH HEALTH LESSON:

90% were aware that cardiovascular disease is the leading cause of death for people with type 2 diabetes

91% correctly identified that having type 2 diabetes increases risk for high blood pressure, unhealthy cholesterol levels, heart attack, and stroke

94% report that they intend to have a conversation with their health care provider about their risk for CVD as a result of the presentation
After receiving the KDBH health lesson participants were likely or very likely to...

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percent of Participants</th>
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<tbody>
<tr>
<td>Take medications as prescribed</td>
<td>97%</td>
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<tr>
<td>Monitor and keep track of blood glucose, blood pressure, cholesterol, and weight</td>
<td>96%</td>
</tr>
<tr>
<td>Take steps to manage stress</td>
<td>94%</td>
</tr>
<tr>
<td>Stop or reduce tobacco use</td>
<td>92%</td>
</tr>
<tr>
<td>Increase or continue to do regular physical activity</td>
<td>92%</td>
</tr>
<tr>
<td>Actively try to achieve or maintain a healthy weight</td>
<td>93%</td>
</tr>
<tr>
<td>Follow a heart healthy diet</td>
<td>94%</td>
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</table>
**SUCCESSES**

- Hosting additional webinars & Zoom classes
- In-person cooking classes
- Community screenings
- Training health extension agents
- Spanish newsletter promotions
- Partner collaborations with churches, area agency on aging, radio, community centers, health systems, neighborhood centers

**CHALLENGES**

- Restrictions of in-person gatherings due to COVID-19
- Collecting clinical metrics due to COVID-19 restrictions
- Promotions of program during pandemic
- Zoom fatigue
- Lack/limited access to internet
SUCCESSES

- Learning and/or implementing new communication strategies
- Strong network and/or support system
- Expansion of programs

CHALLENGES

- Adapting and/or delaying implementation during COVID-19
- Low participation in evaluation
- Maintaining participant engagement
## Program Sustainability

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Plan for sustaining project or program</th>
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</thead>
<tbody>
<tr>
<td>National Association of Community Health Workers</td>
<td>Integrate KDBH into diabetes outreach and use program resources for community education.</td>
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<tr>
<td>Thomas Jefferson University</td>
<td>Continue to educate new patients in cardiac rehab with KDBH and upload educational presentation to cardiac rehab website.</td>
</tr>
<tr>
<td>Texas A&amp;M University</td>
<td>Work with partners and continue to market KDBH to grow enrollment.</td>
</tr>
<tr>
<td>Chicago Hispanic Health Coalition - UIC</td>
<td>Continue to provide education and create community awareness of KDBH information.</td>
</tr>
<tr>
<td>Feinstein Institutes for Medical Research</td>
<td>Further develop infrastructure to support broad dissemination and evaluation of programming.</td>
</tr>
<tr>
<td>Esperanza</td>
<td>Will use KDBH materials in appropriate education settings.</td>
</tr>
<tr>
<td>Gateway Community Health</td>
<td>Continue KDBH on a small scale and use materials to educate patients about disease prevention and management.</td>
</tr>
<tr>
<td>Scripps Whittier Diabetes Institute</td>
<td>Work to share the program with like-minded partners to sustain KDBH in the long-term. Abstract submitted for the ADA’s 82nd Scientific Sessions.</td>
</tr>
<tr>
<td>InquisitHealth, Inc.</td>
<td>Integrate KDBH materials into existing content/programming for all diabetic clients.</td>
</tr>
<tr>
<td>New Mexico State University</td>
<td>Distribute KDBH information as part of existing and ongoing educational efforts.</td>
</tr>
<tr>
<td>Clemson University</td>
<td>Translate promotional materials to Spanish and offer KDBH as part of existing programs.</td>
</tr>
</tbody>
</table>
American Heart News
@HeartNews

Know Diabetes by Heart™ Awards $900,000 for Community Education

ARLINGTON, Va. and DALLAS, February 25, 2021 -- The American Diabetes Association® and the American Heart Association® have awarded the Know Diabetes by Heart Community Grants up to $900,000 to ten organizations in communities of greatest need.

http://newsroom.heart.org

10:04 AM · Feb 25, 2021 · Sprinklr
6 Retweets 15 Likes
"While working on this project, we learned that while we did touch lightly on diabetes and heart disease, this was a significant knowledge gap for our participants. Interestingly, this was a knowledge gap that participants often times didn’t know that they had. This re-affirmed the necessity to integrate the Know Diabetes by Heart materials into the essential framework for every program participant who completes the Diabetes Self-Management Support program."

