An Empowerment-Based Diabetes Self-management Education Program for Hispanic/Latinos
A Quasi-experimental Pilot Study

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Purpose

The purpose of this pilot study was to evaluate the effects of a culturally sensitive, empowerment-based diabetes self-management education program for Spanish-speaking Hispanic/Latinos.

Methods

A prospective quasi-experimental repeated measures design tested the effectiveness of the ¡Sí, Yo Puedo Controlar Mi Diabetes! diabetes self-management education program. In sum, 144 persons residing in 2 Texas counties at the Texas-Mexico border (Starr and Hidalgo) served as participants. Two groups were formed, an intervention and a control (wait list). Clinical (A1C), cognitive, attitudinal, behavioral, and cultural assessments were collected at baseline and 3 months.

Results

Demographic characteristics for the intervention and control groups were similar. Both groups were predominately female, low income, older than 40 years, and minimally acculturated. Baseline and posttest findings showed that the intervention group had a significant reduction in A1C values; median difference was 0.3 (n = 45), especially for those with higher baseline values. Participants in the intervention group also improved in their self-efficacy and self-care scores.
Conclusions

Findings from the study suggest that additional dissemination of a diabetes self-management education program for Spanish-speaking Hispanic/Latinos is warranted to improve clinical outcomes and associated diabetes self-efficacy and self-care behaviors.

Hispanic/Latinos are a growing segment of the US population, burdened with higher rates of diabetes prevalence, mortality, and disease complications compared with whites.\textsuperscript{1} Research suggests that culturally appropriate diabetes self-management education (DSME) for Hispanic/Latinos can positively affect glycemic control (hemoglobin A1C < 7), diabetes self-care behaviors, self-efficacy, and health status.\textsuperscript{2-5} Diabetes education is critical to maintaining glycemic control, with documented short-term improvements in physiologic outcomes and quality of life.\textsuperscript{6} Yet, interventions developed and tested in white non-Hispanic populations are not likely to translate well to other populations, such as Spanish-speaking Texas Hispanic/Latinos with diabetes. Brown et al observed that Hispanic/Latinos are often labeled noncompliant because cultural, linguistic, and literacy barriers make these programs ineffective.\textsuperscript{7} This article reports on the pilot study of ¡Si, Yo Puedo Controlar Mi Diabetes! (Yo Puedo), a culturally competent DSME program designed to overcome these obstacles. Yo Pudo was delivered in Starr and Hidalgo counties, Texas, each situated on the Texas-Mexico border.

Yo Puedo is a 5-week DSME program predicated on the American Diabetes Association’s standards for diabetes medical care and self-management education.\textsuperscript{6,8} This intervention is a patient-centered approach to DSME, guided by the empowerment philosophy. Since the association instituted its national standards for diabetes education in 1982, DSME has evolved from didactic presentations to interventions involving patient empowerment.\textsuperscript{9} Because diabetes patients are responsible for > 90% of their daily care, an empowerment-based DSME is ideally more appropriate for them compared with an individual-oriented program.\textsuperscript{9,10} A large body of evidence suggests that an empowerment-focused DSME offers many benefits: better communication with providers, greater satisfaction with care, improved metabolic outcomes, and better psychosocial well-being.\textsuperscript{10-12} In recognition of these advantages, Yo Puedo was designed to empower participants with knowledge and lifestyle skills to effectively manage their diabetes through community-based group sessions. Group- versus individual-based strategy for diabetes self-management offers several benefits: It is cost-effective, fosters social modeling, leads to greater participant satisfaction, improves hemoglobin A1C, and positively influences lifestyle behaviors, such as diet and physical activity.\textsuperscript{11-13}

The purpose of this pilot study was to evaluate the effects of a culturally sensitive, empowerment-based DSME program for Spanish-speaking Hispanic/Latinos. Secondary goals were to describe characteristics of the participants and their attendance rates.

Methods

Research Study Design

A prospective quasi-experimental repeated measures design tested the program’s effectiveness. Those enrolled in the control (wait list) group received their usual and customary diabetes care from their physicians during the study period. These individuals were provided the intervention at the completion of the program. This approach was used as a retention measure because of their expectation to eventually receive the classes. Ethical approval was obtained from the Texas A&M University Institutional Review Board.

Sample and Recruitment

Using county of residence as the assignment criterion, participants residing in Starr County, Texas, formed the intervention group; those living in Hidalgo County, Texas, formed the control group. The intervention and control groups were not in the same area because of the risk of cross contamination. Classes were held in 4 locations in each county, with class size between 10 and 20 participants. Participation criteria included the following: self-identified Hispanic/Latino, older than 40 years, and diagnosis of type 2 diabetes. Community outreach, flyers, posters, and newspaper announcements were used to recruit participants.

