Results from a Promotora Model for Improving Latino Health Care Access in California's Central Valley

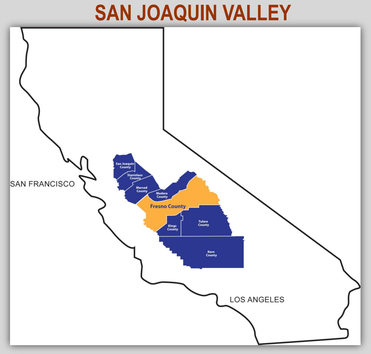
Mariana Ramirez, BA, John A. Capitman, PhD, Tania Pacheco, BA, Alicia Gonzalez, BS
Central Valley Health Policy Institute, Fresno CA

INTRODUCTION

The Central Valley Health Policy Institute (CVHPI) at California State University Fresno seeks policy and program strategies to reduce racial/ethnic and other social inequities in health among San Joaquin Valley residents. Access to health for this particular population is plagued with barriers, but shares many access barriers with the rest of Californians. California's San Joaquin Valley is a poor region, where significant poverty is present in both urban and rural areas.[1] The region has some of the most medically underserved areas in the state, and the problem is worse for residents of Mexican descent. In 2005, over a quarter (34%) of non-elderly San Joaquin Valley adults who reported being without insurance were born in Mexico.[2]

Through a generous grants from the **Centers for Medicare and Medicaid Services (CMS)** , CVHPI has been exploring the "Promotora Model" to increase access to Central Valley immigrant elders, adults, and their children. The CMS project focused on legal resident adults and elders .

SAN JOAQUIN VALLEY



METHODS

The Promotora Model consisted of:

- ❑ 13 Promotoras (CHWs)
- ❑ Promotora training
- ❑ Community outreach and Latino participant recruitment
- ❑ Baseline survey (pre-test)
- ❑ Plan of Action:
  - Referrals
  - Participant follow-up: calls visits
- ❑ Three-month follow-up survey (post-test)
- ❑ Interview with Promotoras

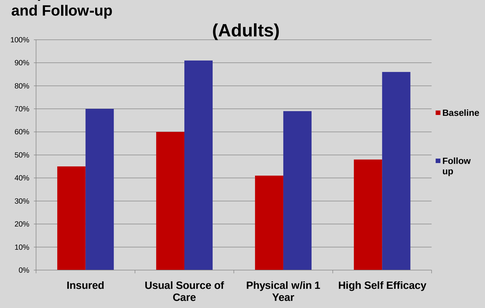


Four indicators of health care access were measured in the baseline and follow-up interviews:

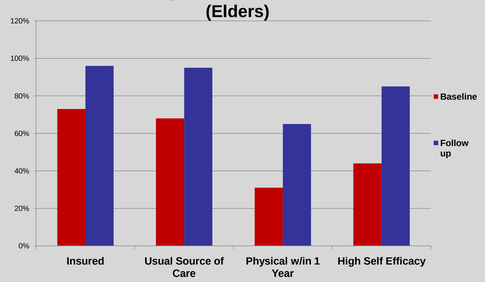
- ❑ Insurance Status: Does the participant have an insurance provider?
- ❑ Source of Care: Does the participant have a medical home or primary care provider?
- ❑ Receipt of Physical: Has the participant received a form of medical preventive care?
- ❑ Self-Efficacy: How comfortable does the participant feel in making his or her own healthcare decisions?

RESULTS

Graph 1. Indicators of Access to Health Care Services at Baseline and Follow-up



Graph 2. Indicators of Access to Health Care Services at Baseline and Follow-up



Graphs 1 and 2 show the improvements in access to health care services pre and post intervention by age group.

1) The percentage of insured participants increased from baseline to follow-up from 40% to 70% for Adults and from 73% to 96% for Elders.
2) The access to a usual source of care improved after the intervention from 60% to 91% for Adults and from 68% to 95% for elders.
3) Receipt of physical for adults increase from 41% to 69% and for elders from 31% to 65%.
4) The self efficacy of respondents was categorized into low and high self-efficacy. At follow-up, more adults reported a high self efficacy (48% to 86%) as well as more adults (44% to 85%).

Table 1. Paired- Sample T-test. Health care access indicators at Baseline and Follow-up

Indicator	Mean	N	SD	t	DF	P
Insured at Follow-up	0.799	284	0.40	8.485	283	0.000
Insured at Baseline	0.546		0.50			
Source of Care at Follow-up	0.919	272	0.27	9.221	271	0.000
Source of Care at Baseline	0.621		0.49			
Physical Received at Follow-up	0.640	283	0.48	6.863	282	0.000
Physical Received at Baseline	0.357		0.48			
Self-efficacy at Follow-up	3.239	289	0.87	12.147	288	0.000
Self-efficacy at Baseline	2.187		1.15			

Table 1 supports the results presented in Graphs 1 and 2. Indicators were analyzed using a paired t-test analysis. All indicator's differences from baseline to follow-up resulted significant at the .000 value.

