El Centro Hispano is a grassroots community-based organization dedicated to strengthening the Latino community and to improving the quality of life among Latino residents in central North Carolina. This article discusses El Centro Hispano's role in providing culturally and linguistically appropriate education, outreach, and referrals to prevent and control diabetes among Latinos.

El Centro Hispano, a 501(c)(3) grassroots community-based organization, is dedicated to strengthening the Latino community and to improving the quality of life of Latino residents in the areas of Durham, Carrboro, and Chapel Hill, North Carolina. The organization was founded in 1992 as the Hispanic Resource Center, a joint project of the Catholic and Episcopal churches in Durham County. Currently, the organization provides programs and services to >10,000 community members annually.

In 2002, El Centro Hispano applied for funds to prevent diabetes in the Durham Latino community because of the high prevalence of overweight and obesity and the lack of physical activity—major risk factors for diabetes—in this population. Since then, El Centro Hispano has implemented diabetes prevention programs for local Latinos, including training and support of diabetes prevention promotores. Promotores are community health workers in the Latino community who promote or advance specific health messages. In Durham, these individuals provide community members with culturally and linguistically appropriate information and social support to implement behavior change (Figure 1). To retain promotores in its programs, El Centro Hispano compensates them with gift cards and other amenities. El Centro Hispano also invites promotores to participate in other activities at the center, such as providing individuals with referrals to its direct support program and assisting them with employment searches.

The El Centro Hispano diabetes prevention program is funded by the North Carolina Office of Minority Health and Health Disparities, and activities include a 20-session diabetes and obesity prevention program called PESA (Promoviendo Estado Saludable [Promoting Healthy Habits]) and program to train community leaders to become diabetes prevention promotores. The PESA program was originally developed by the Duke Hypertension Center in collaboration with El Centro Hispano. PESA includes weekly group sessions led by trained promotores who have completed the PESA program at El Centro Hispano, a medically trained health specialist from El Centro Hispano, and certified physical activity instructors. Sessions are conducted in Spanish and include guided physical activity, nutrition classes, food demonstrations, and self-esteem workshops. Promotores help participants complete registration and evaluation forms, measure participants’ anthropometric characteristics, and provide one-on-one make-up sessions for individuals who enter the PESA program late. One of the benefits of the program is the provision of free child care and snacks during sessions. From August 2010 through March 2011, 56 women aged 19-60 years participated in the program. Participants lost an average of 4 pounds, with an average reduction in body mass index (calculated as the weight in kilograms divided by the square of the height in meters) of 0.5.

In 2011, El Centro Hispano identified and recruited 30 Latino community leaders from among people in the PESA program and those in other El Centro Hispano programs to participate in promotores training and, after completion, provide diabetes prevention education, outreach, and referral to local Latinos. A representative from the Office of Minority Health and Health Disparities and a medically trained health specialist from El Centro Hispano facilitated the training in Spanish at El Centro Hispano. Eighteen participants completed the training, and 13 signed a pledge to continue with the program as promotores. The promotores included 2 men and 11 women aged 18-52 years. Nine were from Mexico, 3 were from Peru, and 1 was from Colombia. The trained promotores worked with the support and guidance of the health specialist to organize and facilitate 24 community workshops, conduct community outreach at 17 community events, and provide 427 glucose screenings and 68 referrals. From January through May 2011, the promotores educated 547 Latino women and 278 Latino men aged 18-60 years.
Peer-to-Peer Learning in the Self-Management of Chronic Disease

Joyce Page, Serena Weisner

The North Carolina Department of Health and Human Services, through the Division of Public Health and the Division of Aging and Adult Services, has adopted an evidence-based self-management curriculum called Living Healthy in NC that uses peer-to-peer learning to improve the ability of persons to manage their diseases, including diabetes, and to prevent or slow the progression of chronic conditions. The program is based on Stanford University’s Chronic Disease Self-Management Program (CDSMP) and is being implemented in North Carolina through broad and diverse partnerships within and between multiple systems.

Kate Lorig and colleagues at the Stanford Patient Education Research Center created and evaluated the CDSMP in the early 1990s, recognizing that physician care is only part of the disease-management process and that persons with chronic conditions must be good self-managers 24 hours a day, 7 days a week. Workshop sessions with a duration of 2.5 hours take place in community settings once each week for 6 weeks and provide tools and support for becoming positive self-managers. The CDSMP is based on years of research addressing patient self-efficacy and is built on several underlying assumptions, including the following: (1) people can learn skills needed to better manage their diseases; (2) people with chronic conditions have similar challenges, regardless of the type of condition; (3) people with chronic conditions deal not only with their disease(s), but also the impact it has on their lives; (4) laypeople with chronic conditions can, when given a detailed leader’s manual, teach the CDSMP as and perhaps more effectively than can health professionals; and (5) the way in which the CDSMP is taught is as important as the subject matter being conveyed.