PARTICIPANT TESTIMONIALS:

"The video clip during the presentation yesterday opened my eyes! I have been having the wrong perspective! Instead of looking at this as a punishment, this is a chance for a whole new life for me!"

"I am a living proof that it doesn’t matter where you come from or your eating habits, you can change. I am greatly appreciated with everyone who has helped me throughout my process. I refuse to be another statistic and will continue to strive to be the best that I can be. I hope that people can see my story and will want to change because your life matters."
SUCCESS STORY – MIRIAM FROM TX

When I came seeking services, I was not aware I had diabetes. I was seen by a healthcare provider and was referred to get lab work done. In my follow up appointment, they informed me I had diabetes and had an A1C of 12.9%. I was shocked and decided I wanted to make a change and take charge of my health. I was referred to diabetes classes and I was eager to learn about diabetes and ways that I could manage it. I gained a lot of useful information. I learned the importance of healthy meal planning, how your medication helps specifically targeting your diabetes, and complications that could arise from uncontrolled diabetes. I enjoyed the discussions and the peer support and the positive and motivating comments. I was so excited and proud of myself that with all of my hard work and putting into practice everything I learned, I was able to lower my A1C to 6.3%. I will continue to practice the healthy lifestyle I have to manage my diabetes.

I am very grateful for participating in the diabetes course. I would refer this course to anyone that has diabetes. I hope other people feel motivated and see that just like me they can be able to lower their A1C and manage their diabetes.
TESTIMONIALS

• “Recently had an A1c result as I did not have it for a long time. I feel better and this makes me feel that I can control my diabetes. This program has made me aware, it motivates me a lot, it is like a good friend who is constantly reminding you to take care of yourself, to eat healthy, to take your medications. It is a constant reminder that comes to you in a simple way. I hope that this program reaches many people and that it helps them as it has helped me take care of my diabetes and my heart.”

• “I now understand how to manage my diabetes and am confident that I can lead a healthy life!”

• “The program motivates me to take care of myself because it makes me more aware of my health care. I am very happy because I am achieving it now. My fasting sugar level is between 120 to 150, before it was 250 and up.”

• “The program is really helpful in helping me eat heart healthy and reminding me to monitor my blood sugar.”
KNOW DIABETES BY HEART

KnowDiabetesbyHeart.org
Know Diabetes by Heart: CHWs Providing Diabetes Support in Health Disparate Communities

• Gateway Community Health Center, Inc. is a federally qualified health center

• Gateway CHC receives special funding from the U.S. Government to take care of patients most in need

• We take care of patients on an outpatient basis without regard of the ability to pay
• Gateway CHC is part of the largest healthcare network in the country

• There are 1,451 FQHCs with 12,743 locations across the U.S.

• There are 73 FQHCs in Texas with over 650 clinic locations

• FQHCs are non-profit organizations

• Serve in high-need areas

• Are led by members of the community
• Gateway CHC takes care of patients with and without insurance.
• Gateway CHC has over 30,000 registered patients – 50% have insurance.
Services Offered

Gateway CHC had over 100,000 visits in 2021.

Services include:

• Primary and preventive medical care
• Primary and preventive dental care
• Primary behavioral care
• Pharmacy
• Laboratory
• Gateway CHC has four clinics in Laredo, TX
• One Clinic in Zapata, TX
• One Clinic in Hebbronville, TX
• One Mobile Unit
• Over 100 healthcare providers

We provide Quality Healthcare for Everyone!
Gateway Diabetes Institute

Mission Statement

“To Provide Quality, Comprehensive, Diabetes Medical Management, Education Support, and Prevention to Laredo and surrounding communities.”
GDI Institute Policies

- **Internal Structure**
  - Mission Statement
  - Annual Goals and Objectives

- **Advisory Board**
  - Meets 2-4 times per year

- **Department Coordination**
  - Training Schedule Form
    - Motivational Interviewing trainings
    - Trauma informed care trainings
    - Social Determinants of health
    - GDI Policies training

- **Standards of care**
  - ADA
  - AACE/ACE

- **Clinical Protocols**
  - Insulin Self-Management Policy
    - Basal Insulin
    - Split dose basal insulin
    - Mixed Insulin (70/30)
    - Rapid-acting Insulin
  - Uncontrolled Diabetes Patients (HbA1c >9%)
  - Pre diabetes
  - Future protocols:
    - Gestational Diabetes
    - Pediatric Diabetes Visits

- **Diabetes Standing Delegation Orders**
  - For medical Assistants
    - Lab Orders
    - Immunization Orders
    - Referral to Dental
    - Referral to DSMES/MNT
    - Off-Site Referral to podiatrist
    - Referral to diabetic supplies and Eye Exam
    - Smoking Cessation

