COMMUNITY-BASED HEALTH SERVICES FOR POOR AND/OR UNDOCUMENTED LATINO IMMIGRANTS IN WASHINGTON

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Introduction

When I began my research on health services for poor and/or undocumented Latinos immigrants in Washington State, I felt overwhelmed by the enormous barriers that this particular population faces in accessing adequate health care. The chapters on public health and health insurance in last year's *State of the State for Washington Latinos* report detailed the obstacles that Latinos encounter when it comes to health care access; for example, they are more likely to be uninsured and to struggle with language and cultural barriers that interfere with the quality of care they receive.[1] Furthermore, recent and/or undocumented immigrants are barred from most government-funded health insurance programs like Medicaid and the State Children's Health Insurance Program (SCHIP). Such barriers have had serious negative consequences for the health of the Latino population in Washington: Latino death rates from HIV/AIDS, asthma, cervical cancer, diabetes, and tuberculosis are twice that of Caucasians.[2] Other reports and scholarly literature that I read upheld these findings. The health care situation for Latinos in Washington seemed quite bleak.

With all of this on my mind, I began talking to people involved in providing health services to Latinos and was amazed by the energy and enthusiasm they displayed in the face of such discouraging trends. Inspired by their motivation and the personal sacrifices they were making to help increase Latinos' access to health care, I decided to focus my research on the impact of these community-based efforts. Specifically, I wanted to answer these questions: What community-based programs exist in Washington to help poor and/or undocumented Latinos access adequate health care? How can these programs be expanded or improved to increase their effectiveness? What steps can the State of Washington take to promote these community-based programs and to foster conditions in which they could be even more successful? I felt that finding answers to these questions could provide concrete ideas for ways in which the health care situation for Washington Latinos could be improved.

I began by searching the databases at Penrose Library for scholarly research on the subject. I also chose two case studies. The first was at the Quincy Community Health Center in Quincy, WA where my community partner, Mary Jo Ybarra-Vega, runs a *Promotores(as) de Salud* (community health worker) program. The second was at Grace Clinic in Kennewick, WA, a Christian clinic that offers free services to the uninsured. I visited both clinics and spoke to staff members about their work. At Quincy, I was also able to interview a woman who had attended a health-related class held at a *promotora's* home. Mary Jo Ybarra-Vega was extraordinarily helpful in helping me to secure this interview and in showing me around the clinic and answering all of my questions. After completing my case studies, I have found both *promotores(as)* programs and free clinics to be admirable and effective responses to the health needs of the communities they serve. I have also found that one major factor that prevents both *promotores(as)* programs and free clinics from being more effective is the large number of Latino immigrants, documented and undocumented, who remain uninsured because of federal government

[1] Secord, "Health Insurance and Access to Health Care for Latinos in Washington State," 2.
[2] Wickramanayake, "The State of Public Health of Washington Latinos," 5.

policies that deny Medicaid to undocumented immigrants and to immigrants who have lived in the United States for less then five years. I argue, therefore, that the government of Washington needs to support these community-based initiatives and that the most important step that it can take in this regard is to ensure that more Latino immigrants are able to access health insurance. It can do this by expanding the Children's Health Program, a Medicaid look-alike program that does not consider immigration or citizen status in its eligibility requirements, and by creating a similar program that would be available to adults. Such programs would greatly reduce the burden carried by community-based initiatives, allowing them to pursue their work even more effectively.

Literature Review

I explored a variety of scholarly literature to provide a context for my case studies. I recognized that free clinics and programs like Quincy's *promotor(a)* program seek to fill the holes that exist in Washington State's health care system, so I sought scholarly literature that would help me to obtain a better understanding of such clinics and programs and the gaps that they might be filling. I first looked at studies on the use of health care by Latinos, especially by recent or undocumented immigrants, in order to identify the steps that Washington State can take to help these populations. I also looked for literature on the role of health care "safety nets," which serve the poor and/or uninsured. These "safety nets" include Federally Qualified Health Centers like Quincy Community Health Center and free/charity clinics like Grace Clinic.[3] Finally, I researched literature that examined the effectiveness of community health worker programs like Quincy's *promotor(a)* program.

Social and Health Services Use By Undocumented Immigrants

Many of those who advocate an increased effort to enforce immigration laws in the United States claim that undocumented immigrants are a burden to the nation's social welfare system and to taxpayers. Studies have shown, however, that health care use among undocumented immigrants, like that of Latinos in general, is rather low. A study by Macias and Morales demonstrated a low use of health care services among Latinos surveyed at a health fair in South Los Angeles County. The survey revealed that the majority of the participants, ninety-seven percent of whom were foreign born, were uninsured, and that many refrained from seeking medical attention because of the expense.[4] A different study by Berk et al. showed that undocumented immigrants come to the United States primarily for employment, not to access social welfare services. This report showed that the ambulatory health care use by undocumented Latinos is low compared to that of both the Latino population as a whole and the national population.[5] It further states that the hospitalization rates of undocumented Latinos are comparable to that of the rest of the nation, though that population has slightly higher rates of