Potential participants were encouraged to call their county extension office to register in Yo Puedo. During the call, a brief screening interview was conducted. Because of ethical considerations, persons not meeting
the study criteria were allowed to enroll in the class but were not included in the sample for data analysis. A total of 83 participants were recruited for the intervention group and 61 for the control.

**Study Setting**

The study sites—Starr County and Hidalgo County, Texas—are situated on the southern tip of the state. Starr County has a population of 62,671, with 97.2% Hispanic/Latinos; Hidalgo County has a population of 741,152 with 89.8% Hispanic/Latinos. This region is disproportionately affected by the higher prevalence of diabetes compared with national rates. The 2 counties served by the project are medically underserved areas, with poverty rates nearly triple the national average. Limited health care resources are likely to negatively affect the availability and access to community-based DSME.

**Intervention**

*Yo Puedo* consists of 5 weekly lessons focusing on experiential and group activities to reinforce lesson concepts. Each class is approximately 2 hours long. A weekly video *novela* (soap opera) series was created as a vehicle to deliver health messages in a culturally appealing manner. The videos were locally produced, with their content written by the lead author. A registered nurse and a dietitian delivered the program, each bilingual and each experienced and trained with the *Yo Puedo* curriculum. Experienced diabetes educators were recruited to instruct the course. Four classes were offered in community settings (eg, church and library). Participants received a free glucose monitor, strips, and pedometer as incentives.

The social cognitive theory and the self-regulation theory serve as the framework for the *Yo Puedo* curriculum. The self-regulation theory, a disease management model, has its underpinnings in the social cognitive theory. Core constructs employed in the curriculum include self-efficacy, social modeling, and behavioral capability. Through a series of learning, modeling, and group activities, *Yo Puedo* aims to improve self-efficacy and promote self-care in patients with diabetes. Table 1 details the key constructs and applications of these principals to the *Yo Puedo* program.

**Data Collection**

Pretest assessments were collected 1 week before the start of the intervention. Posttest was conducted at week 5 of the course. A1C was collected at baseline and 3 months. The participant surveys were completed orally in Spanish by trained bilingual interviewers. Questions were read to participants and responses recorded by the interviewer.

**Measures**

Baseline measures assessed were demographics, acculturation, and literacy. Demographics collected included age, sex, ethnicity, language spoken at home, education levels, income, and health insurance. Pilot study pretest and posttest evaluations included self-efficacy and diabetes self-care and knowledge. A1C levels were measured at baseline and 3 months postintervention. A local medical clinic and laboratory service conducted and analyzed A1C tests. After receiving A1C results, the lead author sent a letter with this information to participants, which included a brief explanation of the findings.

**Instruments**

Literacy levels were assessed with the following questions, developed through formative research:

“Do you remember if learning to read as a child was: (0) very difficult, (1) only a little tricky, (2) or it happened easily?”

“Would you say that your reading now is: (2) better than most other people’s, (1) normal, (0) or something you try to avoid?”

The literacy score was the average of the 2 numerical answers and was converted to a percentage, with a higher score indicating a higher level of literacy (see Table 2).

Acculturation was measured by the 5-item language-based acculturation scale developed by Marin et al. For example, questions included “What languages do you usually speak at home?” and “In which language do you think?” Each question was given a score of 1 (only Spanish) through 5 (only English). The instrument was scored by summing the nonmissing answers for each question, giving a total of 25. Scores were converted to a percentage for participants with no more than 2 missing responses. The score is greater for a more acculturated participant.

Self-efficacy for diabetes was measured by the Stanford 8-item instrument. Questions included “How confident do you feel that you can exercise 15 to 30 minutes 4-5 times a week?” and “How confident do you feel that you
Table 1

