Peers for Progress
Peer Support Around the World
A program of the American Academy of Family Physicians Foundation

NCLR
NATIONAL COUNCIL OF LA RAZA

NATIONAL PEER SUPPORT
Collaborative Learning Network

Person Centered, Population Focused, Community Oriented Peer Support: Toward A Programmatic Approach

Report from
1st Annual Meeting
November 12-13, 2013 – Washington, D.C.

Support for this program is provided by
Bristol-Myers Squibb Foundation
Together ON Diabetes
Communities Uniting to Meet America's Diabetes Challenge

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Person Centered, Population Focused, Community Oriented Peer Support:
Toward A Programmatic Approach

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Expert Conference Report on
Peer Support in Health, Health Care, Prevention, and Well Being

Version 2.0, December 19, 2013

On November 12 and 13, 2013, the National Council of La Raza (NCLR) and Peers for Progress of the American Academy of Family Physicians Foundation hosted a meeting of leaders in health care and in peer support programs to discuss current strengths and needs in the field. This discussion would then guide 2014 activities of the National Peer Support Collaborative Learning Network, a joint activity of NCLR and Peers for Progress, supported by the Bristol-Myers Squibb Foundation's initiative, *Together on Diabetes.* The discussions from this meeting identified features of peer support that point to an expanded, scalable approach to its broad dissemination. This approach would be:

- Patient Centered
- Population Focused
- Community Oriented
- Adaptive and Flexible

Ideally, the approach would serve as a template for broad dissemination and adoption of peer support.

This report contains the comments and observations of the conference, shared here to help the field move beyond peer support projects and toward peer support programs serving populations as a routine part of health, health care and prevention.

Background

Major reviews (1-6) document that peer support (PS) provided by "community health workers," (CHWs) "lay health advisors," "*promotores*," "patient navigators," and individuals with a number of other titles can make important contributions to health, health care and prevention. If individuals spend even an aggregate six hours a year with professionals and clinicians, that leaves 8,760 hours a year (averaging in leap years) that they are "on your own" to manage their health. It is for those 8,760 hours a year that patient education, self management programs, community resources, and PS can be especially helpful (7).

Rosenthal, Brownstein and their colleagues (8) along with others (9-13) have noted a variety of utilities of PS. It can:

- Link people who share knowledge and experience
- Provide health education at the individual as well as community level

- Provide practical assistance for how to achieve and sustain complex health behaviors such as in chronic disease management as well as prevention
- Provide emotional and social support
- Help people cope with the stressors that so often accompany health problems
- Help people get the clinical care as well as other services that they need
- Assist in navigating the health care system
- Build individual and community capacity for understanding health problems and promoting ways of addressing them
- Advocate for patients and their communities
- Build relationships based on trust rather than expertise
- Add cultural competence through peer supporters often coming from the same communities they serve

As Perry and his colleagues conclude in a current review (6) in the 2014 *Annual Review of Public Health*, "…one of the key challenges for the future is to learn how large-scale CHW programs can become as effective as possible in improving the health of the populations they serve … In the U.S., as the Patient Protection and Affordable Care Act moves into full implementation…increased opportunities will become available to test the effectiveness of approaches … that incorporate CHWs…." This recognition of the contributions of PS, the growing opportunities for its dissemination, and the press of health challenges around the world evoke calls-to-action and formal policy recommendations for the implementation of PS approaches (14-16).

To address the challenges of expansion and dissemination of PS programs and the opportunities facing them, such as through the Affordable Care Act, the National Peer Support Collaborative Learning Network (NPSCLN) brought together a group of experts in peer support and in broader health issues on November 12-13, 2013. The NPSCLN is a joint initiative by Peers for Progress and the National Council of La Raza (NCLR) to engage individuals and organizations interested in peer support programs in health, health care, and prevention. The participants included key opinion leaders, experts in the field including researchers, leaders of peer support programs and organizations, funders, Network members, NCLR Affiliates, and other members of the Peers for Progress Global Network as well as stakeholders representing community-based organizations, health care organizations, insurance groups and government agencies.

This report will identify and characterize current knowledge regarding cultural, organizational, and implementation issues central to widespread dissemination of PS programs as identified by the experts gathered for the conference. At the same time, the observations from the conference identify priority areas for the field to pursue including 2014 program priorities for the NPSCLN.

Brief Review of Evidence

Between 2000 and 2011, we identified 24 reviews of assessing peer support to encourage complex, sustained health behaviors for prevention and chronic disease management. These 24 reviews addressed a variety of health problems and settings, e.g. asthma or diabetes management, behavioral health, physical activity, overweight and weight loss. Twenty-one of the 24 focused on PS in a specific problem area of prevention or care, or modality. Three recent reviews that examined PS more broadly included one by

Viswanathan et al.(17) found "moderate" evidence for PS across improvements in knowledge, health behaviors, utilization, and cost/cost effectiveness. It focused on interventions that included PS activities to "create a bridge between community members, especially hard-to-reach populations, and the health care system" (p. 793). Another review by Tyus and Gibbons(18) also focused on PS for those traditionally lacking access to care and limited its focus to US-based programs. It reported "efficacy in enhancing outcomes" across mammography, cervical cancer screening, and a variety of other health/prevention objectives.

A third review by Elstad and colleagues(19) included PS interventions from around the world, addressing a wide variety of prevention and health objectives entailing sustained behavior change (in contrast to relatively isolated acts such as cancer screening), and using a broad definition of peer support entailing assistance and encouragement for those behaviors as well as linkage to appropriate care. It included papers from the US (25 papers), Canada (8), the UK (6), Pakistan (3), Bangladesh (3), and one from each of Brazil, Mozambique, and New Zealand. The health issues papers addressed included Pre/Post-Natal Care (15 papers), Diabetes (7), Asthma (5), Cardiovascular Disease (5), HIV (4), and, with 2 for each, Smoking Cessation, Mental Health, and Drug Use. Across all 47 papers, 39 (83%) reported significant between-group or pre-post changes showing benefits of peer support. Among the 37 papers reporting RCTs, 30 (81%) reported significant between-group or pre-post changes.

The review was conducted as a project of Peers for Progress, a program of the American Academy of Family Physicians Foundation that is directed to promoting peer support in health care and prevention around the world (peersforprogress.org) (20). Peers for Progress has focused much of its work on diabetes, given the global burden it entails and the status of diabetes as an excellent model for most areas of prevention and chronic care. Because of the focus of much of the work of Peers for Progress on diabetes, we examined papers addressing peer support in diabetes included in the review by Elstad and colleagues and extending its scope through July, 2012. Among a total of 20 studies identified, 19 showed statistically significant evidence of benefits of peer support, either through changes within groups receiving peer support interventions (21-31) or in comparisons with control groups (32-39).

Fourteen of the 20 papers on PS in diabetes provided pre- and post-intervention measures of Hemoglobin A1c (HbA1c) as a measure of glucose control (21, 22, 24-28, 31, 33, 35, 37, 40-42). Using the individual publication as the unit of analysis, the average HbA1c declined from 8.63% prior to intervention to 7.77% after intervention ($p = 0.001$). In diabetes circles, a reduction of HbA1c by half a percentage point, e.g., from 8.6% to 8.1%, is generally considered clinically meaningful. Thus, the average reduction across these 14 studies of 0.86 points is very striking and adds considerably to the evidence for the benefits of peer support in diabetes management.

