



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

**NCLR**  
NATIONAL COUNCIL OF LA RAZA

*Peer Support in Health*

# EVIDENCE TO ACTION

An Expert Report of the National Peer Support Collaborative Learning Network

Person Centered, Population Focused, Community Oriented, Comprehensive, Programmatic Peer Support



 AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
FOUNDATION

Bristol-Myers Squibb Foundation  
*Together*  *Diabetes*<sup>®</sup>  
Communities Uniting to Meet America's Diabetes Challenge



*Peer Support in Health*

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# WELCOME

## from Janet Murguía

*President and CEO, National Council of La Raza (NCLR)*



In every neighborhood, there is always someone everyone else relies on for good advice and common sense wisdom. She may not be a doctor but she knows just what to do for a child suffering from a high fever. She may not be a nutritionist by trade but she knows where to get the best and cheapest fruits and vegetables. That was certainly true in my neighborhood in my hometown of Kansas City, Kansas where my Mom depended on her friends and *co-madres* for just this kind of advice.

Tapping into this rich tradition was the catalyst for one of NCLR's most successful programs, the *Promotores* program. What if we could use these trusted and revered pillars in their communities to help improve the health and well-being of Latinos across the country? Who could people trust with their health questions, even the most private ones? Well, our *mamas*, our *abuelas*, our *tias*, our *hermanas*, our *co-madres*, and our *amigas*, of course.

Since 1980, we have trained thousands of these *promotores* or community health workers. And their success has been astonishing. These women and some men have had a measurable impact on reducing HIV/AIDS, promoting cervical cancer prevention, fostering healthier eating to mitigate growing obesity in the Hispanic community, and now are helping the uninsured sign up under the Affordable Care Act to get health insurance for themselves and their families. Our years of work on *promotores* have demonstrated to us that this is a program that can and should be brought to scale.

Now more than ever, the need for effective and cost-effective ways to bring down the cost of health care and improve health outcomes for all Americans is critical. Both the research and our experience show how promising peer support can be to these goals. For all of these reasons, we are delighted to collaborate with Peers for Progress and the American Academy of Family Physicians Foundation in sponsoring the National Peer Support Collaborative Learning Network and to see this wise and inspiring report from its first national conference.

It is time for our country to invest more in peer support. Our future well-being depends on it.

*¡Gracias y adelante!*

A handwritten signature in black ink that reads "Janet Murguía". The signature is fluid and cursive, with a large initial "J" and "M".

Janet Murguía  
NCLR President and CEO

# WELCOME

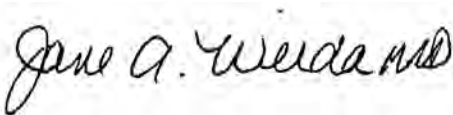
*from Jane Weida, MD*

*President, American Academy of Family Physicians Foundation*

The American Academy of Family Physicians Foundation is delighted to see the publication of this report. It brings together much of the work of Peers for Progress along with our colleagues at the National Council of la Raza and many other leaders in health care and peer support.

Central to family medicine is the integration of care for the individual, the family, and indeed the community. Our commitment to the Patient Centered Medical Home puts these emphases front and center. Among them, peer support is an exciting and versatile strategy. Evidence shows that peer support helps engage patients and link them to their providers. It helps them carry out in their daily lives the plans and strategies they worked out with those providers. It often goes on to link support from families, communities, and the organizations through which we live so much of our lives. It does all of these, as wonderfully emphasized in this report, with a strong emphasis on the whole person, her or his interests, strengths, and needs.

From the deliberations of the conference reported here, we see the potential of comprehensive, patient-centered, population-focused peer support programs. This is an exciting direction for the activities of Peers for Progress, the National Council of La Raza, and our jointly sponsored National Peer Support Collaborative Learning Network. The American Academy of Family Physicians Foundation is delighted to see this work go forward as we are immensely proud to have contributed to it as a clear example of family medicine's vision for health in the 21st century.