[3] Schueler, "Washington's Primary Care Safety Net," 5.
[4] Macias and Morales, "Utilization of Health Care Services Among Adults Attending a Health Fair in South Los Angeles County," 35.
[5] Berk et. al., "Health Care Use Among Undocumented Latino Immigrants," 56.

hospitalization for childbirth.[6] Berk et al. also note that given the high percentage of undocumented immigrants who have children who are U.S Citizens, restricting access to health care and other services for this population is both unlikely to decrease undocumented immigration rates and likely to negatively affect the health of both the undocumented population and children of undocumented immigrants who are U.S. citizens.[7] Undocumented immigrants do not qualify for most social welfare programs, so it is hard to see how they could be placing a burden on this sector. Also, a fact sheet on undocumented immigration from The Urban Institute points out that that undocumented immigrants contribute to the U.S. tax system through real estate taxes and sales and other consumption taxes, which fund much of the costs of schools and other such services at the state and local level. It also states that "the U.S. Social Security Administration has estimated that three quarters of undocumented immigrants pay payroll taxes, and that they contribute $6-7 billion in Social Security funds that they will be unable to claim."[8]

Health Care "Safety Nets"

Several studies have examined the importance of the health care "safety net" in serving low-income and uninsured individuals. One document by Staiti, Hurly, and Katz focused specifically on undocumented immigrants, showing that areas with well-established "safety nets" were better able to serve these individuals.[9] A study by Hadley and Cunningham examined the effect of the proximity of health care "safety net" providers on health care access for uninsured people. This "safety net" includes "public hospitals, private hospitals that perform a safety net function, Federally Qualified Health Centers (FQHCs), FQHC 'look-alike' facilities, and other free clinics that do not receive federal grants." [10] Hadley and Cunningham found that uninsured persons who lived closer to a "safety net" health care provider were more likely to use health care services, demonstrating the "safety net's" importance in increasing health care access among this population.[11] The study also found, however, that this increase in access is small compared to the increase in access that would occur if these individuals were to obtain Medicaid coverage or private insurance coverage.[12] A separate study found insurance coverage to be "more important than supply of medical resources in minority groups' communities, including primary care physicians, charity care, and availability of hospital emergency rooms" in increasing access to care.[13] In other words, the "safety net" is no substitute for insurance coverage.

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[6] Ibid, 56-57.
[7] Ibid, 61.
[8] Capps and Fix, "Undocumented Immigrants: Myths and Reality" n. pag.
[9] Staiti, Hurly, and Katz, "Stretching the safety net to serve undocumented immigrants: community responses to health needs," 2.
[10] Hadley and Cunningham, "Availability of Safety Net Providers and Access to Care of Uninsured Persons," 1530.
[11] Ibid, 1540.
[12] Ibid, 1541.
[13] Hargraves and Hadley, "The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care," 825.

Community Health Worker Programs

According to an integrative literature review on Community Health Workers (CHWs) published in 2002 by Susan M. Swider, community health workers have been present in the United States since the 1960s, but such programs have enjoyed increased popularity since the 1980s. CHWs serve a crucial role in bringing health to groups of people who are missed by more traditional health care models. CHWs often belong to the groups that they are trying to reach out to in some way. For example, a CHW who educates about HIV/AIDS might be a Latino trying to reach out to other Latinos in his or her community, or an HIV-positive individual reaching out to others with the disease. Swider cites one study that identified seven key roles played by CHWs: "cultural mediation, informal counseling and social support, providing culturally appropriate health education, advocating for individual and community needs, assuring that people get the services they need, building individual and community capacity, and providing direct services."[14] This roles illustrate the important part that *promotores(as)* can play in promoting health to poor and underserved Latinos. They understand the cultural beliefs of their fellow community members, and can communicate information to them in appropriate ways. They can help people who might be unsure about the health system (for example, which clinics will give them care without asking for citizenship information) to know what resources are available to them. They can also teach their communities about preventative measures that they can take against diseases like diabetes and HIV/AIDS, which currently disproportionately affect the Latino population both in Washington and in the United States as a whole.

Swider's integrative literature review seeks to synthesize the findings of existing studies that examined the effectiveness of CHW programs. She concludes that while there are indications that CHWs are effective, more studies need to be done to document and measure this effectiveness. She states that CHWs seem to be most effective in increasing health care access, but that studies in this area need to be better designed. She calls for a research agenda that emphasizes "stronger study design, documentation of CHW activities, and carefully defined target populations."[15]

Like Swider, I found there to be a dearth of literature examining the effectiveness of *promotor(a)* programs, and I encountered the documentation issue in my case study. The scholarly literature that I did find that examined the effectiveness of *promotor(a)* models was generally very positive. One study by Reinschmidt et. al. studied the reasons why a *promotora* increased adherence to a chronic disease screening program in Latino women living along the U.S.-Mexican border. In the study, the *promotora* encouraged the women she visited to participate in the chronic disease screening program, served as an educator about health issues, and encouraged women to practice positive health behaviors. The study found that the *promotora* was effective primarily because of the following characteristics: she was female (and reaching out to other women), bilingual,