Peers for Progress has also contributed to the evidence base for peer support by sponsoring 14 evaluation and demonstration projects in peer support for diabetes management in nine countries around the world. Among projects initially funded in 2009 and whose results are now emerging, a peer support program implemented as an extension of clinical teams caring for low income and ethnic minority patients with diabetes in a large health center in San Francisco showed significant reductions in

Hemoglobin A1c measures of glucose control relative to controls (43). Providing evidence for the success of PS in reaching those most in need, the differential benefit of PS was significantly greater among those in the low and mid tertiles for medication adherence at study initiation (44). In Argentina, diabetes education and ongoing support implemented by peers performed "at least as well" as that implemented by professionals in terms of clinical, self management, and psychosocial indicators (45).

Content of this Report

The major portion of the meeting centered on three, 90-minute discussions of each of the following:

- Peer Support and Behavioral Health: Serious mental illness, multi-morbidity, psychosocial factors in chronic disease management
- Audiences and Communities: Reach, engagement, emerging needs and special populations served by peer support programs
- Organizational and System Issues: Systems and staffing models, integration models, Patient-Centered Medical Homes, Accountable Care Organizations, and other settings for Peer Support

These discussions ranged widely. From the detailed notes kept by staff and the brief synopses of comments recorded on flip charts during the discussions, we have culled the comments and observations of participants in this report. As the participants represented a wide range of expertise both within PS and in the broader health arena, so their comments comprise a valuable summary of current knowledge and wisdom regarding peer support, its strengths, its application to new areas, and both the challenges and opportunities it faces.

In editing the comments of the participants, we recognized that, although they emerged from the three discussions noted above, they took wing to touch on a broader range of issues. Rather than confining summaries to the three original topics, we have organized the comments from the discussion according to the categories in which they seemed naturally to fall.

Each of the three discussions was preceded by brief comments of panelists who were asked to provide a few bullets to stimulate discussion. We did not confine these to a rigid format, but left the panelists to their own styles.

Appendices include these brief comments, the full conference agenda and lists of participants.

Participants' Discussion of Key Features of Peer Support:

- ***Strengths***
- ***Application to New Areas***
- ***Challenges and Opportunities***

As noted above, these comments were drawn from discussions of experts in peer support and health care and prevention at the first NPSCLN conference held November 12-13 in Washington, DC. Beyond demonstrations of the efficacy of peer support, expert participants addressed directions the in which the field should evolve in order to extend and better establish peer support as a regular part of health, health care, and prevention.

Note on Usage: Except when a specific type of program is indicated (e.g., *promotora,* community health worker, navigator), "peer support"(PS) and "peer supporter" are used throughout to encourage recognition of the common themes and broach applicability of these points.

ADVANTAGES, BENEFITS OF PEER SUPPORT

PS is valued by recipients: PS enhances individuals' connections with their health providers and becomes a mode of connecting to care that individuals enjoy and value.

Where We can Touch People: There are multiple settings of individuals' lives where PS can reach them, e.g., barber shops and beauty parlors. That peer supporters routinely see and meet people in many such settings confers on PS an advantage in reaching and engaging people through them.

High Need Pockets of Populations: Because of its flexibility, the credibility of "people like me," and the multiple settings in which peer supporters may contact individuals, PS can be especially effective in reaching those of greatest need (e.g., 44, 46, 47).

Beauty of Peer Support – Folks Who Understand their Communities: Because peer supporters are drawn from the communities they serve, they understand the needs, strengths and perspectives of those communities. This enhances their credibility within those communities, but also enables them to convey that understanding to others with whom they work, enabling those others to be more sensitive, and, hence, more effective in their own work.

AUDIENCES, CHANNELS, AND EXTENSIONS OF PEER SUPPORT

AUDIENCES

Challenges: Among the many groups among whom PS can help those who don't receive the care they should are residents of rural communities and older adults. Lack of professional services as well as low income create many gaps that PS can make major contributions to filling.

Since Peer Supporters are Limited, Where are they Most Needed? Allocating PS resources is important. E.g., should they be focused on individuals having substantial problems such as in managing chronic diseases, or on prevention and population needs? The former may be encouraged by Affordable Care Act incentives for reducing high cost care, but the latter may be of greater value to the community at large. This reflects the broader tension between clinically

focused services and population-focused health care and prevention.

Health Plans Classify Individuals by Risk – How can we Move from Individual to Family Care? Need to develop ways of characterizing the risks – or perhaps the healthiness – of families.

CHANNELS

Working with Children Who Educate Their Parents: Children can be an important source of "peer support" for their parents, conveying health messages learned through school, encouraging parents' and family efforts, and accentuating the interest of parents in being good role models for their children.

Public Housing Disappearing is a Barrier to Reaching Low-Income Groups: This illustrates the ways in which PS can reach individuals, in this case through peer supporters living in the same settings as those they serve.

Schools as Settings for Primary Prevention: In addition to being a setting for reaching children, schools can also be channels for reaching those children's families as well as whole communities which often perceive their schools as important and highly valued institutions.

EXTENSIONS

Peers can Help with Logistics: Following disasters like hurricanes as well as community traumas like mass shootings, peers can help with logistics as well as providing emotional support through hotlines, telehealth counseling, or on the ground services. Peers can also help with logistics like finding housing, etc.

Health Information Needs to be Following Us: PS can provide feedback from communities served to drive greater responsiveness of health information to the needs of those communities.

Concern: Some Communities are Not Ready for Information Technology: Community needs and strengths need to guide program planning, but it should be recognized that PS can be effective in introducing new perspectives, new capacities – such as IT, to communities.

How do we reach those not yet sick? Those who have not experienced health problems may not see themselves as standing to benefit from health care or prevention efforts. Thus, they may not be interested in programs. However, as "peer coping models," PS can be an effective way to communicate perspectives such as the value of prevention to those who have not adopted such views.

BEHAVIORAL HEALTH AND RELATED ISSUES

DEFINITIONS

Avoid the distinction between behavioral health and chronic disease: As with behavioral health "carve outs," there is a long tradition of treating behavioral health as distinct from other health problems. In some cases, this may be helpful, as with, perhaps schizophrenia or some other "Serious Mental Illnesses." However, the overlap between behavioral health and "other" chronic illness is great suggesting integration of delivery and organization of care to avoid confusing and sometimes conflicting objectives and services.

What is relationship between behavioral health and health behavior?
"Behavioral Health" is now being used to refer to the full range of normal variation in emotional status as well as mental health problems and "serious mental illness." Behavioral health services include those provided by a variety of professionals, psychiatrists, psychologists, social workers, psychiatric nurses, etc.
"Health Behavior" refers to those behaviors – healthy lifestyles, medication adherence, disease

self management, attendance at regular care, etc. – that influence development, course, and management of disease.

Don't Focus PS on Diagnostic Categories but on Lives as Lived.

NAVIGATION

Navigation: Great confusion about behavioral health services so people need help navigating alternatives. PCPs cannot explain alternatives in 12-15 minutes.

ADVANTAGES OF PS

Engage, sustain treatment: In many areas (e.g., PTSD in the Veterans Administration), effective, practical interventions are available. Challenge is to engage people in treatments and sustain that engagement sufficiently long for them to benefit.

Informal involvement: A strength of PS approaches is their informality which is effective in reaching those who may be wary of formal care providers, especially in behavioral health.

