Impact of “organizational home” on sustainability of peer support programs: A few comments

John Elder, PhD, MPH

San Diego State University
Co-Investigator, Peers for Progress-Imperial County (CA)
Peer-led interventions:

• Show substantial potential for controlling chronic disease
• Improve investigators’ ability to retain participants in studies for long-term follow-up
• Can attract motivated and enthusiastic volunteers
• May improve reach, visibility and PR of primary care organization
But what about cost-effectiveness?

• A primary care physician with a panel of 2500 patients would spend:
  – 7.4 hours per day to deliver all recommended preventive care (Knox presentation)
  – 10.6 hours per day for chronic care

• BUT
  – Peer leaders require substantial ‘care and feeding’, material support, and replacement
  – Volunteer coordinators have to be added to payroll
  – Resistance from primary care staff to integrating volunteers and promotoras into primary care team
Three group, randomized experiment

351 participants, randomly assigned to

- Off-the-shelf print
- Targeted and tailored print
- Targeted and tailored print + 
  promotora/face to face communication
Promotora Experience: ‘Secretos de la Buena Vida’

• Impact was generally greater in promotora group
• Mailing, supplies and personnel costs for usual care = $9 per participant.
• per participant cost = $45 for the tailored print-only condition.
• Promotora-related expenses, especially mileage reimbursement, raised the cost of this approach to slightly more than $135 per participant
• Costs per reduced gram of dietary fat were $1.30, $5.11 and $8.28.
And Are We Promoting Health Equity?

• Peer-led interventions increase access to primary care and promote patient adherence
• MD shortage in underserved areas: e.g., Wilcox County (AL): 2 MD’s; 50 mile drives to clinics being common
• coverage is often provided by professionals who aren’t well acquainted with a culture or language, e.g. Asian immigrant doctors in much of the Southeast; Anglo/English-only doctors in the Southwest
But………………

• Do we reduce health disparities with peer, auxiliary and promotora-led programs OR do we institutionalize them?
• In other words are peer led programs permanent answers, or band-aids until affordable “high quality” health care is available?
• Do we add stress to the clinic’s stretched resources and its professional environment?
Empirical Challenges
Since “one size does [not] fit all”…..

- Can we really learn from one another’s experiences between cultures and nations, or even between clinics within regions, and regions within a nation?
- If we cannot standardize interventions, how can we standardize measures in a way that produces interpretable outcomes?
- How do social desirability and other threats to validity play out across cultures?
- To what extent does the organizational environment predict peer success, and how do we measure that?
Are we measuring the correct outcomes?

• Is quality of life better manifested through emotional well being (less depression, diabetes distress) than physical/physiological indices?

• What changes in the peers themselves, the patients’ social networks, clinics/ health care organizations and their communities are evidenced?

• Are we underselling impact of peer-led interventions?