Jane Weida, MD

President, American Academy of Family Physicians Foundation



# KEY FINDINGS AND MOVING FORWARD

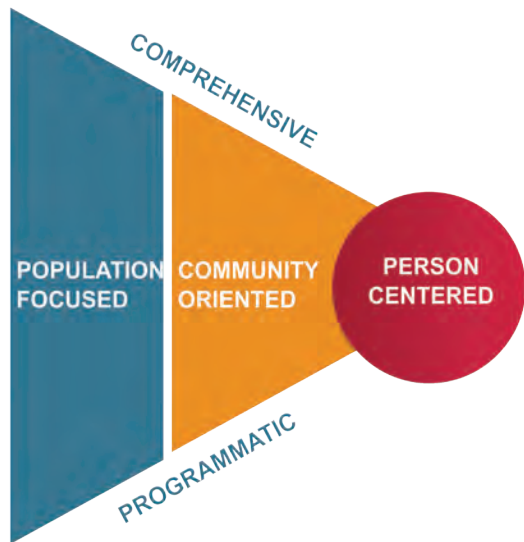
Toward Person Centered, Population Focused, Community Oriented, Comprehensive, Peer Support Programs

## The Evidence Is Strong

**Major reviews** document that peer support provided by “community health workers”, “*promotores*”, etc. make important contributions to health, health care and prevention (Viswanathan et al. *Med Care* 2010 48, 792-808; Gibbons et al. *Prog Community Health Partnersh* 2007 1, 371-381; Swider. *Public Health Nurs* 2002 19, 11-20; Perry et al. *Annu Rev Public Health* 2014 35).

In **diabetes** management, **19 of 20** articles published between 2000 and 2012 showed **significant evidence** of benefits of peer support.

Among 14 of the 20 diabetes papers that reported pre- and post-measures, the **average HbA1c declined** from 8.63% before intervention to 7.77% after intervention ( $p = 0.001$ ) (Linnan et al. *Am J Health Promot* 2013 28, TAHP2-10).



This report shows that **peer support works** and goes on to highlight:

- the unique strengths peers can bring to health promotion and health care
- the importance of the community-grounded nature of peer support and its versatility in ranging from individuals to families to organizational settings to neighborhoods and communities
- the value of peer support in providing a point to which individuals can turn for feeling understood and helped within the contexts and settings of their own lives
- how peer support can be defined and standardized while remaining flexible and responsive to the people and communities it serves
- the importance of peer support as a way of reaching those too often passed over by prevention and health care
- growing emphasis on integrating peer support, behavioral health, and primary care
- the importance of quality assurance – supervision, management, and organizational factors in providing a setting in which peer support can be effective and sustained
- understanding evaluation as a practical part of quality improvement
- within the context of 21st century health care, the connection between sustainability of peer support programs and their ability to extend to whole populations who need them
- the need for regulatory frameworks that standardize peer support services while allowing for flexibility to match the specific needs of unique populations and settings





*As a result, the field needs to develop program models that are:*

**Person Centered** – taking full advantage of peer support’s ability to meet individuals where they are and to reflect their needs, strengths, lives, and aspirations

**Population Focused** – organized, implemented, and sustained to meet the needs of all those for whom they are designed, e.g., all subscribers with diabetes or all recently retired elders, not just a few hundred enrolled in a particular program

**Recognition of Peer Support as a Key Part of Comprehensive Health Care**

will advance political and policy support and long-term financing of programs. The Affordable Care Act includes numerous provisions for funding PS programs. Enabling regulations and guidelines must advance comprehensive, programmatic approaches to PS and encourage its responsiveness to individual, community and population needs, opportunities and strengths.

**Community Oriented** – reflects the importance of communities in health behavior, addresses community resources, and helps individuals take advantage of them

**Comprehensive** – flexible in the modes and content of peer support interventions to meet varied needs and circumstances of intended populations

**Programmatic** – attentive to the system, organizational, management, supervision, monitoring, and improvement features needed to sustain peer support, extend it to those it serves, and assure its quality

# EXPERT CONFERENCE REPORT

ON Peer Support in Health, Health Care,  
Prevention, and Well Being

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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 conference of the National Peer Support Collaborative Learning Network, bringing together leaders in health care and peer support to discuss current strengths and future needs in the field. The National Peer Support Collaborative Learning Network (NPSCLN), a joint activity of NCLR and Peers for Progress, is supported by the Bristol-Myers Squibb Foundation's *Together on Diabetes Initiative*.