PS Behavioral and Chronic Disease Issues: The person-centered and subjective, empathic perspective of PS transcends clinical distinctions among individuals' problems, often approaching these as the individual's challenges in daily life rather than clinical entities. Thus, PS may benefit and support individuals' efforts to cope with both behavioral health and other health problems. Also, self management and problem-solving approaches are of benefit in both behavioral health and other health areas and are well suited to implementation through PS interventions.

CHALLENGES

Privacy and Confidentiality: This is a commonly voiced concern. Unclear how much it is a major obstacle. It is of substantial importance in behavioral health given concerns about stigma, etc.

Finding and engaging those with Serious Mental Illness: this can be a major challenge, but the access of PS to informal networks and settings of individuals may enable their engaging people through those channels.

Importance of Language: Example in Rahman's work with "Lady Health Worker" intervention for post-partum depression in Pakistan. The word "depression" does not appear in the intervention materials.

Integrate Behavioral Health in Primary Care: There is growing interest in this, particularly as primary care may be an effective channel in reaching many who could benefit from behavioral health services, and because behavioral health is so much a part of many of the problems with which patients present in primary care.

EXTENSIONS

Behavioral Health can use Diverse Channels, e.g., Telehealth: Although we have in the past thought of counseling as requiring close, face-to-face contact, the complementarity of "High Tech and Soft Touch" extends to behavioral health, in which, e.g., telehealth and other eHealth interventions are increasingly common and shown to be helpful.

EVALUATION OF PEER SUPPORT

ROLE OF EVALUATION IN PEER SUPPORT

Measure! **But measure what's important!** PS and its benefits often do not fit conventional clinical research designs and measures. This does not, however, mean that PS cannot and should not be evaluated. The field needs to assert the values, objectives and measures that suit PS as well as appropriate evaluation designs to capture its impacts and benefits.

Balance of Community Research and Data Collection for Peer Supporters is Too Burdensome: Keeping records pertinent to tracking and documenting PS *should be* incorporated in routines of responsible, high quality PS. Extensive completion of surveys and evaluation instruments for research, however, needs to be avoided so as not to "burn out" peer supporters or distort the mission of programs from the communities they serve.

Role of Organizational Culture: In communities, worksites, housing complexes, or health care organizations, organizational culture is very influential. PS needs to be tailored to it. In some cases, PS may also need to ameliorate its effects.

Substance Abuse and Mental Health Services Administration (SAMSHA) and HRSA released an issue brief through the Center for Integrated Health Solutions that recommends guidelines for primary and behavioral health integration, including the importance of measurement and evaluation of peer supporters.

The World Health Organization is Changing What is Good Health and Wellness – Developing New Indicators. This is an important development to legitimize some of the quality-of-life indicators that PS can be especially effective in impacting. Examples include the "Happiness Index" in Bhutan or work of the Patient-Centered Outcomes Research Initiative in the US.

ROLES OF PEER SUPPORT IN EVALUATION

Community Based Participatory Research – Buy In: By engaging peer supporters in CBPR approaches, evaluation may be enhanced and made more harmonious with overall program goals, and peer supporters "buy in" may be enhanced.

Peer Supporters Should NOT be the Ones Collecting Data: Generally this should be assigned to staff. However, if peer supporters are trained and paid for data collection, they can be effective in this.

IMPLEMENTATION OF EVALUATION

How Do We Teach a Clinical Team that Rigorous Evaluation can Happen in the Community? There are rigorous alternatives to Randomized Controlled Trials (RCTs) in numerous fields such as educational evaluation and quality improvement. These often fit community facing programs like PS better than research models from clinical pharmaceutical research. This needs to be asserted and adopted in NIH and other granting procedures and policies.

Peer supporters need to be trained to help with needs assessments and creating action plans. Representing the communities they serve, peer supporters make an important contribution to formative evaluation and program planning, but they need to be trained to perform this well.

Evaluation Training (e.g., Webinars, Technical Assistance) for Peer Supporters: Rather than just "dumping" evaluation tasks on peer supporters, training them in evaluation and providing associated technical assistance can enhance their roles and their skill sets.

CBPR Evaluation Should Have Two Parts, Quantitative and Qualitative: The quantitative often provides concrete information about what was accomplished and, sometimes, about what program features may have been statistically linked with outcomes (e.g., numbers of face-to-face meetings with peer supporters).
The qualitative helps investigators understand more details of how programs worked and worked best, such as participants' preferences that may have made one program feature especially attractive or ineffective.

Follow-up Data Collection to Show Behavior Changes is Still a Challenge: Elements of the challenge include tracking individuals as their circumstances change over time, and implementation of measures among those who may no longer receive services from the

organization conducting the evaluation.

Population Health Outcomes – What's the Right Mix of Clinical and Community Team Members: Because PS often focuses on communities as well as clinical populations, it confronts a challenge in balancing evaluation indicators reflecting clinical samples versus community health.

Important to Take Back Data Analysis to the Community – Community Institutional Review Board (IRB for reviewing research proposals) Training Available: This illustrates the potential for engaging peer supporters in research, rather than reinforcing a "two worlds" view of research/evaluation and practice.

Look at a Different Model – Dynamic, Real-Time Rapid Feedback: Quality improvement methodologies such as promoted by the Institute for Health Improvement provide sound alternatives to conventional research designs for testing program innovations and using lessons learned for program improvement.

Moving to QI from Research Based Approach: The goal of quality improvement is not to prove that something is effective in some absolute sense (leaving aside questions as to whether this is possible). Rather, QI methodology is to improve interventions in the settings and populations for which they exist, using direct observation of their impacts on valued outcomes in those settings.

How do we fit what is happening outside the clinic – in the community re: data? Evaluations of programs need to incorporate trends and developments in their surroundings, e.g., the impact of a new public education campaign on pre-existing PS interventions addressing the same problem.

COMMUNITY AND POPULATION FOCUSED ASPECTS OF PEER SUPPORT

STRATEGIC ISSUES

Background, long-term stressors, including racism: PS often combats impacts on groups of long-term stressors such as racism. This needs to be recognized as an important feature of PS. It illustrates a more general point, that PS is not focused just on the specific disease management or prevention task, but at the overall experience and situation of the recipient.

Settings of PS: Where PS is organized influences its content and the values it promotes. If peer supporters work out of agencies or clinical settings, they will tend to promote the interests of those institutions. On the other hand, if they are community based, they will tend to reflect the needs and values of those communities.

What people want – to connect: The desire to connect and be connected with others is strong and widely held, providing a strong base for PS interventions.

Understand perspectives of audience, rather than conforming audience to program's perspectives: Many PS interventions succeed by focusing on understanding the perspectives of those they help and posing objectives from those perspectives, rather than engaging recipients in the objectives of the health care provider or system.

In Implementation, *Not* "One size fits all": In implementing PS, responsiveness to the individual is foundational.

Strategically, *Not* "One size fits all": At a strategic level, PS interventions will vary depending on objectives, needs, settings, etc. so that all the "rules" such as those stated here may vary somewhat in their applicability to different programs.