[14] Swider, "Outcome Effectiveness of Community Health Workers: An Integrative Literature Review," 11-12.
[15] Ibid, 19.

around the same age as the woman she intended to help, and was empathetic and concerned for the women's health. These factors helped clients to trust the *promotora* and to feel motivated to participate in the chronic disease screening program. *Promotoras* can therefore promote a connection between health providers and the community by building a link of trust. Like most programs, however, the *promotora* program does not seem to work for all clients: two out of the forty-three women interviewed stated that they would have preferred a *promotora* that they did not already know so well as a friend or coworker.[16]

Some additional studies that I found were also encouraging regarding the effectiveness of *promotor(a)* programs. One study by Elder et al. found that utilizing a *promotor(a)* program in conjunction with the mailing of educational print materials tailored to meet the specific needs of the sendee was more effective in changing the dietary practices of Latinos than mailing the materials alone in the short term. However, the study also found that these effects dissipated in the long term, and suggested that further research involving follow-up visits from a *promotor(a)* should be performed to determine if such visits would increase the longevity of the positive results.[17] Another study by Warrick et al. found a *promotora* program to be a very effective method of reaching pregnant women in a farmworker community for prenatal education. This study also mentioned that the effectiveness of the program was due in part to personal characteristics of the *promotoras* and their demonstration of "caring, warmth, and encouragement."[18]

Research Methods

I found some data about Federally Qualified Health Centers like Quincy Community Health Center and free clinics like Grace Clinic on the Washington Department of Health website, especially in the Office of Community and Rural Health section. I also found information on social and health services on the Washington State Department of Social & Health Services website. One frustrating factor was a lack of data on the effectiveness of *promotores(as)* programs in Washington State specifically. My topic area does not lend itself to much statistical data.

I chose Grace Clinic as a case study because I was interested in the role of the free clinic in the "safety net." Grace Clinic was recently able to secure funding from the United Way to build a new facility in Kennewick, and I was interested in what made a clinic successful. I was also interested in exploring the limitations of free clinics, especially those limitations that were related in some way to a shortage of public health insurance available to immigrants, documented and undocumented. I hoped to better understand the findings of the scholars I had read that demonstrated that expansions in the "safety net" were less effective than expansions in the health insurance system. In

[16] Reinschmidt, et al., "Understanding the Success of *Promotoras* in Increasing Chronic Disease Screening," 259-260.
[17] Elder, et al. "Long-term effects of a communication intervention for Spanish-dominant Latinas," 159.
[18] Warrick, et al., "Evaluation of a Peer Health Worker Prenatal Outreach and Education Program for Hispanic Farmworker Families," 23-24.

order to accomplish this, I visited the clinic on a busy Saturday afternoon and spoke extensively with a dedicated volunteer, Maria Martinez. She was very honest about the challenges that Grace Clinic faced as well as the factors that made it successful. While it was difficult to determine exactly what factors accounted for the relative success of Grace Clinic, I got a sense of the devotion and perseverance required from volunteers to make such a clinic successful, as well as the role that religion can play in this success. I also understood that the clinic had limited resources with which to help its patients and that reducing the number of uninsured would be the best way to increase the effectiveness of the clinic.

Given the positive reports that I found in my literature review about community health worker programs, I was really interested in exploring such a program in Washington State. Quincy's *promotor(a)* program has been around for several years, and has been instrumental in helping to set up other such programs around the state. My community partner's involvement with the program also made it seem attractive as a possible case study. In looking at Quincy's program, I was specifically interested in investigating for myself what factors make a *promotor(a)* program successful, and what accounts for the successes of individual *promotores(as)*. I wanted to see if the factors that I uncovered in my scholarly research held true at the Quincy program; for example, if single-sex outreach efforts or classes were more effective than efforts that involved both sexes, and if the personal characteristics of a *promotor(a)* such as kindness and compassion were important to the program's success. In order to get this information, I spoke extensively with my community partner, Mary Jo Ybarra-Vega, who had established the program and continued to run it. I was also able to speak to one of the first *promotoras* in the program about her work. Finally, I interviewed Lupe Hernandez, a woman who had attended a class on sexually transmitted diseases (STDs) after being invited by a *promotora*. I was interested in interviewing her in order to get her perspective on why *promotora* interventions are successful (or not). I therefore tailored my questions in such a way as to determine precisely what factors accounted for the *promotora's* success in that particular situation. I also asked questions to test whether other approaches might have been successful as well. The interview took place in English at the Quincy Community Health Center and lasted for about 25 minutes. I tape recorded the conversation, and a transcription of the recording can be found in Appendix A.

Data Presentation

I will first present some background information on the situation of undocumented immigrants and documented immigrants who have lived in Washington for less than five years, and then go on to discuss the options available in Washington State for the poor and/or uninsured.