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As we look to the broad dissemination of peer support, conference participants advocated an expanded, scalable approach focused on the following features:

- **Person Centered**
- **Population Focused**
- **Community Oriented**
- **Comprehensive**
- **Programmatic**

This is in sharp contrast to many of the reports in the field which describe single peer support interventions implemented with relatively small numbers of people. Instead, this report points to approaches for scaling up comprehensive, versatile peer support programs for entire populations.

The pages that follow reflect the expert commentary and our observations of the conference. This report is shared freely to contribute to the development of peer support programs serving populations as a routine part of health, health care, and prevention.



# NPSCLN

The National Peer Support Collaborative Learning Network, a joint initiative of Peers for Progress and the National Council of La Raza (NCLR), is a collaborative network of peer support organizations and leaders funded by the Bristol-Myers Squibb Foundation's *Together on Diabetes Initiative*. The Network focuses on developing and sharing evidence of benefits of peer support programs, best practices, effective evaluation methods, models of organizing peer support within health systems as well as effective models of advocacy. The NPSCLN facilitates meetings, educational webinars, trainings, Work Groups and Advisory Committees focused on topics of priority to Network members and the field.

## To get involved, please contact:

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*For more information on the NPSCLN and partners, please visit:*

*Peers for Progress*  
[www.peersforprogress.org](http://www.peersforprogress.org)

*National Council of La Raza*  
[www.nclr.org](http://www.nclr.org)

*American Academy of Family Physicians Foundation*  
[www.aafpfoundation.org](http://www.aafpfoundation.org)

*BMSF Together on Diabetes Initiative*  
[www.bms.com/togetherondiabetes](http://www.bms.com/togetherondiabetes)

## Organizations Represented

*Alivio Medical Center*  
*American Association of Diabetes Educators*  
*American Psychological Association, Practice Directorate*  
*Bristol-Myers Squibb Foundation, Together on Diabetes*  
*Brown University Warren Alpert Medical School*  
*California State University, Long Beach, Center for Latino Community Health, Evaluation and Leadership Training*  
*Camden Coalition of Healthcare Providers*  
*Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion*  
*Correio*  
*Department of Health and Human Services, Office of Minority Health*  
*G.V. Montgomery VA Medical Center*  
*Harvard Law School, Center for Health Law & Policy Innovation*  
*Hildago Medical Services – Center for Health Innovation*  
*Humana*  
*La Clinica de la Raza*  
*La Clinica Del Pueblo*  
*Mary's Center for Maternal & Child Care*  
*Mental Health America*  
*MHP*  
*Morehouse School of Medicine, National Center for Primary Care*  
*Northwestern University, Department of Preventive Medicine, Feinberg School of Medicine*  
*Patient-Centered Primary Care Collaborative*  
*Rehabilitation Institute of Chicago, Center for Rehabilitation Outcomes Research*  
*Robert Wood Johnson Foundation*  
*South Carolina Clinical and Translational Research Institute*  
*TransforMED*  
*University of North Carolina-Chapel Hill, Gillings School of Global Public Health, Department of Health Behavior, NC TraCS Institute, North Carolina Area Health Education Centers Program*  
*Uniformed Services University of the Health Sciences, Department of Medical & Clinical Psychology*  
*University of Alabama at Birmingham, Division of Preventive Medicine*  
*University of Arizona, Center of Excellence in Women's Health*  
*University of Illinois at Chicago, Midwest Latino Health Research Training and Policy Center*  
*University of Michigan Medical School, Michigan Diabetes Research and Training Center, REACH Detroit Partnership*  
*University of Texas, Health Science Center, Institute for Health Policy*



People across the country are joining the NPSCLN to advance the field of peer support. The Network embraces interdisciplinary collaboration between primary care, behavioral health, and community health, as well as the diverse perspectives of clinicians, researchers, policy makers, and funders.