Need to Address What's Behind Costs: There are a range of factors that cause disproportionate health care costs or disease burden in some groups. These include socio-economic as well as

access factors, along with individual and family characteristics. PS needs to address these background factors and not be limited to providing "band aids" for the problems they cause.
Don't Focus PS on Diagnostic Categories but on Lives as Lived of Those They Help: With many problems and in many settings, PS should provide help to the whole person and in terms of their life objectives, needs, and strengths, not just their diagnostic category. (Nevertheless, there are some health problems that may need PS tailored to a particular problem or to the challenges of a particular disease, e.g., type 1 diabetes or schizophrenia or advanced cancer.)
Treating High Risk Settings versus Individual: Example is placing peer supporters in community colleges for ready access by veterans whose PTSD symptoms may be exacerbated by classes, etc. Are there other high-risk settings for locating PS, e.g., supermarkets, clinic waiting rooms to prepare people to make better use of their appointments?
Socio-Ecological Model for Evolution of PS: The socio-ecological model suggests a movement from services for individuals to services engaging and benefiting individuals through families, friends, organizations, including workplaces, and communities.
Lifespan Perspective: As we extend our planning of PS to encompass families, friends, organizations, etc., we will address individuals at all stages of life. Embracing this can enhance the impacts of PS, extend PS programs to wider audiences, and enable PS to draw on assistance from wider range of groups and interests.
POPULATION AND PERSON FOCUSED
Whole Person *and* Whole Population: The emphasis of PS on considering the entirety of circumstances of an individual runs naturally to an emphasis on the population of which the individual is a part. The individual cannot be engaged comprehensively if taken out of that population, and engaging the population is often of great importance in reaching the individual.
How to Promote Better Health at the Community Level? PS can address the needs of communities as well as individuals such as through encouraging residents to work together on their own behalf, facilitating participation of community members in decision making around services, etc. This is a rich part of the *promotora* tradition as well as many approaches to Community Health Workers.
TAILORING TO COMMUNITIES
Understanding the Realities of What Works Well and What Doesn't within a Community: Effectiveness is community-specific. This is probably true to some extent in all areas but is surely the case in PS and other programs that engage community characteristics. Effectiveness research often fails to grasp this. PS can inform programs regarding "what will work" and what will not work in specific communities. Programs need to embrace this kind of knowledge from PS, and policies need to value it as well as effectiveness research in setting funding guidelines.
Needs – Where PS Fits? PS can be directed at problems at the level of individuals, communities, or systems and policies. It is important to develop PS programs mindful of these levels and to make sure the level of services provided is appropriate to the problem, its background causes, as well as the needs and strengths of the people served.
IMPLEMENTATION
Population Approach and a Registry Encourage Allocation of PS, Outreach: Considering the needs of an entire population and developing a registry to track those needs enables allocation of PS resources where they can be most beneficial and also raises the visibility of those who otherwise might "fall through the cracks."
Peer Supporters Leading Healthy Behavioral Change Efforts, Working with Grocery Stores:

This illustrates again the value of alternative settings for prevention and even many health care campaigns.

FUNDAMENTAL ASPECTS OF PEER SUPPORT & BROAD CONCEPTUAL ISSUES

Defining Peer Support – Apples and Oranges: General need for definition and standardization to avoid chaos, but equally important value of flexibility of PS in reflecting and responding to the perspectives and considerations of individuals, groups, and communities.

Downside of One Box: There is value in being able to clearly and reliably describe what PS is, but this should be achieved in a manner that retains flexibility in application and tailoring so as not to compromise the core value of PS in reflecting the needs and perspectives of diverse groups.

KEY FEATURES AND EMPHASES OF PEER SUPPORT

Treating Medicine and Health Care Like a Business: As long as health care is organized as a competitive business, driven by profits, PS interventions will tend to be compromised by that context.

PS is Different – Listening is Central: Fundamentally differentiating PS from clinical care or educational interventions that convey information is the centrality to PS of listening. The individual's experience is the foundation of PS and the shared sense of understanding is the starting point from which help is provided.

"Integrated" vs. "Comprehensive": The objective is services that comprehensively address the recipient's needs, including their subjective and emotional needs. Integration of care may enable comprehensive services but integration is not the objective, comprehensiveness is.

Transformative, Not Palliative: PS is sometimes used to make up for the failings of the health care system. But its raising up of the perspective of the individual in a system that historically has objectified individuals makes PS fundamentally transformative of roles in health care and the systems that surround them. PS should grasp and advance this transformative role, even as its more immediate effects may often be palliative.

Value of Tailoring Functions: Tailoring of the Four Key Functions of PS is essential to achieving the objectives of reflecting needs associated with specific problems, the circumstances of specific settings, and the perspectives of specific populations.

Long-Term Vision and Maximizing Potential of Peer Supporters: Although PS can have short-term benefits such as improved clinical status or reduced hospital or emergency costs, maximizing the potential of PS requires a long-term view that incorporates community development and capacity building. By investing in people and community change, PS can increase the skills and resources of individuals and communities.

DEFINING PEER SUPPORT

Articulate Core Features or Functions of PS – Four Key Functions of Peer Support: Peers for Progress has promoted four key functions as a template for planning and extending PS programs. These include i) assisting in daily prevention and self management, ii) social and emotional support, iii) linkage to appropriate clinical care and community resources, and iv) ongoing availability of support. A number of programs have found these helpful in providing a clear articulation of key features of PS with, at the same time, flexibility for tailoring according to the objectives and population served of a particular program.

Use Spectrum of Roles: There are many roles peer supporters can take. These include providing concrete assistance or instruction, active listening and emotional support, link between the individual and the health-care team, community advocate and development of social capital. PS

programs should draw flexibly from these in responding to population needs and perspectives and opportunities within health systems or communities.

Don't Equate PS with a Particular Type of Person or Provider: For example, PS is not "a women's program"; in China, men are more likely to be peer supporters than women. This illustrates the extent to which PS programs are shaped by their contexts, including broad cultural and socio-economic factors.

OPPORTUNITIES AND NEW DIRECTIONS

Focus on Families – Family to Family Support: Many health problems pose family problems and PS can address the family's needs and strengths, not isolating individuals within their families.

If One Person has Diabetes, Family is at Risk: Biologically, behaviorally, socially, culturally, and often socio-economically, diabetes and other chronic diseases are challenges for the family, not just the individual. Peer supporters usually have the flexibility to work with both individuals and families.

ACA = Make More Money by Spending Less Money: Although the Affordable Care Act includes many provisions favorable to extending PS programs, fundamentally, it is a system to increase efficiencies and reduce health care costs. In some instances, those motives are likely to pose barriers to the quality and reach of PS programs.

What is the Interface Between Peer Support and the Health Care System? That the question needs to be asked illustrates the challenge. Recognizing that there is not one answer underscores the value of diversity in PS programs and their connections to health care. Individuals need a web of resources to support their health, not just one or two "best practices."

Wellness – Beyond Just Classes! Wellness is much more than discrete messages conveyed in a classroom. PS can promote that broader view of wellness encompassing life satisfaction and health as a contributor to that satisfaction, not so much an end in and of itself.

Consider Life-Span Approach when Training Peer Supporters: The life-span approach is a helpful strategy for promoting holistic PS services. Considering not only where the individual is, but where she/he has come from and where they want to go is a way of broadening the understanding of current health challenges and bringing to bear on them long-term goals and aspirations. The life-span approach is also pertinent to the peer supporters themselves, who need to consider their work as peer supporters as part of a larger trajectory, whether it is gaining valuable job skills for the individual in their 20s, or developing productive engagements for the recent retiree.