The undocumented immigration of Latinos into the United States is currently a divisive issue, one that is made more complicated by a lack of accurate data. General population surveys such as the Current Population Survey do not ask non-citizens about their legal status, so approximations of the size of this population are gathered by other

methods, such as analyzing the responses to other survey questions.[19] Estimations of the number of undocumented immigrants in the United States are therefore rather uncertain. A report from the Pew Hispanic Center places the number at about 10.3 million people as of 2004, with 5.9 million of these coming from Mexico and 2.5 million coming from other Latin American countries.[20] According to these figures, undocumented immigrants make up 3.7 percent of the U.S. population. Another Pew Hispanic Center report estimates that there are between 200,000-250,000 undocumented migrants in Washington State, and it is plausible that many of these are Latinos.[21]

The legal status of undocumented immigrants creates barriers to health care access in addition to those already faced by Latinos who are documented immigrants or U.S. citizens. For example, undocumented immigrants are barred from most social welfare programs including Medicaid and the State Children's Health Insurance Program (SCHIP) and are disproportionately concentrated in employment areas such as farm labor which often do not provide health insurance. Some undocumented Latinos might be hesitant to seek medical attention for fear of deportation. Such barriers put an increased burden on undocumented Latinos, who often have to deal with other barriers such as low educational attainment, poverty, high costs of care, limited care availability, limited access to health insurance (public, private, or employer-based), and language and cultural differences.

In Washington, undocumented immigrants do not qualify for Medicaid or SCHIP, and documented immigrants are barred from the program for five years following their arrival. This five year bar is a result of some of the provisions of the Personal Responsibility and Work Opportunity Reconciliation Act and the Illegal Immigration Reform and Immigrant Responsibility Act, which were both passed in 1996. When the act was passed, Washington was one of thirteen states to create Medicaid look-alike programs to meet the needs of recent and undocumented immigrants. Before 2002, approximately 25,000 documented and undocumented immigrants who did not qualify for Medicaid were enrolled in these programs, generally called Medical Assistance. In 2002, however, the Washington legislature passed a bill ending the program, stating that those currently benefiting from the program should enroll in Basic Health, the state's insurance program for those who do not qualify for Medicaid. Unfortunately, Basic Health differs from Medical Assistance in that it requires higher premiums and provides fewer benefits. Many immigrants who were already struggling financially were unable to make the transition, and it is estimated that 17,000 individuals lost their health insurance. Furthermore, Basic Health does not provide as much coverage for children with chronic illnesses as Medical Assistance did, and requires more complicated documentation processes that can cause serious delays and frustrations in the approval process. The report also questions if the program change met the legislature's objective, as it stated that the money saved by reducing coverage has resulted in increased expenses in other

[19] Brown, et al. "Racial and Ethnic Disparities in Access to Health Insurance and Health Care," 20.
[20] Passel, "Unauthorized Migrants: Numbers and Characteristics," 4.
[21] Passel, "Estimates of the Size and Characteristics of the Undocumented Population," 6.

parts of the health care system, hurting providers, community health organizations, and local public health agencies.[22]

Washington recognized the findings of the report and in 2005 reinstated, with limited funding and enrollment capacity, the Children's Health Program. When it was first reinstated, the program had room for only 8,800 children, with an annual cap of 4,300. These slots quickly filled and a waiting list of over 10,000 children formed. The Children's Alliance estimates that between 25,000 and 27,000 Washington children are eligible for the program.[23] In 2006 the Washington Legislature expanded funding for the program, providing spaces for 14,000 children. Currently, only 7,700 are enrolled.[24] This suggests that outreach for the program needs to be increased. The program could be expanded further to provide coverage for all eligible children, and a similar program could be instated to provide coverage for immigrant parents.

In addition to the Children's Health Program, undocumented immigrants who are not covered under Basic Health can qualify for three medical assistance programs from the state, each rather limited in scope. These are the Alien Emergency Medical program (AEM), Pregnancy Medical, and the Consolidated Emergency Assistance Program (CEAP). Descriptions of each of these programs follow:[25]

Alien Emergency Medical (AEM): AEM provides medically necessary services for the treatment of an emergency medical condition.

Pregnancy Medical: Pregnancy Medical provides services to pregnant women, with coverage extending for two months after delivery.

Consolidated Emergency Assistance Program (CEAP): CEAP is available to pregnant women and families with dependent children who meet the income-eligibility requirements. CEAP provides cash assistance that can be used for minor medical emergencies as well as things like food, shelter, and clothing. A family or pregnant women can receive assistance from CEAP for not more than 30 consecutive days every twelve months.

In addition to these programs, documented immigrants who do not qualify for Medicaid because of their immigration status are also eligible for the following programs:

General Assistance (GA): GA provides financial assistance to those who are poor and cannot work because of a physical or mental medical condition.

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[22] Gardner and Varon, "Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations."
[23] Children's Alliance, "Responding to the Crisis," 5.
[24] Source: Washington Department of Social and Health Services, http://fortress.wa.gov/dshs/maa/Eligibility/ChildrensHealth.html
[25] Source: Washington Department of Social and Health Services, www1.**dshs**.wa.gov

State Family Assistance (SFA) cash: State Family Assistance is a program similar to Temporary Assistance for Needy Families (TANF) available to immigrants who are still in the five-year waiting period. SFA provides cash grants to pregnant mothers and families with children.