- **Patient Education**
  - Referral Process
  - Standard Operating Procedures and Workflows for DSMES & MNT
    - Virtual Education
    - Facebook Support “Gateway Diabetes Institute”
    - ADA DSMES certification

- **Technology**
  - Continuous Glucose Monitoring (CGM) In-House Protocol/Workflow
  - Glucose Testing Supplies Protocol

- **Quality Improvement**
  - CQI Worksheet
  - Quarterly measures

  (Framework follows American Diabetes Association’s Standards for Accredited Diabetes Self-Management Education & Support Program)
HRSA GOALS set in 2019

- QI project to improve access to Drug Assistance Program & referrals in rural clinical
- Point of care A1C testing, decrease number of missing A1C Values
- Motivational Interviewing training for providers & staff

“Know Diabetes By Heart” Initiative
## Institute Performance Annual Outcomes

### Total Diabetes Patients

<table>
<thead>
<tr>
<th>Date</th>
<th>12/31/19</th>
<th>12/31/20</th>
<th>12/31/21</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4895</td>
<td>4906</td>
<td>5266</td>
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### # uncontrolled

<table>
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<th>12/31/20</th>
<th>12/31/21</th>
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<tbody>
<tr>
<td></td>
<td>1503</td>
<td>1444</td>
<td>1468</td>
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### % Uncontrolled

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<th>12/31/21</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30.7%</td>
<td>29.4%</td>
<td>27.9%</td>
</tr>
</tbody>
</table>

### Improve on Missing A1Cs- A1C Point of Care

<table>
<thead>
<tr>
<th>Date</th>
<th>12/31/19</th>
<th>12/02/20</th>
<th>12/31/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing A1c</td>
<td>500</td>
<td>357</td>
<td>332</td>
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</table>

### % Missing A1c

<table>
<thead>
<tr>
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<th>12/31/19</th>
<th>12/02/20</th>
<th>12/31/21</th>
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</thead>
<tbody>
<tr>
<td>% Missing A1c</td>
<td>10.53%</td>
<td>7.74%</td>
<td>6.16%</td>
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</table>

"Know Diabetes By Heart" Initiative
### Diabetes Drug by Class

<table>
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Change in prescribing trends by quarter.
2021 Service Objectives Met

• Implemented Diabetes Protocol for patients with A1C > 9% with all adult providers.

• Increased provider and patient awareness of cardiovascular health risk for patients living with diabetes.

• Participated in the “Know Diabetes by Heart” initiative sponsored by the American Diabetes Association and the American Heart Association, goals to achieve:
  • <25% of patients with A1C >9%
  • Increase statin therapy in patients with Diabetes and high LDL cholesterol to greater than or equal to 70 and less than 190 in >70% of patients
  • Manage Blood Pressure to < 140/90 in 70% of patients

• Recognition by the American Diabetes Association for meeting national standards for Diabetes Self-Management Education and Support.
  • Education modules added to meet need of special populations: children living with diabetes, gestational diabetes.

• CDC Recognized National Diabetes Prevention Program.
Courses available to ALL Gateway patients
- Year-Round Education
- Virtual sessions
- Text support between classes
- Average wait time to classes -21 days after assessment with Diabetes Educator

English Classes Added

Class Outcomes
- Average change in A1C -1.67%

Facebook Page Support Program – Gateway Diabetes Institute
Integration of
Know Diabetes by Heart
and
Gateway Diabetes Institute
Program Implementation Goals

1,620 individuals enrolled in the Diabetes Support Program

3,343 individuals joined the ADAs online Living With Type 2 Diabetes

6,059 individuals received education on KDBH as single sessions
Intervention Strategies

- Partnerships
- Presentation to Healthcare Providers
- Presentation to Nutritionist and Registered Dietitian
- Training to Promotores de Salud/CHW
- Virtual one to one sessions
- Virtual group sessions
- Information booths
- Virtual health fairs
- Loteria
- Flipchart
Partnerships

- South Texas Promotores Association
- Consulate General of Mexico in Laredo, TX
- Head Start Child Development Program
- United Way
- Maranatha Christian Church
- Centro de Fé Christian Church
- Senda de Gloria Christian Church
- Larga Vista Community Center
- Nuestra Gente Adult Daycare
- Esmeraldas Adult Daycare
- Holding Institute
- Families for Autism
- Ladrillito Community Center
- Buenos Dias Adult Daycare
- South Texas Training Center

Support from faith-based organizations, education entities, social services agencies, businesses, and local associations.
Registered dietitian and nutritionist are using the Know Diabetes by Heart education materials and website presentations with patients.
Program Promotion
Education Tools

Lotería

Flipchart
Meal planning is key to accomplish the goal of managing diabetes. Mr. Chapa invests time on preparing healthy meals for his breakfast, lunch and dinner every day.
Gateway’s Diabetes and Cardiovascular Disease Self-Management (CVD) guide was designed to address the seriousness and prevalent chronic health conditions of diabetes and cardiovascular disease.