GOOD PRACTICES IN PEER SUPPORT PROGRAMS

SUPPORTING THE PEER SUPPORTERS AND PROGRAM QUALITY

Peer Supporters have problems too: Peer support can be stressful for the peer supporter. Peer supporters need ready access to supervision, back-up, and opportunity to discuss their work with each other.

Importance of Back-Up for Quality Assurance: Peer supporters are selected to be reliable, responsible, and resourceful. Faced with a problem with no resources to address it, they will tend to improvise. This can lead to errors in responding to the varied problems those they help often present. Instead, the PS program should offer easily and reliably obtainable back-up (e.g., a 24/7 number with which to reach a nurse who is part of the program). The peer supporter will use it, often resulting in a net improvement in how emergent problems are managed.

WORKFORCE DEVELOPMENT

Important to Pay *Promotores*/Peer Supporters: There is a rich tradition of volunteer peer support in many settings. However, in programs in which peer supporters will have extensive responsibility or be required to meet goals such as numbers served, or be responsible for keeping fixed hours and extensive records of their work, commensurate reimbursement is appropriate and should be provided.

Continuing Education to Prevent Peer Supporter Burnout: In addition to support and supervision and back up, peer supporters should receive continuing education to enrich their jobs and provide opportunities for personal advancement, an important by-product of many PS programs.

NEW DIRECTIONS IN PEER SUPPORT PROGRAMS

NEEDS AND NEW DIRECTIONS

"High Tech and Soft Touch": Although we often think of the interpersonal warmth of PS as almost antithetical to eHealth and other "high tech" approaches, the two may often be complementary. PS can help introduce the world of high tech to those who have not entered it. And, just as with professionals, telehealth and other eHealth approaches can extend the reach and availability of PS.

Multi-national *Promotores* Network: The *promotora* model extends throughout Latin America. There is a great opportunity for enhancing knowledge through hemispheric cooperation and exchange.

Practice and Patient Informatics – CHWs out in the Community with iPads, Linking Community Members to Services and Information: There are many opportunities for blending PS with high tech, eHealth. This can include helping communities become more able to benefit from information technology.

Veterans Administration App that Links to Service Provider: This illustrates the potential of IT to extend and enhance PS and related services.

What Systems Do We Want for the Future? Planning of PS needs to incorporate the health care systems and other community settings and systems through which PS will take place.

RESOURCES

Veterans Administration is Hiring and Training Peer Supporters to Provide a Network of Peer Supporters: Illustrates growth of opportunities for PS and PS programs.

Veterans Administration Computer System and health systems medical records are free and can be used as a resource by anyone: Again, this illustrates the availability of resources, including IT and evaluation resources. The Veterans Administration is becoming a leader in PS programs and related support systems.

Opportunities within Health Care Reform: Among the opportunities for PS are:

- Accountable Care Organizations (ACOs), Chronic Health Homes, etc.
- Reimbursement through Medicaid

These can be challenging to put into place, but very helpful if established.

ADVOCACY

NEEDS AND OBJECTIVES

Disconnect between dollars and outcomes: The role of behavioral influences in health, illness,

morbidity, mortality, and health-care costs is enormous (40% of premature death is attributable to behavior), but the allocations of resources to Behavioral Health (< 6%) and behavioral and community health promotion is very small relative to other areas of health care and prevention.

Challenge of Getting US Federal Government to Invest and Commit to PS: The organization of the National Institutes of Health around disease categories, the prominence of "routine science" in many of the activities it supports, and concerns that federal funds not be wasted on "frivolous" activities all create barriers for funding of "nontraditional" care like PS.

Problem = Fragmentation: Fragmentation of services and the health care system is, at once, a problem for PS but also a problem that PS can help reduce, at least in terms of helping individuals gain a coherent understanding of their health and the services that advance it.

Resistance of managers, professionals: Managers have concerns about reporting and job procedures. Professionals are concerned about misinformation and mishandling of patients and about peer support disrupting their relationships with their patients.

ARGUMENTS *FOR* PEER SUPPORT

PS increases care, decreases costs, and increases reach to populations.

Peer Support is Traditional Care: Peer support is as old as homo sapiens and well engrained in many cultures, such as in the *promotora* tradition in Latin American culture. Further, it rests on the fundamental importance of social support, the absence of which is as lethal as smoking cigarettes (5, 48). Thus PS can be understood as a very traditional bedrock of care and helping.

ADVOCACY STRATEGIES

Peer Supporter Stories and Who they are to Elevate their Importance: Stories of program success examples of individuals helped, and testimonies from PSers can be highly effective in promoting programs.

How do We Engage the Skeptics? Show that it is win-win. Need to show how PS programs are congruent with the goals of professionals. Show worries about losing control, misinformation, etc. are not well-founded. "The self-management program [has] made my life easier—I can focus on being a doctor"(49). Testimonials from physicians and other health leaders may be highly effective.

How Can We Market the Concept of Peer Supporters as Care Managers to Payers and Clients? The health care system, as in the Affordable Care Act, is becoming more aware of the importance of frequent and flexible contact, follow up, monitoring of critical adherence (e.g., daily weigh-in in heart failure) and recognizing that PS can provide much of this kind of service, almost always more cheaply and often more effectively than professionals. Also should consider model of peer supporters as extenders of professional care managers, e.g., a care manager coordinating the outreach and follow-up work of a half dozen peer supporters.

FINANCIAL ISSUES

Transition from Funding PS to Financing PS: To realize fully the potential of PS, need to move toward financing the infrastructure and delivery of PS rather than reimbursing instances of care meeting specific guidelines.

Behavioral Health Funding is Very Limited: There is a need to expand funding for behavioral health and ways of integrating behavioral health into other channels of care in order to gain funding for it. This illustrates fact that, no matter the readiness of professional community to accept PS in behavioral health, funding is essential.

Emerging Models of Payment – How Can Peer Support Be Involved? There are substantial

opportunities emerging, and risks of missing those opportunities. Development of PS programs needs to engage those involved in setting policies and address these issues with vigor.

ORGANIZATIONAL AND SYSTEM ISSUES

INTEGRATION

Colocation does not Guarantee Integration: The design of service settings and practice routines must promote interplay and interaction among peer supporters and others in order to achieve integration of their services.

Many Levels of Integration: Integration may take place at the level of services to the individual, at the level of care providers and their activities, at the level of organizations providing care, and at the level of policies and reimbursement (e.g., behavioral "carve outs").

Integration Needs Attention: Integration does not happen spontaneously, even through policies that may enable it. It needs to be promoted and carried forward by those directing and implementing programs – and those receiving their services.

Care Models – How Do We Integrate PS? Need to recognize that integration is complex, not just a matter of willing it so, and that there are varied models of integration.

What Does a Successful Integration Look Like? Is it Respectful of CHWs? What policies and procedures should be in place? What has to take place for it to function well?

Statewide Transitional Care: This program in North Carolina provides a good model of PS contact in the home, addressing behavioral health, adherence and other issues important to reducing rehospitalizations.

ORGANIZATIONAL DEVELOPMENT

Business Perspective – Why tackle ill health from the perspective of "ill health"? Consider developing, marketing, etc. of PS as service for positive well being or good health. We spend thousands on hospitalization but have few resources to prevent hospitalization, even though prevention is much more cost-effective.

Veterans Administration Mandated PS at Sites, but Lacks the Requisite Expertise at All Sites: This illustrates the fact that PS programs require an infrastructure for training, ongoing support of the peer supporters, monitoring, supervision, back-up, and linkage to the rest of the care team.