Yo Puedo Education Program Concept and Intervention Strategies

<table>
<thead>
<tr>
<th>Theoretical Framework: Social Learning and Self-regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Format</strong></td>
</tr>
<tr>
<td>1. Five weekly 1.5- to 2-hour sessions</td>
</tr>
<tr>
<td>3. Guided discussion on the video novela (soap opera) messages</td>
</tr>
<tr>
<td>4. Experiential activities reinforcing dietary principals</td>
</tr>
<tr>
<td>5. Multiple repetitions of key concepts occurring at every session</td>
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<tr>
<td>6. Individual goal setting</td>
</tr>
<tr>
<td>7. Family support</td>
</tr>
<tr>
<td>8. Modeling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intervention Strategies</th>
<th>Knowledge</th>
<th>Attitudes</th>
<th>Diet</th>
<th>PA</th>
<th>SMBG</th>
<th>MA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Video novela with guided discussions</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>2. Blood glucose–monitoring instruction</td>
<td>×</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Short presentations of key intervention messages</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>4. Group learning games</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>5. Problem solving (group and individual)</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>6. Individual goal setting</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>7. Family support</td>
<td>×</td>
<td></td>
<td>×</td>
<td>×</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Modeling</td>
<td>×</td>
<td></td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Feedback opportunities (review of weekly homework, reinforcement of positive behaviors and attitudes)</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>10. Emphasizing one message at a time</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Cognitive reframing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Visual aids (food photo cards, pictorial handouts, and pictorial homework sheet)</td>
<td>×</td>
<td></td>
<td>×</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Use of food measuring aids</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Meal planning with healthy plate concept</td>
<td>×</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Food label reading</td>
<td>×</td>
<td></td>
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</tr>
</tbody>
</table>

+PA, physical activity; SMBG, self-management blood glucose; MA, medication adherence.

know what to do when your blood glucose level goes higher or lower than it should be?” Each question was given a score of 1 (not confident at all) through 10 (totally confident). The self-efficacy score was the mean of the nonmissing answers and was converted to a percentage, with a higher score indicating a higher level of self-efficacy.

The diabetes self-care activities were measured by the scale developed by Toobert et al.10 Twelve items were used to assess participants’ general diet, specific diet, exercise, monitoring blood glucose, foot care, and smoking habit—such as “In how many of the past 7 days have you followed a healthy eating plan” and “In how many of the past 7 days did you check your blood glucose?” The self-care score was a sum of the responses and was converted to a percentage, with a higher score indicating better self-care of diabetes (see Table 2).
Data Analysis

Descriptive statistics (mean and standard deviation) were reported for normally distributed data, with normality being assessed using the Shapiro-Wilks test. To compare differences between the intervention and control groups on continuous data, t tests were employed, after checking for equal variances using the Levene test. For data showing evidence of a lack of normality, median and interquartile range were reported. To compare the intervention and control groups for such data, the Wilcoxon-Mann-Whitney rank-sum test was used. Confidence
intervals (CIs) for medians were calculated using quantile regression. The Pearson \( \chi^2 \) test for independence was used, or Fisher exact test if cell size was less than 5, to compare the intervention and control groups for dichotomous variables. Multivariate regression models to estimate medians were fit using quantile regression; logistic regression models were used to estimate proportions and percentages. In both cases, backward stepwise was used to determine the parsimonious model. All statistical analyses were carried out with Stata MP 11.1.

### Results

The intervention group (\( n = 74 \)) and the control group (\( n = 65 \)) had some similar demographic characteristics: 70% lived on \( \leq \$20,000 \) and 97% spoke Spanish at home. Both groups were minimally acculturated—more than half the sample had a score of 0%, whereas 100% indicated highly acculturated. Overall, 50% of participants in both groups reported not having medical insurance. Group differences were observed in age, sex, education, and literacy. The intervention group was younger (mean, 59.4 years; \( n = 71 \)), had more females (71.6%, \( n = 74 \)), and were mostly high school graduates (84.5%, \( n = 71 \)) with a median literacy score of 50% (\( n = 68 \)) (see Table 3).

The median number of classes attended by those in the intervention group was 4 out of 5 (interquartile range = 3). About 35% completed all 5 classes (95% CI, 24%-47%), and 72% (95% CI, 60%-81%) attended at least 3 classes. Age was significantly associated with class...
attendance: Younger participants (≤70 years old) were most likely to attend at least 3 classes, with attendance rates at 78% (n = 61; 95% CI, 66%-88%), whereas only 38% of older participants attended 3 or more classes (n = 13; 95% CI, 14%-68%).