Those who do not qualify for state-funded medical assistance or who cannot afford coverage can still seek health care at clinics across the state. The Office of Community and Rural Health at the Department of Health lists 125 clinics in its "Primary Care Core Safety Net," which offers services to people regardless of their ability to pay. Many of these clinics, like Quincy Community Health Center, receive federal funding to serve the uninsured and are considered Federally Qualified Health Centers. Twenty-one of the clinics are free or charity clinics like Grace Clinic. These clinics offer all of their services for free.[26]

Case Studies

I chose my case studies to get a first-hand perspective on the information that I had uncovered in my scholarly research and data collection. I wanted to better understand the role of free clinics in the health care "safety net" and to study an actual *promotor(a)* program to comprehend its structure and effectiveness.

Grace Clinic

Grace Clinic is a non-profit, nongovernmental, volunteer clinic in Kennewick, WA. The clinic does not receive any federal funding and must rely on donors such as the United Way and various businesses and individuals in the community to fund its operating costs. It is open only three days a week and is staffed almost entirely by volunteers. Only two positions at the clinic provide salaries: a nurse coordinator and the administrative coordinator. After operating in the cramped church basement for several years, the clinic was able to move into a new facility in September 2006. The clinic has five consultation rooms, a triage room, and two counseling rooms, and hopes to provide dental services in the near future. Its newest project is a women's clinic, which plans to bring a mobile mammogram program from Seattle to the clinic once a month. There is also a food bank that is open to patients who are having trouble meeting their nutritional needs.

Grace Clinic is a Christian organization, and most of those who volunteer there heard about the clinic through their church. A pastor comes to the clinic each day it is open to provide spiritual care to the patients. The dedication of the volunteers is impressive. Doctors and nurses come in to work on their days off, and volunteer translators, counselors, pharmacists, and administrative staff dedicate countless hours to serving the clinic's patients. The clinic offers its services free-of-charge, though it does not serve those with any sort of health insurance in order to save its resources for those most in need of them. This eliminates the barriers that the sliding-fee scales at Federally

[26] Source: Washington State Department of Health Office of Community and Rural Health, "Inventory of Washington State Safety Net Clinic Locations," www.doh.wa.gov/hsqa/ocrh/har/safetynet.xls

Qualified Health Centers pose to some clients. As a non-profit, volunteer-run clinic, Grace Clinic is understandably limited in the sorts of services that it can provide. If a patient is found to need a consultation with a specialist or another service that the clinic cannot offer, volunteers will work tirelessly to try to find doctors or hospital services that will see the patient free-of-charge. Patients who need prescriptions can fill them for free three times at the clinic's pharmacy, and are also referred to a local agency called Access to Care which helps patients enroll in prescription drug programs. The clinic also has its own lab where it can perform tests for patients for free.

Grace Clinic seems to demonstrate the power in community mobilization around a problem. It seems that religious beliefs can play a crucial role in this sort of mobilization, as many of the volunteers at the clinic seemed motivated by their religious value systems to dedicate their time to the clinic. Because many Latinos, who make up the majority of the clinic's patients, hold religious beliefs, the presence of spiritual support at the clinic can be beneficial as well (of course, such support is only provided when it is requested). On the other hand, Grace Clinic's religious affiliation could be considered a liability, as the clinic will not promote birth control or participated in needle-exchange programs. Still, the dedication that church members show to the clinic cannot be denied. The clinic has made enormous strides in addressing the health care needs of community members, but the challenges that they face in securing care for patients who need more than just routine health care demonstrate the need for expanded state medical coverage, especially with respect to chronic illnesses. Maria Martinez, the volunteer I interviewed while I was at the clinic, expressed this need for increased public insurance coverage to me repeatedly. This sentiment is consistent with my findings on the limitations of health care "safety nets" in my literature review.

Quincy Community Health Center

One of the first structures one encounters when entering Quincy, WA is the Quincy Community Health Center. The Quincy Clinic boasts of two physicians and three physician assistants, including specialists in pediatrics and internal medicine, as well as dental care facilities and a separate clinic for children and pregnant mothers. The clinic has its own lab and pharmacy, and is currently expanding its X-ray services in order to allow patients to avoid going to the hospital for such services when possible. A representative from the Department of Social and Health Services works on-site to save patients a long drive to another town to apply for medical and social services. After business hours, the facility often serves as a gathering place for residents of Quincy to participate in community meetings or classes on topics such as diabetes management and parenting.

Mary Jo Ybarra-Vega works as a social worker in the clinic. In addition to meeting with patients, she runs a *Promotores(as) de Salud* program that she started in 2003. The program has been awarded the National Health Service Corps award, and has been utilized by outside groups who recognize its effectiveness, for example, by a group of epidemiologists concerned about the possibility of a flu pandemic and needing a way to reach migrant workers. Ybarra-Vega believes that the program has made the Quincy

Community Health Center a more integral part of the community than any other health clinic she knows of. She is constantly making use of her connections in the community to promote health and to advocate the center's programs in informal settings: as she aptly states, "There is a seamlessness to what we do."