Complexity of How Health Care Plans are Managed: Need to start with recognition of complexity of organizational dynamics, especially in health care systems. Instead of heroes and villains, "it's the system!"

Influenced by CMS: This illustrates the large role of policies, systems, and reimbursements in directing the development of PS programs.

If One Person Has Diabetes, Family is at Risk: Family Support Model Combined with investing in communities to Increase Social Capital.

CHW Central, funded by USAID, Provides Online Resource at International Level: This illustrates the availability of good resources and knowledge on PS but the lack of sufficient utilization of such resources.

CERTIFICATION OF PEER SUPPORTERS???

Several states have certified peer supporters for varying functions and then reimburse programs for those PS services (8).

Certifying Organizations versus Individual Certification, Core Competencies: Among the issues surrounding quality control, certification, etc. it may be helpful to consider certifying organizations based on core competencies for training peer supporters rather than individual certification according to degrees, training completed, etc.

Areas for Future Work

At the conclusion of the meeting, participants reflected on the day's discussions and identified topics and priorities that the field should address. As well as sharing these with the broad community of those interested in peer support, both in the US and worldwide, these will shape the activities of the National Peer Support Collaborative Learning Network in 2014.

At this point, we have listed suggestions within the broad categories in which they fall. In the interest of ensuring that we capture all good ideas offered, we have not worked to eliminate overlap among suggestions at this time.

DEFINITION OF PEER SUPPORT, CERTIFICATION, QUALITY CONTROL, WORKFORCE DEVELOPMENT
Colocation does not Guarantee Integration: The design of service settings and practice routines must promote interplay and interaction among peer supporters and others in order to achieve integration of their services.
Many Levels of Integration: Integration may take place at the level of services to the individual, at the level of care providers and their activities, at the level of organizations providing care, and at the level of policies and reimbursement (e.g., behavioral "carve outs").
PS as transformative not palliative
Standardization (what's in common?) and flexible response to individuals and communities (VA as model with national guidelines but local "flavor"?)
Approaches to enhancing CHWs' health, preventing burnout
Tremendous wellspring of potential peer supporters – how engage, deploy? Peer support as a culture shift Roles of peer supporter: e.g., "life cycle educator"
Models of preserving "peerness" in health care settings
Perhaps agree on a specific name for PS
How to strike balance of PS certification while maintaining the core essence
Career ladder development and lateral ability for peer supporters (volunteer, full-time, part-time)
What are those core competencies of PSers?
National standards for CHW skills and competencies
Certification of organizations, not individuals
Create guidelines for certification of organizations employing/managing PSers
Develop or specify clinical expectations/goals for PS programs and how this influences training/certification
FINANCIAL MODELS
Colocation does not Guarantee Integration: The design of service settings and practice routines must promote interplay and interaction among peer supporters and others in order to achieve integration of their services.

Many Levels of Integration: Integration may take place at the level of services to the individual, at the level of care providers and their activities, at the level of organizations providing care, and at the level of policies and reimbursement (e.g., behavioral "carve outs").
Payment models; Financing systems rather than services
Business model of PS owned by PSers
Opportunities in ACA, e.g., PS in care management
Business model of PS program owned by Peer Supporters

INTEGRATION OF PEER SUPPORT IN PRIMARY CARE

Model(s) for integrating behavioral health and primary care (including PCMH, ACO) Ideal models to respect CHWs
Many Levels of Integration: Integration may take place at the level of services to the individual, at the level of care providers and their activities, at the level of organizations providing care, and at the level of policies and reimbursement (e.g., behavioral "carve outs")
Integration: Multi-dimensional within individuals, communities, systems
Better integrate peer support into a system of care. There seems to be a desire to connect them more with a community than with a provider team. To start to make case for peer support, they probably need to initially start closer to the provider and administrator.
Non-fragmented approaches
Team-based care model, not PS model

BUILDING THE EVIDENCE BASE

Outcomes in behavioral health and in general; research methods for PS
Continue to do systematic reviews. I am not sure we are done with efficacy. There are several studies showing peer support is helpful but it's in different areas or conditions. If PS is going to be including in practice guidelines we will need more systematic reviews showing abundance of evidence. In reviews we could start to evaluate what works well for whom and when.
Consider efficacy "done": What are scalable implementation models? Who benefits most, with what intervention? PS through community settings, e.g., public housing PS creating healthy communities
Online catalog of scientific reports on peer support—successes, problems in implementing, lessons learned, how to sustain
Evaluation should build upon good partnership between researchers and programs

NEW DIRECTIONS AND COMMUNITIES TO SERVE

Rural communities

Deploying to hi-risk settings (e.g., comm colleges), not hi-risk individuals Using IT to support PS, using PS to support IT, HIE
PS focused on families rather than individuals
Modeling PS to achieve healthy individuals and communities rather than preventing and managing disease, e.g., WHO emphasis on wellness, "happiness"
PS and Population health impact (social determinants)
Build structures for primary prevention / healthy living to layer with secondary prevention
PS in schools or based in schools or addressing problems of student populations

ADVOCACY

Advocating to create flexibility in implementation in ACA
Models of PS as good care for all people, not cheap care for poor people
SAMHA model for PS that can be a good example
Attach PS to the definition of health
Mainstream PS as health care strategy

OBJECTIVES OR STRATEGIES FOR NATIONAL PEER SUPPORT COLLABORATIVE LEARNING NETWORK

Establish the uniqueness of "Peers for Progress" and peer support in the larger realm
Explore how NPSCLN can act as a resource for peer supporters and their employers
Dissemination of NPSCLN Work Group products
Collaboration with other work groups
Developing a dissemination strategy of NPSCLNs' work groups
Online catalog of scientific reports on peer support—successes, problems in implementing, lessons learned, how to sustain
Options for mode, channels of activity:
Regional work groups and meeting face to face once a year (time is an issue)
Include peer supporters in work groups (commentary/advising role) and in meetings of NPSCLN
Best practices – telling the story
Story banking (digital stories; YouTube channel)
Peer mentoring opportunities – Opportunities for established programs and their leaders to mentor other programs
Collaborating with other groups National Rural Health Association Meeting APHA, CHW caucus Annual Family Medicine Meeting Conference on Practice Improvement – family medicine

Meetings that address higher level/systems-focused – Patient-Centered Collaborative Care Collaborative
Sustainability messaging – cost savings
Link with US CHW movement
Identify and pursue grant opportunities
Have a Sharepoint site for everyone to put best practices and PDSAs that worked and didn't work
Create a synergistic NPSCLN consortium

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Appendices

Appendix A. Meeting Agenda **p. 28**

Appendix B. Introductory Comments from Panels **p. 31**

Appendix C. Participants, Invitees, Meeting Organizers **p. 37**

Appendix A. Meeting Agenda

Tuesday, November 12, 2013 – NPSCLN Work Group Members

National Peer Support Collaborative Learning Network Work Group Member Meetings

Members of the six pre-existing Work Groups will meet to discuss their projects, lessons learned and next steps.

