

Clinicians and *Promotores* Teaming to Provide In-Home Primary Care to Frail Older Adults

Neela K. Patel, MD, MPH,
CMD, FAAFP^{1,2}

Jasmine Rodriguez, MPH¹

Angelica Vanessa Davila, MD,
MS^{1,2}

Elisha Edrington-Medina, FNP^{1,2}

Deepa Wagle Sharma, FNP^{1,2}

Cynthia De La Garza-Parker,
CHW^{1,2}

James Walter Tysinger, PhD¹

¹Department of Family and Community Medicine, UT Health San Antonio, San Antonio, Texas

²Glenn Biggs Institute for Alzheimer's and Degenerative Diseases – South Texas Alzheimer's Disease Research Center, UT Health San Antonio, San Antonio, Texas

Ann Fam Med 2023;21:377. <https://doi.org/10.1370/afm.2998>

THE INNOVATION

Temporarily closing our clinic due to COVID-19 challenged the quality of primary care we provided to frail, older adults. We initiated telehealth visits, but technology barriers limited their use with many Hispanic, low-income, and home-bound patients. Sending *promotores* (community health workers) with internet hot spots and laptops to patients' homes to assist with visits was promising, but hearing and vision impairments decreased visit effectiveness. Pairing a clinician with a *promotor/a*^{1,2} for in-home visits produced positive outcomes for patients, their families, and our clinicians.

WHO AND WHERE

The University of Texas (UT) Health San Antonio Geriatrics and Supportive Care Practice's clinicians teamed with *promotores* to provide primary care in patients' homes. These trained bilingual personnel from the patients' communities understood the culture, and helped patients overcome the fear of clinicians' bringing COVID-19 into their homes.

HOW

After our institution mandated telehealth visits in March 2020, we found about one-half of our patients, many of whom were Hispanic, lacked internet access and were reluctant to accept in-home visits. Realizing that pairing patients in long-term care facilities with nursing staff during virtual visits enhanced quality, we discussed ways to obtain reliable assistance during telehealth visits. After learning a local non-

profit's *promotores* took food to our patients' homes, we collaborated with the organization to have its *promotores* take a hand-held device and internet hot spot to patients' homes and help conduct telehealth visits. Visit quality still suffered due to patients' hearing and visual impairments. Seeing the trusting relationship that the *promotores* had with patients, we teamed a clinician with a *promotor/a* to pilot in-home visits to refine the visit process, and identify essential equipment and supplies. In addition to addressing patients' medical and social issues, the team specified responsibilities for follow-up and/or strategies for overcoming challenging social determinants and established goals with patients. The improvement in outcomes with these in-home visits led us to obtain grants to hire 2 trained *promotores* to work in our practice.

Teaming *promotores* with clinicians increased in-home visits to homebound patients (3,005 visits to 6,883 visits [229%] in several underserved zip codes in Bexar County). Our team also increased access to homebound persons with dementia who would not have been seen by a health care clinician until they required emergency care. Between 2021 and 2022, inpatient admissions and emergency department visits (per 1,000 persons) decreased from 490 to 411 (17%), and 920 to 830 (11%), respectively. The costs of care also decreased by ~\$3,000/member/year for our accountable care organization-attributed participants. Patient satisfaction (n = 343) ("overall recommend practice") increased from 92% to 98.5%.

LEARNING

Patients and their families respond well to a clinician-*promotor/a* team approach and in-home visits and *promotores*' knowledge of cultural issues, language skills, and patient relationships can be an effective bridge between patients and their clinicians. Working as a team, clinicians and *promotores* can provide a wider range of cultural and medical services that overcome the social determinants of health and psychosocial barriers. In-home visits help team members identify patients' needs and assign responsibilities to address and follow-up on those needs. *Promotores*, initially supported by grants, are now integrated into and play essential roles in our practice.

 [Read or post commentaries in response to this article.](#)

Key words: primary care; *promotores*; community health workers; teams; frail older adults; telehealth; in-home visits; social determinants of health

Submitted November 26, 2022; submitted, revised, February 7, 2023; accepted March 7, 2023.

Funding support: Impact San Antonio, The Nancy Smith Foundation, and The Baptist Health Foundation

REFERENCES

1. Ferrer RL, Schlenker CG, Cruz I, et al. Community health workers as trust builders and healers: a cohort study in primary care. *Ann Fam Med*. 2022;20(5):438-445. [10.1370/afm.2848](https://doi.org/10.1370/afm.2848)
2. National Academies of Sciences, Engineering, and Medicine. *Integrating Serious Illness Care into Primary Care Delivery: Proceedings of a Workshop*. The National Academies Press; 2022. <https://doi.org/10.17226/26411>

Conflicts of interest: authors report none.

Corresponding author

Neela K. Patel
UT Health San Antonio
The Department of Family and Community Medicine
7703 Floyd Curl Drive, MC 7843
San Antonio, TX 78229
PatelN4@uthscsa.edu