Ybarra founded the *Promotores(as) de Salud* program at Quincy after attending a conference in which she learned about such programs and received information on how to start one. She identified community members who were already considered leaders and asked them if they would like to receive training in health promotion. After being trained, the new *Promotores(as)* first step was to identify some health topics that community members wanted to learn more about. Their outreach efforts revealed several areas of interest, including sexual health, HIV/AIDS, insurance availability for both adults and children, and more information about the health system in general. With this information in hand, the *promotores(as)* began their work. They focused their efforts in areas that were already gathering places in the community, such as ESL classes and migrant Headstart meetings. They also did education sessions in homes (their own and those of other community members) and in the orchards where many community members work. This year, the *promotores(as)*, in addition to their normal education work, are also doing a survey to gather information about health, housing, employment, and civic involvement in their community. The *promotores(as)* hope to perform 200-400 surveys to collect this information.

Ybarra-Vega has around five or six *promotores(as)* working for her at any given time. The *promotores(as)* are all volunteers, though Ybarra does try to provide them with occasional gift certificates for their hard work. She also tries to work out other arrangements for their benefit, such as guaranteed spots in local ESL classes, which fill up very quickly. Some *promotores(as)* are high school students who can use their work as a senior project. Noting that it was difficult to set up and run the program on her own, Ybarra has worked to set up a state-wide community health worker network to share information and provide mutual support. She has also helped set up other programs across the state, including the program at Blue Mountain Heart-to-Heart in Walla Walla. She is currently helping to establish a program in Moses Lake.

One problem that Ybarra-Vega mentioned in relation to the program was the difficulty in documenting the work of the *promotores(as)*. Though aware of the importance of documentation, she stated that it puts an additional burden on the *promotores(as)*. The informal nature of the *promotores(as)* work makes this especially difficult.

Esmeralda Blancas, a *promotora* who I had a chance to speak with, felt that her work was very important and effective in her community. She notes that most of the educational sessions that she and her fellow community workers do are events to which they are invited, which demonstrates the interest that the community has in learning more about health related issues. She also states that she integrates health promotion into her everyday interactions; the day before I spoke to her, she had found herself in a living room with a group of older women who had just come from Mexico, and she started up a

conversation about breast cancer prevention that was well received. Blancas estimates that about ninety percent of the people in the Quincy area that she educates about health issues are undocumented Latinos. When I asked her if she ever had any frustrations about her work, she stated that she was often saddened by low health insurance rates that she noted in her community, noting that health education and low-cost care could sometimes only do so much.

The successes of the *promotor(a)* program is put into perspective when contrasted with the resources for diabetes education available in Walla Walla, WA. The diabetes educator hired by Walla Walla General Hospital, Margaret Caicedo, is overwhelmed with trying to serve a population that is so negatively affected by the disease. Caicedo states that the hospital charges $180 an hour for one-on-one diabetes education (this was confirmed by the hospital). This fee is sometimes covered by insurance or the hospital's charity care program, but the service can clearly be rather costly for both the hospital and for patients. Caicedo currently runs a free monthly class on diabetes in conjunction with the hospital and SOS Clinic (a free clinic in neighboring College Place, Washington), but she worries that patients are not getting the one-on-one, personalized help that they need to manage their illness. She states that this problem is urgent because Latinos are more likely to suffer from serious side-effects related to diabetes such as heart attack and stroke, and that this trend is related to a lack of education about the disease.

Caicedo's comments show the necessity for education on heath-related topics like diabetes that is both easily accessible and inexpensive/free. A *promotores(as)* program can offer these advantages, though it is clearly a different approach to education than professional one-on-one counseling and is not necessarily a substitute. As Blancas notes, however, any education efforts can be limited in their effectiveness when community members are not able to access adequate health insurance.

Interview Discussion

My interview with Lupe Hernandez underscores the importance of health education that meets the needs of community members. Though Hernandez had received some STD education in high school, she reports being too shy to ask questions about it in class, especially in the presence of boys. The setting created by the *promotora*, on the other hand, made talking about STDs easier, more like a conversation between friends. She demonstrates that conversations about health issues in which questions can be raised and answered can be much more effective than reading a pamphlet or fact sheet. Hernandez seemed to feel that a lot of other young women in her community felt the same sort of shyness about topics like STDs as she did. If this is so, open conversations in small groups about these issues can help women feel less embarrassed about the subject, which might lead them acting more assertively in situations where they need to advocate for their own health and well-being. When Hernandez spoke to me about her experience in the class, I could tell that she had been very much affected by what she had learned, and felt very strongly about giving other young women the chance to participate in similar classes, especially at earlier points in their lives. To me, this demonstrated the power that a *promotor(a)* model can have in a community, and the importance in

fostering health education programs that can empower groups of people to gain a sense of control and agency over both their health and their lives.