Venue: National Council of La Raza, 1126 16th Street, NW, Suite 600 Washington, DC 20036, ABC Conference Room, Lobby Level

12:00 pm	Meet & Greet, *LUNCH*
1:00 pm	Individual Work Group Meetings
3:00 pm	Members of all Work Groups: Lessons Learned/Moving Forward
4:00 pm	*ADJOURN*

Tuesday, November 12, 2013 – All Attendees

Venue: Mayflower Renaissance Hotel, 1127 Connecticut Ave NW, Washington D.C. 20036

Networking Reception & Poster Session

Poster session highlighting the efforts of six Peer Support Work Groups in 1) Recruitment, Training, Management, Retention and Back-up of Peer Supporters, 2) Quality Improvement & Evaluation, 3) Ongoing Support, 4) Behavioral Health & Peer Support Interventions, 5) Organizational & System Factors, and 6) Sustainability & Advocacy.

Venue: Mayflower Renaissance Hotel, Cabinet Room, Lobby Level

6:00 pm	Hors d'oeuvres and Networking Welcome: Janet Murguía, President and CEO, *National Council of La Raza*

Dinner & Meeting Kick-Off

Dinner and opening remarks from the National Council of La Raza, the American Academy of Family Physicians Foundation and Peers for Progress.
Venue: Mayflower Renaissance Hotel, Senate Room, Lobby Level

7:00 pm	Group Dinner & Discussion
9:00pm	*ADJOURN*

Wednesday, November 13, 2013 – All Attendees

Venue: National Council of La Raza, 1126 16th Street, NW, Suite 600 Washington, DC 20036, ABC Conference Room, Lobby Level

07:30am	*BREAKFAST* **Reminder, hotel check out time is 12:00pm*	
08:00am	**Overview of Peer Support, National Peer Support Collaborative Learning Network** Edwin Fisher, PhD Global Director, Peers for Progress	**CROSS-CUTTING THEMES** Health Care Reform and other funding sources for peer support Advocacy Preserving peer support as a humanizing force in a system oriented toward objective and financial outcomes Retention, certification, quality improvement, and related issues in peer support programs
08:45am	**PANEL 1:** **Peer Support and Behavioral Health** Serious mental illness, multi-morbidity, psychosocial factors in chronic disease management *Facilitator:* Justin Nash *Panelists:* E. Lee Rosenthal, Katherine Nordal, Jeanne Gabriele	
10:00am	*COFFEE BREAK*	
10:30am	**PANEL 2:** **Audiences and Communities** Reach, engagement, emerging needs and special populations served by peer support programs *Facilitator:* Martha Funnell *Panelists:* Hector Balcazar, J. Nell Brownstein, Aida Giachello, George Rust	
11:45am	*LUNCH*	
12:45pm	**PANEL 3:** **Organizational and System Issues** Systems and staffing models, integration models, Patient-Centered Medical Homes, Accountable Care Organizations, and other settings for Peer Support *Facilitator:* Charlie Alfero *Panelists:* Gertrudes Holder, Bert van den Bergh, Maggie Morgan	
02:00pm	*BREAK*	

Wednesday, November 13, 2013 – continued	
02:15pm	**STRATEGIC DISCUSSION:** **2014 Priority Areas for the National Peer Support Collaborative Learning Network** **Possible Activity Foci for 2014** To be presented, based on earlier discussions **Possible Activities or Products:** Webinars Work groups White papers Journal publications Business cases Program toolkits and resources Advocacy activity Advocacy toolkit Other?? **Consider Cross-Cutting Themes as Organizing Structure** Health Care Reform, other funding sources Advocacy Preserving peer support as a humanizing force Retention, certification, quality improvement, etc.
03:00pm	*ADJOURN*

Appendix B. Introductory Comments from Panels

PANEL 1: p. 28
Peer Support and Behavioral Health
Serious mental illness, multi-morbidity, psychosocial factors in chronic disease management

Facilitator: Justin Nash
Panelists: E. Lee Rosenthal, Katherine Nordal, Jeanne Gabriele

PANEL 2: p. 31
Audiences and Communities
Reach, engagement, emerging needs and special populations served by peer support programs

Facilitator: Martha Funnell
Panelists: Hector Balcazar, J. Nell Brownstein, Aida Giachello, George Rust

PANEL 3: p. 37
Organizational and System Issues
Systems and staffing models, integration models, Patient-Centered Medical Homes, Accountable Care Organizations, and other settings for Peer Support

Facilitator: Charlie Alfero
Panelists: Gertrudes Holder, Bert van den Bergh, Maggie Morgan

Introductory Comments for Discussion of:

Peer Support and Behavioral Health

Serious mental illness, multi-morbidity, psychosocial factors in chronic disease management

Facilitator: Justin Nash
Panelists: Jeanne Gabriele, Katherine Nordal, E. Lee Rosenthal

Key Points:

Jeanne Gabriele

- Research on the effectiveness of peer support programs has focused mostly on patients with severe mental illness, addiction, or comorbid chronic and mental health conditions. However, there are substantial, unmet needs among individuals with anxiety and mood disorders. The Veterans Administration began with peer support specialists for SMI patients and addictions but sites are starting to extend this to other areas. These may provide models for extensions to other populations.
- The vision of the VA and many other mental health systems is to provide ready access to comprehensive, evidence-based care. Peer support specialists are frequently being used to provide ongoing support to individuals with behavioral health needs. Specific services include sharing personal recovery stories, showing recovery from mental illness is possible, and teaching goal setting, problem solving, and symptom management skills. Although these reduce provider demand and extend resources, there may be ways we can better use peer support to assist with this vision of providing accessible, evidence-based care.
- The key component to evidence-based practice is shared-decision making between the patient and provider in treatment planning. Veterans often indicate that choosing a behavioral health treatment can be difficult. Providers often lack time to provide detailed explanations of treatment. Veterans also report that they are more likely to trust what a Veteran who completed treatment says about their treatment experience than what a provider says. Thus, peer support specialists may assist in the evidence-based practice process by discussing and answering questions about their treatment experiences with Veterans who are deciding among different treatments.
- Numerous evidence-based psychotherapies have been identified as effective treatments for mental health conditions. Despite wide availability through the VA, few Veterans receive an adequate dose of treatment, e.g., < 1 in 5 Iraq/Afghanistan Veterans with PTSD receive an adequate dose of psychotherapy. High drop-out rates and low utilization of treatment are common. There may be opportunities to use peer support specialists to reach Veterans in need of treatment and keep Veterans engaged in the treatment process.

- Recovery and rehabilitation have become a key component of mental health programs. According to the National Consensus Statement on Mental Health Recovery, peer support is one of the 10 fundamental components of recovery. Peer support models, which move a Veteran from a patient to provider role, are congruent with recovery models. Unfortunately, there are large numbers of Veterans interested in being peer support specialists but only a limited a number of spots. Finding more opportunities for Veterans to be able to provide support to other Veterans may facilitate their recovery process.

Katherine Nordal

- Making the "business case" for peer support
- Certification/credentialing for peer support
- Funding mechanisms in public and private sectors

E. Lee Rosenthal

- Peer support for behavioral health can address health and system challenges on many levels:
  - With Individuals and Families
    - Peer support provides tailored information and support to help individuals and families take positive steps to prevent illness, improve health, and manage chronic conditions.
  - In Agencies and Institutions
    - Peer support helps to create a supportive "climate" in health and human service agencies promoting access to medical, behavioral, and mental health services.
    - As extended members of *health care home teams*, peers provide needed social support and information helping agencies and providers to create effective systems of caring.
  - Out in the Community
    - Peer support for improved behavioral health in communities creates healthy environments that improve community opportunities for health.
    - Peer –led community activities such as *health walks or community kitchens* offer community members important opportunities for socializing and practicing health behaviors.