# BACKGROUND

Major reviews (1-6) document that peer support (PS) provided by community health workers (CHWs), lay health advisors, *promotores*, patient navigators, and nonprofessionals 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) to manage their health “on your own.” 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 PS utilities. It can:

- Link people to 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 that are needed in chronic disease management and prevention
- Provide emotional and social support
- Help people cope with the stressors that so often accompany health problems
- Help people get the clinical care and 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
- Build cultural competence through peer supporters that often come from the communities they serve

As Perry and his colleagues conclude in a current review 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...” (6). This recognition of the contributions of peer support, the growing opportunities for its dissemination, and the pressure of health challenges around the world evoke calls-to-action and formal policy recommendations for the implementation of peer support approaches (14-16).

To address the challenges of peer support program expansion and dissemination as well as the emerging opportunities, such as through the Affordable Care Act, the National Peer Support

**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) to manage their health “on your own.”**



Collaborative Learning Network brought together a group of key opinion leaders, experts in the field, researchers, leaders of peer support programs and organizations, funders, Network members, NCLR Affiliates, and other members of the Peers for Progress Global Network. The diverse stakeholders at the conference represented community-based organizations, health care organizations, insurance groups and government agencies.

Drawing from our dialogue with these participants, this report distills their collective wisdom regarding cultural, organizational, and implementation issues central to the development of comprehensive peer support programs and their broad dissemination.

The major portion of the conference centered on three, 90-minute discussions around the following themes:

- 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

Each of the three discussions was preceded by brief comments of panelists who were asked to provide a few bullets to stimulate discussion. We refrained from prescribing a rigid format, and left the panelists to their own styles. Appendices include these panelists' brief comments, the full conference agenda, and lists of participants.

These discussions covered a wide range of opinions and priorities. This report documents and organizes the key participant comments based on detailed notes taken during the discussions. Representing wide ranging expertise within peer support and in the broader health arena, participants' 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.





# BRIEF REVIEW OF EVIDENCE

A review by Perry and colleagues in the 2014 Annual Review of Public Health (6) concludes that there is “compelling evidence” for peer support or Community Health Workers. It summarizes evidence that:

**CHWs can make major improvements in health priority areas, including**

- reducing childhood undernutrition
- improving maternal and child health
- expanding access to family-planning services
- contributing to the control of HIV, malaria, and tuberculosis infections.

**Evidence indicates that CHWs can contribute to reducing disease burden in**

- the management of hypertension
- in the reduction of cardiovascular risk factors
- in diabetes control
- in the management of HIV infection,
- in cancer screening, particularly with hard-to-reach subpopulations.

Peers for Progress conducted a review of peer support interventions for a variety of problems and health objectives, including Pre/Post-Natal Care, Diabetes, Asthma, Cardiovascular Disease, HIV, Smoking Cessation, Behavioral Health, and Drug Use (17). Countries represented included the United States, Canada, the United Kingdom, Pakistan, Bangladesh, Brazil, Mozambique, and New Zealand. Across a total of 47 papers, 39 (83%) reported significant between-group or pre-post changes showing benefits of peer support. Among the 37 papers employing RCTs, 30 (81%) reported significant between-group or pre-post changes.

Because much of the work of Peers for Progress is on diabetes, we also examined papers addressing peer support in diabetes and extended the literature search through July, 2012. Across 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 (18-28) or in comparisons with control groups (29-36).

Fourteen of the 20 papers on peer support in diabetes provided pre- and post-intervention measures of Hemoglobin A1c (HbA1c) as a measure of glucose control (18, 19, 21-25, 28, 30, 32, 34, 37-39). Using the individual publication as the unit of analysis, the average HbA1c declined from 8.63% prior to intervention to 7.77% after intervention ( $p = 0.001$ ).