The goal of the guide is to provide an effective training by utilizing a community-based and culturally sensitive approach to support individuals in the prevention and management of diabetes and cardiovascular disease.
The guide promotes participation to make the learning process an enjoyable activity. The guide is adaptable to the needs and resources of organizations working towards a common goal of health education and disease management.

The ten-session course is designed to be offered in a 2-hour session for ten consecutive weeks. The sessions include topics on nutrition, portion control, physical activity, diabetes and CVD complications, self-monitoring, medication and stress management.

The versatility of this guide is such that it may be used by healthcare professionals, health educators, and community health workers (Promotores).
The guide was developed by incorporating years of experience and eight self-management principles:

- Active Learning
- Goal Setting
- Problem Solving
- Knowledge
- Responsibility
- Social Support
- Respect
- Skills Building
Module 1:
Let's start................................................................. 1-6

Module 2:
Learning about diabetes and cardiovascular disease............ 7-16

Module 3:
How is my body doing?.................................................. 17-26

Module 4:
Exercise to better health................................................. 27-36

Module 5:
Understanding the Plate Method and Review Session........... 37-46

Module 6:
What am I eating?.......................................................... 47-56

Module 7:
Herbs, pills, and more!................................................... 57-66

Module 8:
Joining forces.............................................................. 67-74

Module 9:
The silent killers........................................................ 75-88

Module 10:
Graduation and celebration .......................................... 89-95
Activity Examples
Evidence Base

Goal:

• Diabetes Management: Ensure that the proportion of diabetic adults with an HbA1c value **greater than 9 percent, is at or below 34%** (Medicaid 75th percentile) by the end of the year. Medicaid 90th percentile, 28%.

• Hypertension Control: Ensure that the proportion of hypertension adults whose **blood pressure is under control (systolic blood pressure <140 mmHg and diastolic blood pressure <90mmHg) is at 64%** (Medicaid 75th percentile), by the end of the year. (Medicaid 90th percentile, 79.6%).

Results:

• Diabetes: Total Sample (N=1095)

  **Outcome:** 21% (231) of the patients had an HbA1c greater than 9%.

• Hypertension: Total Sample (N=934)

  **Outcome:** 73% (682) of the patients had their Blood Pressure under control.
Best Practices

• GCHC has integrated promotores (community health workers or CHW) into the care team and developed a training model and curriculum tailored to the patient population. The program covers a number of disease states including, diabetes, hypertension, and cancer. This program can help the following initiatives:

• UDS clinical measures (specifically diabetic A1c, hypertension BP <140/90, cancer screening);
• Meaningful Use clinical quality measures, which has now been rolled into the MACRA QPP Program;
• Patient Centered Medical Home; and Potentially, Healthy People 2020 diabetes objectives.
• A health education/CHW Program in and of itself would not be a Best Practice. But, in addition to increasing patients' health literacy and knowledge of their chronic diseases and importance of preventive services, the program incorporates the following aspects that are unique to community health worker programs:

• Holistic approach to improving quality of life: The program has developed a number of engaging activities to teach patients about their disease and how to manage it. The way the activities were structured is what was particularly striking. Staff use activities to not only teach health topics, but to teach participants skills, such as public speaking, problem solving, negotiation, and managing stress that will affect all aspects of their life. These skills not only positively impact adverse social determinants of health, but they provide participants self-confidence and help to improve their overall quality of life.
Best Practices

Workforce Development: The promotores program has been approved by the Texas DSHS CHW program. It incorporates the following eight competencies: communication skills, interpersonal skills, service coordination, capacity building, advocacy, teaching skills, organizational skills, and knowledge base. As the primary provider workforce does not meet current demand for services, having appropriately trained staff to help patients is vital, and this program allows for development of staff without extensive formal education to make a positive impact on their community and in their own lives.

Source: This report has been prepared on behalf of the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA/BPHC) for the purposes of oversight and guidance of HRSA/BPHC programs. The report contains final findings and recommendations reviewed and approved by HRSA/BPHC.
Thank you!