At posttest (week 5), the intervention group reported significantly higher diabetes self-care scores compared with the controls; median increase in score was 22%, compared with 0% change for the control group (see Table 4). The largest improvement in self-care was recorded in checking blood glucose the recommended number of times per day (increased from a median of 2 to 7 days per week), having at least 30 minutes of physical exercise each day (from 2 to 6 days), following a healthful eating plan (from 3 to 6 days per week), and eating 5 servings of fruit and vegetables per day (from 3 to 5 days). Least change

Table 4
Pretest-Posttest Differences in Key Outcome Variables

<table>
<thead>
<tr>
<th>Score</th>
<th>Intervention</th>
<th>Control (Wait List)</th>
<th>Wilcoxon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Median</td>
<td>IQR</td>
</tr>
<tr>
<td>Self-care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline, %</td>
<td>83</td>
<td>40.48</td>
<td>26.2</td>
</tr>
<tr>
<td>Posttest, %</td>
<td>65</td>
<td>66.67</td>
<td>16.7</td>
</tr>
<tr>
<td>Days to posttest</td>
<td>65</td>
<td>35</td>
<td>21</td>
</tr>
<tr>
<td>Difference, %</td>
<td>64</td>
<td>22.02</td>
<td>24.4</td>
</tr>
<tr>
<td>Difference in question response: On how many of the past 7 days have you . . .</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Followed healthful eating plan</td>
<td>65</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Checked blood glucose as often as should</td>
<td>63</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Followed eating plan in last month</td>
<td>65</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Performed 30 minutes physical activity</td>
<td>65</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Had 5 or more servings fruits and vegetables</td>
<td>65</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline, %</td>
<td>84</td>
<td>56.25</td>
<td>28.1</td>
</tr>
<tr>
<td>Posttest, %</td>
<td>65</td>
<td>88.75</td>
<td>21.3</td>
</tr>
<tr>
<td>Difference, %</td>
<td>65</td>
<td>27.5</td>
<td>30.0</td>
</tr>
<tr>
<td>Difference in question response: How confident do you feel that you can . . .</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control diabetes so does not interfere</td>
<td>65</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Prevent low glucose during exercise</td>
<td>65</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Choose good food when hungry</td>
<td>65</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Exercise 15-30 min 4-5 times a week</td>
<td>65</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Follow diet when cooking for others</td>
<td>65</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Judge changes in illness, go to doctor</td>
<td>65</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Know if blood glucose is too low or high</td>
<td>65</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Eat meal every 4-5 hr, including breakfast</td>
<td>65</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

*Posttest subtracted from pretest. IQR, interquartile range.

1 = not confident, 10 = confident.
was reported in eating high-fat foods, such as red meat and dairy (decrease from 3 to 2 days). Minimal change was observed in checking feet and blood glucose at least once per day (from 6 to 7 days) and checking blood glucose daily (from 5.5 to 7 days), probably because both values were already high at baseline. Only 3 participants in the intervention group reported smoking, and all reported a reduction in smoking at posttest.

At posttest (week 5), the intervention group reported significantly higher diabetes self-efficacy scores compared with the controls; median increase in scores was 27.5%, whereas only 2.5% change was observed in the control group. The greatest increase in confidence in controlling diabetes was observed in the following: does not interfere with activity choices (increased from 5 to 10), preventing blood glucose level from dropping during exercise (from 5 to 9), exercising 15 to 30 minutes 4 to 5 times a week (from 5 to 9), and choosing the appropriate foods when hungry (from 5 to 9). The least change was observed in the confidence about eating meals every 4 to 5 hours every day, including breakfast every day (from 7 to 8).

Baseline median A1C for both groups was not significantly different: 7.90% for the intervention group (n = 66) and 7.40% for the control group (n = 54). Posttest A1C collected at an average of 3 months was 7.10% for the intervention group (n = 45) and 7.40% for the control group (n = 24). A reduction in A1C from baseline to posttest was found among the intervention group; median difference was 0.3% (n = 45), with no change in the control group (n = 18).

Defining high A1C as > 7.0%, a Pearson $\chi^2$ test indicated no significant difference in baseline A1C ($P = 0.148$) and follow-up A1C ($P = 0.077$) between the intervention and control groups.

While this difference was not significant according to the crude test based on Wilcoxon-Mann-Whitney ($P = 0.35$), a multivariate quantile regression on the A1C difference, including the interaction between intervention and baseline A1C squared, showed significant evidence of a change for those in the intervention group with high baseline A1C. More precise, for those in the intervention group with baseline A1C > 8%, a statistically significant (at the 5% level) reduction in A1C of approximately 1 percentage point was found. Furthermore, the size of the reduction increased as the baseline A1C increased, which was seen by the increasing slope group versus individual-based strategy. Lowering A1C, an indicator of effective diabetes management, offers several benefits: It is cost-effective, fosters social modeling, leads to greater participant satisfaction, improves hemoglobin A1C, and positively influences lifestyle behaviors such as diet and physical activity (Figure 1).11-13

**Figure 1.** Reduction in A1C, by baseline A1C, for the intervention and control groups.

**Discussion**

Methodologically sound and replicable interventions that can be translated in community settings are needed to address disparities in diabetes care for Hispanic/Latinos. Yo Puedo, developed by Texas AgriLife Extension Service, was an initiative to fill this gap in health programming. As a state agency, AgriLife Extension has the capacity to deliver the program in both clinical and community settings, utilizing its statewide cadre of county agents and community partners. Through this collaborative effort, community coalitions are formed to implement Yo Puedo. It is this grassroots mobilization of human capital and resources that makes Yo Puedo sustainable. Importantly, given this diffusion method, Yo Puedo has the potential to reach large numbers of underserved Hispanic/Latinos, particularly in rural communities served by AgriLife Extension.