**Among 20 studies of diabetes management, 19 showed statistically significant evidence of benefits of peer support.**

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 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 the projects initially funded in 2009 and for which 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 (40). Providing evidence for the success of peer support in reaching those most in need, the differential benefit of peer support was significantly greater among those in the low- and mid- tertiles for medication adherence at study initiation (41). 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 (42).





# PARTICIPANTS' DISCUSSION OF KEY FEATURES OF PEER SUPPORT



As noted above, the comments that follow were drawn from our discussions with experts in peer support, health care, and prevention at the first National Peer Support Collaborative Learning Network (NPSCLN) conference held from November 12-13 in Washington, DC. Beyond demonstrating the efficacy of peer support, expert participants addressed directions 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.

Although they emerged from the three discussions noted in the Background, these comments took wing to touch on a broader range of issues. Rather than confining our summaries to the three original topics, we organized the comments according to the categories in which they seemed most naturally to fall. Specifically, insights from the expert participants illuminated conceptual issues, success factors, strategies, and examples for program development and management. These comments are organized into the following categories:

## *Note on Usage:*

*Except when a specific type of program is indicated (e.g., promotora, community health worker/CHW, navigator), “peer support” (PS) and “peer supporter” are used throughout this report to encourage the recognition of the common themes and broad applicability of these terms.*

- **Conceptual & Strategic Issues, including Definition of Peer Support**
- **Program Development**
- **Evaluation of Peer Support**
- **Organizational & System Issues**
- **Program Sustainability**



# CONCEPTUAL & STRATEGIC ISSUES

## Definitional Issues – Balancing the Needs for Standardization and Flexibility

- **Defining Peer Support – Apples and Oranges:**  
Standardized definition is needed to avoid chaos, but flexibility of PS is equally important because it enables PS to reflect and respond to the perspectives and considerations of individuals, groups, and communities.
- **Describing Peer Support – 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 to avoid compromising the core value of PS in reflecting the needs and perspectives of diverse groups.
- **Core Features of PS – Four Key Functions of PS:**  
Peers for Progress has promoted four key functions as a template for planning and extending PS programs (7). 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 for articulating the key features of PS while allowing flexibility for tailoring according to programmatic objectives and the target population.
- **Defining Roles of PS – Spectrum of Roles:**  
Peer supporters can take on many roles. These include providing concrete assistance or instruction, emotional support, linkage between the individual and the health-care team, community advocacy, and development of social capital. PS programs should draw flexibly from these in response to population needs and perspectives, and opportunities within health systems or communities.
- **Characterizing Peer Supporters – Not a Particular Type of Person or Provider:**  
A peer supporter doesn't equate 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.
- **Differentiating PS – Centrality of Listening:**  
Listening is central to PS and differentiates PS from clinical care or educational interventions that convey information in one direction. Shared experience is the foundation of PS and the starting point from which help is provided.



## Advantages and Benefits of Peer Support – Recognizing Its Strengths and Versatility

- **Understanding How Valuable PS is to Recipients:** PS is greatly valued by recipients. It enhances individuals’ connections with their health providers and becomes a mode of connecting to care that individuals enjoy and appreciate.
- **Identifying Where We can Reach People:** There are many settings in which PS can reach and engage people, e.g., barber shops and beauty parlors. Peer supporters routinely meet people in such settings, conferring on PS an advantage in reach and engagement.
- **Reaching 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 with greatest need (e.g., 44, 46, 47).



- **The 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, and also allows them to convey that understanding to professional colleagues, enabling professionals to be more sensitive, and, hence, more effective in their own work.
- **Recognizing Informality as a Strength of PS:** The informality of PS approaches makes them effective in reaching those who may be wary of formal care providers, especially in behavioral health.



## Lessons Learned from the Veterans Administration

The Veterans Administration (VA) Health System employs peer supporters (peer specialists) to help patients with behavioral health issues. The VA is a national leader in PS programs and related support systems.