Research has shown the CDSMP to be effective across socioeconomic and education levels, settings, populations, and chronic conditions. The CDSMP results in statistically significant and measurable improvements in physical and emotional outcomes and in self-rated overall health and health-related quality of life. Whereas people with chronic illnesses are generally expected to make more trips to the emergency department and to have more hospital admissions as their condition worsens, this is not the case for those who have participated in the CDSMP. Participation in CDSMP has been shown to result in reductions in health care expenditures. Many of these health benefits persist over a 3-year period [1].

One or preferably both of the peer leaders who facilitate each workshop have chronic conditions and act as “models” for participants, because participants tend to have a greater sense of trust and understanding when workshops are led by people facing similar challenges and problems. Topics covered include techniques to deal with problems such as frustration, fatigue, pain, and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with family, friends, and health professionals; nutrition; and how to evaluate new treatments.

The peer-to-peer characteristic of the CDSMP was one of the primary reasons the Division of Public Health adopted the program in 2005 as part of an effort to improve disease self-management. At that time, the CDSMP complemented existing programs that used community health workers through the Division of Public Health’s Diabetes Prevention and Control Program.

In 2007 and 2010, the Division of Aging and Adult Services received grants from the US Administration on Aging to further disseminate the CDSMP statewide. These grants also made it possible to expand Stanford University’s Diabetes Self-Management Program (known in North Carolina as Living Healthy with Diabetes), the CDSMP’s “sister” program that targets individuals with type 2 diabetes.

Together, Living Healthy and Living Healthy with Diabetes are the leading providers of chronic disease self-management services in North Carolina. These programs are supported by 17 regional coordinators in the state’s Area Agencies on Aging, local health departments, Community Care of North Carolina, the North Carolina Cooperative Extension, the University of North Carolina–Chapel Hill Institute on Aging, the American Association of Retired Persons, faith-based organizations, the Associations of the General Baptist State Convention of North Carolina, Strengthening the Black Family, the Eastern Band of Cherokee Indians, and dozens of local community-based organizations. Since 2005, >3,000 people have taken part in one or both of the programs, and >1,500 of those persons have participated in the past 15 months.


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Workshops, outreach, screenings, and referrals took place in churches, participants’ homes, flea markets, laundry mats, grocery stores, Mexican tiendas (small stores), health fairs, and the El Centro Hispano office. During workshops, promotores used visual displays to describe the types and symptoms of diabetes, the risk factors for diabetes, and the health care resources for people living with or at risk for diabetes. During workshops, outreach, and screenings, promotores gave participants brochures related to diabetes prevention and treatment, nutrition, and physical activity, as well as a list of local diabetes-related resources. Promotores conducted individualized home visits for 58 people with or at high risk for diabetes. During home visits, promotores assessed family history of diabetes, habits related to physical activity and nutrition, access to medical care, and physician-prescribed treatment regimens. For participants without a medical home, promotores provided a referral to the local federally qualified health center. Individuals were also instructed to select a personal goal to prevent or help manage their diabetes. Personal goals included improving nutritional habits, keeping medical appointments, and taking medications as prescribed.

The promotores worked as a team, organized activities in their respective churches, and participated together in groups. For example, at a church event, 4 promotores worked together to educate >60 community members. Also, promotores organized themselves into teams to visit the local flea market, offering diabetes screening every weekend for 2 months.

The health education specialist brought together a focus group at the end of the promotores program to capture the reactions of the promotores. The promotores reported that the Latino community was very receptive to the diabetes prevention information and that the majority of people contacted by the promotores had either diabetes or family members living with the disease; many of the contacted individuals wanted to know how to prevent or manage diabetes through lifestyle changes. The promotores also acknowledged that participation in the promotores program had enriched their lives by allowing them to help and learn from the community. Onepromotor explained that “the aspect of [the program] that had the greatest impact on me was that I could serve my community with this information, especially helping those who needed it most.” Another reflected on the personal impact of their realization that, before contact with promotores, “people had very little information and didn’t know where to find treatment or found it hard to pay for treatment for their diabetes.” A third promotor remarked that the training received through the program helped them minimize their stress and frustration, adding that it “not only helped me a lot but also [helped] those with diabetes.”

It is apparent that engaging key community members is critical when it comes to improving the health and well-being of Latinos in and around Durham and Chapel Hill. Recruiting, compensating, and sustaining the number of promotores, as evidenced through many successful programs, is proving to be an effective strategy for reducing common health risks and enhancing overall quality of life in this population.

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