RESULTS (CONTINUED)

TABLE 2. Logistic and Linear regressions by indicators of access to health care services at follow-up and categorized independent variables.

	Insurance EXP (B)	Source of Care EXP (B)	Physical EXP (B)	Self-Efficacy B	SE	t
DEMOGRAPHICS						
Adults (Elders)	.132**					
First Generation (Third Generation)		5.042*		-0.393**	0.117	-3.342
US Resident (Other)				-0.476**	0.155	-3.071
RACE AWARENESS						
How Often Thinks of Own Race			1.222*			
Treated the Same As other Ethnic groups (Treated better than other ethnic groups)	2.553*					
Treated Worse than when seeking health care services (Treated better than when seeking health care services)			.296**			
OTHER HEALTH SERVICES						
Needs Help Scheduling Appt. (Does not Need Help Scheduling Appointments)	.408*					
Wants Health Education (Does not want health education)			2.887**			
Chi2	36.246***	13.058*	25.117***	R2		0.208***
DF	4	4	5	Adj. R2		0.192***
R2	0.162	0.063	0.115			
-2Log Likelyhood	137.929	72.248	244.135			
Percent Correct	86.00%	95.00%	70%			

*$p<.05$; **$p<.01$; ***$p<.001$

Logistic and linear regressions in Table 2 show the following:

1) More adults needed help getting health insurance.
2) Being first generation immigrant increased the odds of having a source of care. However they're less efficacious than third generation immigrants.
3) Being treated "worse than" other ethnic groups when seeking health care services decreases the odds of people receiving a physical.
4) People who expressed wanting health education at baseline were more likely to receive a physical at follow-up than their counterparts.

Figure 1. Respondents' Barriers in Accessing Health Care Services Prior to Promotoras' Intervention.

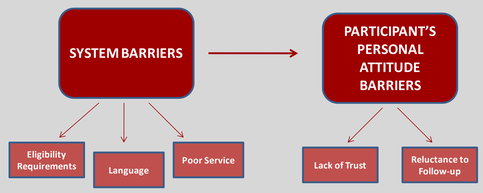
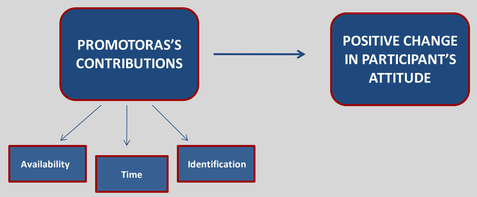


Figure 2. Promotoras' Role and Impact



Figures 1 shows that participants' barriers in accessing health care services are both, systematic and personal. However, personal attitude barriers resulted from barriers participants faced with the health care system.

On the other hand, **Figure 2** shows that promotoras' availability, time spent with participants, and identification influence participants' change of attitude towards seeking health care services.

LESSONS LEARNED & RECOMMENDATIONS

Lessons Learned:

❑There is a continuing need for sustainable funding for promotoras services to achieve appropriate health-care access and utilization for low-income Latinos.

❑The study was designed to measure the impact of a limited promotora intervention over a period of three months. Promotoras became particularly interested in participant needs beyond the study requirements. In order to address participant access barriers, they went beyond their responsibilities- being readily available to participants, volunteering more time, more phone calls, and mileage than required.

❑Through their contributions, promotoras provided a unique service for participants to overcome system barriers, change their attitudes about, and access to healthcare.

Recommendations:

❑Ongoing guidance and supervision from the project coordinator is necessary to ensure that promotoras feel supported and encouraged.

❑Institutionalization of such a service could be significantly efficient.

❑Until there are state and national policies that recognize the need for community health workers for those with health care access limitations, promotora model interventions will need to rely on philanthropic funding.

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[2] Growing a Healthier San Joaquin Valley: Recommendations for Improving the Public Health and Healthcare Infrastructure. Capitman, J.A., Riordan, D.G., Paul, C.M. (2007).

[3] Capitman, J.A., Pacheco, T.L., Ramírez, M., Gonzalez, A. *Promotoras: Lessons Learned on Improving Healthcare Access to Latinos*. Fresno, CA: Central Valley Health Policy Institute, 2009.

CONTACT INFORMATION

John A. Capitman
Central Valley Health Policy Institute
Central California Center for Health and Human Services
1625 E. Shaw Avenue, Ste. 146
Fresno, California 93710

T: 559.228.2157
F: 559.228.2168
E: jcapitman@csufresno.edu

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