### Utilizing “High Tech”

- VA mobile app links peer specialists to service providers. This illustrates the potential of IT to extend and enhance PS and related services.
- VA computer systems and medical records are readily available for anyone with the appropriate application and approval. This illustrates the availability of IT and evaluation resources.

### Supporting Peer Supporters

- VA mandated the roll-out of PS to all sites but has met numerous implementation barriers. This illustrates the importance of having an infrastructure for training, ongoing support of the peer supporters, monitoring, supervision, back-up, and linkage to the rest of the care team.



- **Benefiting Behavioral and Chronic Conditions:**  
The person-centered and subjective, empathic perspective of PS transcends clinical distinctions between “disease conditions”, 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 co-occurring health problems. Also, self-management and problem-solving approaches are applicable to both behavioral health and chronic diseases, making them well-suited to implementation through PS interventions.
- **Peer Coping Models for 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 the value of prevention to those who have not yet adopted such views.
- **Promoting Better Health at the Community Level:** PS can address the needs of communities as well as individuals by 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 and the legacy of Community Health Workers.



## Needs and Objectives – Addressing Person Centered, Population Focused Perspectives

- **Understanding Needs – Where PS Fits:** PS can be utilized at the level of individuals, communities, or systems and policies. It is important to be mindful of these levels in the course of developing PS programs, to make sure the provided services are appropriate to the problem, its background causes, as well as the needs and strengths of the people served.
- **Focusing on Whole Person and Whole Population:**  
The emphasis of PS on considering the entirety of an individual’s circumstances naturally extends to the population of which the individual is a part. The individual cannot be engaged comprehensively if removed from the community, and engaging the community is often of great importance in reaching the individual.
- **Addressing Health and Economic Disparities – A Range of Underlying Factors:** There are a range of factors that cause disproportionate health care costs and 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 problems downstream.
- **Shaping Objectives – “Integrated” vs. “Comprehensive” Care:** The objective is services that comprehensively address the recipient’s needs, including their subjective and emotional needs. Integration of care may enable comprehensiveness but integration is not the objective, comprehensiveness is.

- **The Identity of PS – A Transformative, Not Palliative Role:** PS is sometimes used to make up for the failings of the health care system. By elevating the perspective of the individual in a system that has historically objectified individuals, PS challenges and fundamentally transforms the roles in health care and the health care system itself. 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 for effectively addressing the needs associated with specific problems, the circumstances of specific settings, and the perspectives of specific populations (7).
- **Avoiding the Distinction between Behavioral Health and Chronic Disease:** As with behavioral health “carve outs”, there is a long tradition of treating behavioral health distinctly from other health problems. This may be helpful in some cases, as with schizophrenia or other serious mental illnesses. However, the significant overlap between behavioral health and chronic disease suggests that integration of service delivery and organization of care is necessary to avoid confusing and sometimes conflicting objectives and services.



## Strategic Issues – Tailoring to the Persons and Settings with a Long-Term Vision

- **Planning Strategically – No “One size fits all” Program:** 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 in their applicability to different programs.
- **Putting PS into Practice – No “One size fits all” Approach at the Individual Level:** In PS practice, the ability of a program to be responsive to the individual is paramount.
- **Impact of Work Settings on PS Values:** The setting in which PS is organized influences its content and values. 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.
- **Remembering What People Want – The Desire to Connect:** The desire to connect with others is strong and widely held, providing a strong affinity for PS interventions.
- **Understanding and Respecting Audience Perspectives:** Many PS interventions succeed by understanding the perspectives of those they help and building objectives around those perspectives, rather than imposing predetermined objectives of the health care provider or system.
- **Changing the Focus from Diagnostic Categories to Lives as Lived:** PS should help the whole person in terms of their life objectives, needs, and strengths, not just their diagnostic category. Nevertheless, some health problems may need PS tailored to a particular problem or to the challenges of a particular disease, e.g., type 1 diabetes, schizophrenia, or advanced cancer.



