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

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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


SECRETOS
DE LA BUENA VIDA

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?