Introductory Comments for Discussion of:

Audiences and Communities

Reach, engagement, emerging needs and special populations served by peer support programs

Facilitator: Martha Funnell
Panelists: Hector Balcazar, J. Nell Brownstein, Aida Giachello, George Rust

Key Points:

Hector Balcazar

- How can systems of health, health care and prevention initiatives in the U.S. and in the world move towards optimal health and wellbeing, by embracing a unified, systematic and holistic approach to peer support that has at its core feature providing a humanistic value to achieve progress for all?
- How can different audiences and communities in great need and the disenfranchised have access to peer support that can be deployed readily to serve these vulnerable groups?
- What would it take from systems of health, health care and prevention initiatives in the U.S. and/or in the world to "legitimize peer support systems" that are reaching audiences and communities with justice, dignity and hope, and make this legitimacy an intricate part of a "new development" model of progress for communities, countries?
- How can this new model of development of progress be part of the umbrella of the U.S., the United Nations and the World Health Organization so that monitoring and evaluation of the "movement and philosophy of peer support" can be fully integrated in the U.S. and/or in a world discourse for achieving justice in health and wellbeing for all?

J. Nell Brownstein

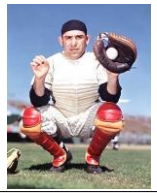
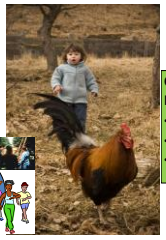
- Peers are part of hospital discharge teams to follow-up with patients, with no insurance or who go to clinics for low income patients, to provide support and ensure they get and take prescribed meds, do rehabilitation activities, seek follow-up care, and get their questions answered
- Peers are links to public housing and provide support, referrals, and health promotion/disease prevention activities for clients in public/low income housing
- Peers are links to schools and provide education, support, and referrals (health and social services) for families
- Peers are trained and are quickly mobilized in times of natural disasters or political upheavals so community members get access to needed medicines, food, water, and shelter

Aida Giachello

- *Living in rural communities*. There are a growing number of H/Ls living in rural communities across the United States who represent 2nd or 3rd generations of migrant farmworkers but are not working in the fields or who have settled in rural areas for other reasons. H/Ls in rural communities are experiencing a host of health problems, from obesity, to diabetes type 2, CVDs, HIV/AIDS, etc. The network of Migrant Farm Workers (MFWs) may not serve them because they are not technically migrant farmworkers, and/or they live in small towns or areas where the MFWs organizations may not have services. What strategies do you suggest for the National Peer Support Collaborative Learning Network to develop to reach out and provide the needed educational services?
- *Persons 60+ years of age and older*. Hispanic elderly is the fastest growing population group within the H/Ls. An increase number (close to 50%) are either living alone, and/or in senior housing, or living in long-term facilities (e.g., Assistance Living, Nursing home,

etc.). What type of peer support services can be developed to improve their health status and health-quality of life in the diverse settings and institutions; or, if they live within an extended family system, what types of peer support can be provided to caregivers? Can we be able to train sufficient number of peer support workers to meet the demand.

George Rust

Concept	Key Point
Mental Health ←→ Physical Health  "Baseball is 90% mental -- the other half is physical." -- Yogi Berra Multimorbidity / Whole Person Health "I'd like to get your arrow count down."	The goal is to achieve improved "whole-person" health outcomes, integrating behavioral health and physical health components seamlessly. One-disease-at-a-time programs only work for patients who agree to have only one disease at a time.
Free-Range Humans *(when patients escape from the exam room!)*  Integration! **Community-Level:** • Patient at home • Family and culture • Social Determinants Population Outcomes Community Healthcare System Practice Person	People don't live in the clinic, and they don't make their health-changing decisions in the clinic. They are "free-range humans" and make little decisions all day long that drive their health outcomes. So a health outcomes team must have a presence in people's lives, in the context of their families and communities.
Primary Care is Relational Care *Personalismo y Confianza* Cultural Relevance / Cultural Ownership South Central Foundation – Anchorage, Alaska	I am passionate about primary care as a relationship, and believe in the power of the doctor-patient relationship. But the more important, culturally-relevant relationship with the health team may be through a trusted member of the family or community.
Teamwork! • Community Health Workers (*Promotoras*) • Medical Assistants • Nurses / Nurse Practitioners • Pharmacists • Social Workers • Health Educators • Respiratory Therapists • Physical Therapists • Primary Care Practitioners • Psychologists • Behaviorists • Sub-Specialists • Administrators Health Care ***with*** the "We-All" Factor Moving from Collaboration to Full Integration -- Diverse Teams Performing Complex Tasks!	Too often the community interventions in hair salons and church fellowship halls are isolated from the "inside-the-clinic" care that is being delivered. We need to break down the clinic walls to build cohesive teams that work effectively together.
Community Health Workers *(Promotores de Salud)* Career Lattice Focus Area → / Training / Certification ↓ | SPMI Peer Counselors | Cancer Patient Navigators | Diabetes & CV Risk Reduction (ABCs) | Depression PTSD Substance Use | Prenatal / Maternal-Child Health | HIV/AIDS & Sexual Health Cultural Relevance + Focused Training Basic Health Literacy + Certificate Programs Community College One-Year Certificate Associate's Degree Programs	Community health workers or peer support specialists are not a one-size fits all model. In fact, there should be a built-in ability to grow in depth and in breadth over a "career lattice" to build a life's work in community health. *(career development = community development)*

Introductory Comments for Discussion of:

Organizational and System Issues

Tools and systems, staffing models, integration models

Facilitator: Charlie Alfero
Panelists: Gertrudes Holder, Maggie Morgan, Bert van den Bergh

Key Points:

Gertrudes Holder

- Challenge of coordination across corporate divisions: Human Resources, Clinical Disparities and Cultural Diversity, Marketing, and Corporate Social Responsibility
- Barriers to older adults' participation: transportation, concern about impact of participation on future benefits, stimulating member-provider support for program
- Incorporate educating providers about program prior to initiation
- Continued challenges in quantifying program benefits, cost savings, financial impact of using community health workers with a medical home
- System changes required to make a CHW and medical home model viable

Maggie Morgan

- Moving away from fee-for service systems: What could alternative payment models provide?
  - Reimbursement for comprehensive, culturally competent healthcare teams including peer supporters/promotoras
  - Routine patient access to vital services such as community-based diabetes education, follow-up support, and non face-to-face services (e.g. phone support) – all of which can be provided by peer supporters/promotoras
  - Flexibility to design payment and delivery systems that meet the needs of "hardly reached" patients, including minorities and rural populations
- Peer supporters within healthcare teams: What are some avenues for integration?
  - Inclusion within larger provider networks, including Accountable Care Organizations, Managed Care Organizations, and Patient-Centered Medical Homes
    - Potential for peer supporters to be used without formal credentialing in these systems
  - Medicaid Section 1115 waivers and State Plan Amendments
    - Likely will include a credentialing requirement
    - Advocacy opportunity: Credentialing the program, not the provider

Bert van den Bergh

- Good and ill health as the dynamic coproduction of biology, environment and behaviour
- Health care strategies as the focus on mainly standardized and simplified biology, the risk of the "Fallacy of misplaced concreteness" and the scenario of "a future of brilliance in irrelevance" with medical specialization
- Peer support as part of a strategy to pursue "Person led, individually optimized, flexible and integrated care"

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