## Audiences, Channels and Extensions – Working to Reach Those with Most Need



- **Targeting High-Risk Settings vs. Individuals:**

For example, placing peer supporters in community colleges for ready access by veterans whose PTSD symptoms may be exacerbated by classes, etc. Additional high-risk settings for locating PS are supermarkets, clinic waiting rooms to prepare people to make better use of their appointments, etc.

- **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.

- **Using a Lifespan Perspective to Extend PS to Wider Range of Audiences:**

As we extend our planning of PS to encompass families, friends, organizations, etc., we will encounter individuals at all stages of life. Embracing this can enhance the impacts of PS, extend PS programs to a wider range of audiences, and enable PS to draw on assistance from a wider range of groups and interests.

- **Maximizing the Potential of Peer Supporters – A Need for Long-Term Vision:**

Although PS can have short-term benefits such as improved clinical status or reduced medical 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.

- **Rural Residents and Older Adults:** Among the many groups that PS can help are residents of rural communities and older adults who frequently don't receive the care that they need. In addition to low incomes, the lack of professional services in their communities create many gaps that PS is capable of filling.

- **Identifying Where Peer Supporters are Most Needed:**

Allocating PS resources is important. Since the workforce capacity of peer supporters is limited, where are they most needed? Should they be focused on individual chronic disease management, 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.

- **Children as an Important Source of PS:** Children can be an important source of “peer support” for educating their parents, conveying health messages learned through school, encouraging parent and family effort, and accentuating the motivation of parents in being good role models for their children.

- **Low-Income Groups:** The disappearance of public housing is a barrier to reaching low-income groups. This illustrates ways that PS can reach individuals, in this case through peer supporters living in the same settings as those they serve.



- Helping Health Plans to Focus on Family Care:** Health plans for individuals are classified by risk. To move from individual to family care, we need to develop ways of characterizing the risks, or perhaps the healthiness, of families.
- Schools as Channels for Primary Prevention:** In addition to being a setting for reaching children, schools can also be channels for reaching children’s families and communities, which often perceive their schools as important and valuable institutions.
- Using High Tech for Behavioral Health:** 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 telehealth and other eHealth interventions are increasingly common and shown to be helpful.



- Working with Grocery Stores to Change Behaviors:** Peer supporters lead healthy behavioral change efforts by working with grocery stores. This illustrates again the value of alternative settings for prevention and health care campaigns.
- Extending Roles of Peers during Rapid Response:** 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.
- Driving Greater Responsiveness of Health Information:** PS can provide feedback from communities served in order to drive greater responsiveness of health information to the needs of those communities.

# PROGRAM DEVELOPMENT

## Key to Management – Supporting the Peer Supporters and Program Quality

- **Relieving Stress of Peer Supporters – Ready Access to Supervision and Support:** Peer support can be stressful for the peer supporter. They need ready access to supervision, back-up, and opportunities to discuss their work with each other.
- **Importance of Back-Up:** Peer supporters are selected to be reliable, responsible, and resourceful. Faced with a problem and no resources to address it, they will tend to improvise. This can lead to errors in responding to the varied and complex problems presented by those they serve. But, as responsible people, they will use back-up resources if they are provided.

**PS programs 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), resulting in a net improvement in how emergent problems are managed.**

- **Population Approach and a Registry to Enhance Allocation of PS:** 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.”

## Workforce Development – Creating Opportunities for Personal Advancement and Fulfillment

- **Valuing PS Contributions – Compensating *Promotores*/Peer Supporters:** There is a rich tradition of volunteer peer support in many settings. However, commensurate reimbursement is appropriate for programs in which peer supporters have extensive responsibilities, are required to meet goals such as numbers served, or are responsible for keeping fixed hours and extensive records of their work.
- **Training Peer Supporters in a Lifespan Approach:** The lifespan approach is a helpful strategy for promoting holistic PS services. Considering not only where the individual is, but where they came 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 lifespan approach is also pertinent to the peer supporters themselves, who need to consider their work 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.
- **Preventing Burnout of Peer Supporters – Continuing Education:** An important retention strategy is to provide continuing education to enrich peer supporters and provide opportunities for personal advancement.