Hernandez confirmed many of the factors that I had found contributing to *promotor(a)* success in my scholarly research. For example, the fact that she received information from a female *promotora* seemed crucial to the success of the interaction, supporting the findings of Reinschmidt et al. and Warrick et al. She also stated that she was glad to have a friend ask her to come to the class instead of someone she didn't know, emphasizing the importance of trust in a *promotor(a)* program. It is reasonable to assume that such factors are especially important when it comes to a topic like STDs.

Conclusion and Recommendations

Community-based initiatives have enormous power to affect the health care situations in their communities, and should be recognized for their efforts. Programs like the *promotor(a)* program at Quincy seem to have an even greater chance of success than top-down programs because of the social and cultural commonalities that community health workers have with the people they serve. *Promotor(a)* programs are cost-effective and motivated by community leaders who are dedicated to the health and well-being of their friends and neighbors.

Washington State can do several things to support these programs. My suggestions are as follows:

1. I believe that the single most effective thing that Washington State could do to support these initiatives is to expand the Children's Health Program to provide for all eligible children and to reintroduce a Medicaid look-alike program that has no eligibility requirements related to immigration or legal status that would cover immigrant parents. Such a program would benefit the health system as a whole and would help community-based initiatives do their work more effectively. Washington must take this step if it is serious about meeting the health needs of its residents. It is also essential that Washington increase outreach efforts for the Children's Health Program so that eligible children can be enrolled.

2. Given the strong indications that Community Health Worker programs like the *promotor(a)* program are effective ways of filling the gaps in the current health care system, I would recommend that Washington State consider creating a program that funds these initiatives specifically. Such funding could be used in several ways:

   a. Because *promotor(a)* programs often struggle to document their effectiveness, Washington could fund research on the effectiveness of these programs. This research would add to the existing knowledge about the effectiveness of *promotores(as)* and could help Washington decide if it would like to fund the activities of these programs directly.
   b. There are strong reasons to believe that *promotor(a)* programs are effective. Therefore, it would not be inappropriate for Washington to begin directly funding these programs right away. The funding could be used for stipends for

promotores(as), with the condition that they follow documentation procedures for their activities. This would generate more knowledge on the effectiveness of programs and would also compensate *promotores(as)* for all of the extra time they would be taking to document their work.

c. State money could also be used to begin CHW programs in other parts of the state. Existing *promotor(a)* programs could be utilized in this process.

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Appendix A: Interview Transcript

Interview with Lupe Hernandez, 24-year-old single mother of two. Ms. Hernandez attended a class on STDs at the home of a *promotora*. She now works at the Quincy Community Health Center as a Medical Assistant. The interview took place at the Quincy Community Health Center on Tuesday, October 10, 2006, and lasted for approximately twenty-five minutes.

So why don't you just tell me how you ended up in the class … what made you decide that you wanted to attend this class?

This girl named, her name was Myra, and she came up to a lot of us, her friends, and told us about some programs, the program that was going on here in the clinic, and they told us that they were going to have a lot of information about it, about STDs, and what you should learn about STDs, and, actually it gave more information than it told you like if I ever felt like using a female condom they showed us that, they showed us how to insert a condom, symptoms of STDs, they told us information that I really never knew. And it wasn't really because I was, you know, I was, I just didn't know, and like before we were too embarrassed or scared, you know what I mean, like, it was different before. And that, Mary Jo told us like a lot about everything. It was pretty nice.

So, I mean, they didn't teach this sort of thing…first of all, how long have you lived in Quincy?

All my life.

And this sort of information was never given to you like in high school, or anything?

It was, it was given in high school but the problem was, at high school it was like more embarrassing, at the time maybe because I was younger and I just, well maybe because I just didn't care, it didn't really bring me to the idea of thinking about, no, it can't be me who could get that, why, but I actually learned that you could get it, you know, in a different way, and it actually got me more information than I thought I was even going to get.

So what, I mean, what made you want to go to this, to the workshop? Is there anything that she said to you in particular? Because before, you know, maybe you were too embarrassed to talk about it, didn't care, but what changed that and made you want to go to the workshop?

Maybe because there was going to be a lot of girls there instead of mixed. Actually I think that's what it was. And I was just scared because I have a friend that she had an STD, and, it just, I wanted to know what was the symptoms. Yeah family planning does help a little, because it gave you information, but I just want to really talk to somebody, like in the community, and find out the truth, like, what really, really is out there, you know?

So if, would you say that by attending this workshop you got more information than you could just from, maybe like pamphlets that people hand out?

Yeah, I actually got more information that way because we talked about it and the problem is me reading a pamphlet it was just like, and who's going to answer my questions, you know, and there you have somebody answering your questions someone that really knows and, I don't know, I just prefer like a class like that, because… I'm worried about me talking about myself, there was other girls there that thought about the same thing because, yeah, we read those pamphlets about STDs but we really didn't even know, you know, it was, it was actually good because they showed us how to put a condom and, you know how, well, there's my way of thinking there's some guys that don't even know how, and if you get to learn yeah a girl, sometimes you know how they say oh, well, why does a girl need to know how a guy needs to put on a condom, no they should know, because, there, you know, like a rip or anything because they're not putting on it properly. And that's why there's a lot of teenagers getting pregnant because they're embarrassed and I went through that. I have two children and, you know, it was embarrassing to tell a guy "put on your condom," you know? Because, that's what I went through and I'm pretty sure that a lot of teenagers are going through the same thing, because I know some that, you know they're embarrassed. And those kind of classes would be good for teenagers to take because, I don't know, I went through a lot. I learned a lot.