Data from the study demonstrated that Yo Puedo significantly improved participants’ engagement in diabetes self-care behaviors in tandem with increases in self-confidence. These findings provide evidence that a culturally sensitive DSME program for Hispanic/Latinos, particularly one that is empowerment based, can yield positive metabolic and self-care behavioral benefits. It is worth noting that improvements were observed in program completers as well as those who attended some of the classes.
The reduction in A1C (at least 0.5 percentage points) among those in the intervention group with a high A1C baseline (greater than 8%) was shown to be statistically significant. These improvements were more pronounced in those with greater A1Cs, a reflection of increased glycemic control. According to the Diabetes Control and Complication Trial, a 0.5–percentage point reduction in A1C results in a significant decrease in diabetes-related complications. Lowering A1C values and attaining glycemic control among Yo Puedo participants could have long-term positive outcomes for patients with diabetes.

Consistent with prior reports, improvements in self-efficacy were associated with changes in diabetes self-management, including increasing health behaviors and a reduction in A1C. Results from the study revealed a significant increase in participants’ confidence to control their diabetes, so there was no interference in their daily activities. Findings suggest that participants felt better control and were motivated to take action to maintain safe blood glucose levels. Furthermore, there was a significant increase in participants checking blood glucose the recommended number of times per day in self-care behavior. As Heisler et al. noted, diabetes patients with knowledge of their A1C value were more likely to report better diabetes care.

Another positive outcome of Yo Puedo was the high class attendance rate. This might be attributed to the following: free transportation and glucose meters and strips, personal recognition from class leaders and peers, and the intrinsic benefits from learning and applying new behaviors. Participants were highly responsive to the weekly “power phrases” recited aloud in class. The power phrase served to communicate the central theme “Yes, I can control my diabetes!” This strategy generated a lot of positive feedback from participants, as well as class leaders.

Utilizing experienced and trained diabetes educators enhanced and was an asset in the delivery of Yo Puedo. The instructors’ competence in both content and teaching style created an environment that was conducive to learning. Furthermore, their fidelity to the empowerment-based curriculum was instrumental to achieving program objectives. These combined factors likely contributed to the improvements observed in the study. However, future research to assess the impact of instructors’ experience on program outcomes is suggested.

Limitations

Findings were subject to some limitations. First, the lower baseline A1C values may be indicative of good glycemic control. An A1C of < 7% is recommended to reduce the risk for diabetes complications. The lower rates of A1C contrasted with those reported in the Starr County Border Health Initiative. Because most participants had lower levels of acculturation, it can be speculated that this group may be consuming a traditional Mexican vs Western diet. Additionally, participants using alternative therapies warranted further investigation. Other studies have reported that use of herbal remedies and folk healers (curanderos) affects blood glucose management for Mexican Americans with type 2 diabetes. Second, the small sample size (N = 144) limited generalizability. Last, data were lost because participants dropped out or did not attend the final class to complete the posttest assessment. Given these limitations, further research is needed to elucidate the reason for low A1C levels and to conduct a more comprehensive test with a larger sample size.

Recommendations for future implementation of Yo Puedo include removing obstacles that can hinder attending classes (eg, lack of transportation, limited resources to purchase blood glucose–monitoring supplies) and developing follow-up booster sessions. Participants expressed the need for more class sessions, especially classes to help them with behavior maintenance.

Implications

Diabetes educators as well as health care providers can benefit from evidence-based DSME programs tailored to the unique needs of diverse populations such as Hispanic/Latinos. Evidence from the study contributes to the growing body of literature demonstrating that culturally appropriate DSME programs targeting Hispanic/Latinos can be efficacious.

Achievements observed in the Yo Puedo pilot suggest that an empowerment-based DSME has potential for the low-literate, Spanish-speaking Hispanic/Latino. Reducing disparities in diabetes care among Hispanic/Latinos is a national imperative. The study provides strong evidence that Yo Puedo is an effective DSME that can respond to the diabetes care disparities, especially among the underserved communities.

References


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