Now, you mentioned that the embarrassment of, you know, like having to tell a guy to put on a condom, did the class address any of those issues of, you know, really standing up and asserting yourself in that way, or did it mostly provide information about like how to put on a condom?

Actually they told us, they actually told us a good way to let them know, like if you're embarrassed just let them know in a good way, like, you know, "let's wear a condom, you know, it will be good," you know, she told us a good way to tell them. She gave us information, but she also told us, you know, it's good to wear a condom, you know, you never know, it's just being safe.

And would you say that in high school if you had had a friend tell you about a similar program, do you think that you would have gone at that point before you'd had as much life experience?

Yeah, I would have gone, maybe, hmmm, yeah I would have gone, just to learn because at school yeah they give you information but they don't really talk, there's, I don't know, maybe I grew up in a time where they wouldn't really tell you that information, because we had an "Operation Awareness" something like that…they told us some information like yeah, wear condoms, but you know, they don't really tell us...I don't remember and I'm pretty sure that I had my eyes on that, they didn't really tell us and we were embarrassed to talk, yeah, because there were guys there so we didn't really want to talk.

I would have gone if there was a class like only girls, because I'm really open, I'm really open and I'll talk. Yeah, I was embarrassed before, but not anymore.

And what if you'd just seen a flier for this class on a grocery store bulletin board or something saying that there's this workshop at the Quincy Community Health Center, and you hadn't heard about it from a friend, do you think that you still would have gone?

Sometimes it's actually better to know who's going, and get to know who that person's going to be there talking, why, because, umm, I just, I'm the kind of person that would like to know before. And there's actually, I have friends who actually prefer not to know the person because they could be open-minded that way, but then again there's different people out there. And anything works, if you could just get information out there.

Is this the only program that you have attended through the health center?

Yes this is the only one that I've gone to.

Would there be any other issues that you'd be interested in going to workshops for?

Parenting would be good if they did some sort of parenting classes, like an open-minded like the STD classes, parenting classes or like, for people with depression, or I don't know, trying to get teens out of drugs, that would be really good. Those kind of classes would be pretty good for teenagers.

Can you tell me a little bit more about what happened at the workshop? About how many people were there with you, and what ages?

The youngest girl there, that I know because it's one of my friends, she was fourteen, the oldest of the girls that were invited was like 28? And um, approximately, ten, maybe, girls were there. Maybe something like that.

And how did they structure the workshop? About how long was it, and was it discussion-based or was it a lecture with time for questions afterward?

It was actually two days, that we had that, it was actually really good that we had it two days, for people with kids that was really good. They actually showed us, my way of thinking that was good because they showed us and they demonstrated stuff. They let us ask questions in between, that was really good because you know how sometimes you forget the question at last, and that was really good because they let us, you know, ask questions in between.

You mentioned before that it was nice to know the woman to asked you to come to the meeting. Do you think that if you had had to go to another community to attend the meeting that it would have been as effective for you?

Now at my age I wouldn't mind. I wouldn't mind going anywhere else, talking about it, or the way my life has gone and what helped it, with that class, because it really did help a lot. I wouldn't mind to let people know what I went through, what helped with that program, that class that I went through. But before I probably wouldn't. I was, I was just scared, I was just, I don't know I'm not sure really, but now I would. After this class, what I went through, now I would.

Is there anything else that you think is important, that I should know?

These kind of classes are really good, they should get it out to the schools, get the kids more involved, and I know Mary Jo's trying to do that, maybe she has places out there, but it would be really good if teenagers could know the stuff I know now, because maybe there is people letting them know, but there's still teenagers getting pregnant, you know what I mean? It would be really nice, condoms for free, you know? Yes parents would get mad but come on it's better to get kids using condoms than kids getting pregnant, because it's kids having kids. It's really hard being a, you know, sometimes it is easy to become a single mother because when you're young you make the mistake of having kids and then, yeah, you're with your boyfriend but sometimes your boyfriend does get tired of you because they're young, you know? They don't think. You become a single mother and it's really hard to raise up a kid being a single mother. Then when, you know, you get classes like that, like parenting and you let other girls know it's not easy being a single mother.. Yeah, DSHS, but come on, you get to the point, DSHS is not going to support you. Yeah and you're going to have, what, money coming in? You're not going to be able to have fun like you used to, you're not going to be able to do what you used to do, oh the money's there, yeah, the money's there, but there's going to be a limit, where DSHS isn't going to be helping you through. Why because they're out there just having kids and they're not going to, some girls don't even like to work and do nothing, and I don't know, these kind of classes, they should let girls know that too, you know what I mean? DSHS is not always going to be there for you. Cause I know some girls who are going through that now. And yeah, they're like, well yeah I want my mom, or their grandma's going to help them or something. It's not funny. It's not easy.