## Opportunities and New Directions – Wellness, Families, and Technology

- **Promoting Wellness Beyond the Classroom:** Wellness is much more than discrete messages conveyed in a classroom. PS can promote a broader view of wellness encompassing life satisfaction and health as a contributor to that satisfaction, and not so much an end in and of itself.
- **Family-to-Family Support:** Individual health problems can impact the entire family. PS can address the family’s needs and strengths, instead of isolating individuals from their families.
- **“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 encountered it. And, just as with professionals, eHealth approaches can extend the reach and availability of PS.
- **Blending PS with Practice and Patient Informatics:** There are many opportunities for blending PS with eHealth. This includes preparing communities to reap the benefits of information technology. For example, we have seen CHWs out in the community with iPads, linking community members to services and information.

### MAKING A CASE: WHY FOCUS ON FAMILIES

**If One Person Has Diabetes, the 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. We need a Family Support Model combined with community investment to increase social capital. Peer supporters usually have the flexibility to work with both individuals and families.

## Challenges and Considerations – Addressing Individual, Community, and System Barriers

- **Community Readiness for Information Technology:** 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 and new capacities – such as IT.
- **Addressing Privacy and Confidentiality:** Although this is a commonly voiced concern, it is unclear whether this is a major obstacle. It is of substantial importance in behavioral health given concerns about stigma, employment, etc.
- **Tackling the Challenge of Reaching and Engaging those with Serious Mental Illness:** Finding and engaging those with serious mental illness can be a major challenge. Access to informal networks enables peer supporters to engage people through those channels.
- **Importance of Language in Increasing Program Acceptance:** A good example can be found in Rahman’s work with the “Lady Health Worker” program in Pakistan on post-partum depression. The word “depression” does not appear in the intervention materials.
- **Needing a Web of Resources for Individuals:** Diversity in PS programs and their connections to health care is invaluable. Individuals need a web of resources to support their health, not just one or two “best practices.”



# EVALUATION OF PEER SUPPORT

## Role of Evaluation in Peer Support – Measuring What’s Important

- **“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.
- **Balancing Community Research Needs and Burden of Data Collection:** Tracking and documenting PS should be incorporated into routines of responsible, high quality PS. However, extensive completion of surveys and evaluation instruments for research 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 Peer Support in Evaluation – Providing Proper Training to Peer Supporters

- **Understanding 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 address 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 and policies need to value it, as well as effectiveness research in setting funding guidelines.
- **Engaging Peer Supporters in CBPR to Increase Buy-in:** By engaging peer supporters in Community-Based Participatory Research (CBPR) approaches, evaluation may be enhanced and better tuned to overall program goals. Peer supporters’ “buy-in” may be enhanced as well.
- **Training Peer Supporters to Help with Needs Assessments and Action Plans:** Representing the communities they serve, peer supporters make an important contribution to formative evaluation and program planning, but they need to be well-trained in these skills.
- **Importance of Evaluation Training:** Rather than just “dumping” evaluation tasks on peer supporters, conducting training (e.g., webinars) and providing associated technical assistance can enhance their roles and their skill sets.



## Implementation of Evaluation – Rethinking Designs and Approaches for Clinical and Community Needs

- **Finding Alternatives to RCTs for Community**

**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 National Institutes of Health (NIH) and other grant-making procedures and policies.

- **Incorporating What is Happening outside the**

**Clinic:** 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.

- **Quantitative and Qualitative Evaluation in CBPR:**

The quantitative evaluation 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 evaluation helps investigators analyze how programs worked and what worked best, such as participants' preferences that may have made one program feature especially attractive or ineffective.

- **Connecting Research and Practice – Importance of Taking Data Analysis Back to the Community:**

Training for service on Community Institutional Review Boards (IRBs for review research proposals) is available. This illustrates the potential to engage peer supporters in research, rather than reinforcing a “two worlds” view of research/evaluation and practice.



- **Balancing between Clinical and Population Health**

**Outcomes:** PS often focuses on communities as well as clinical populations, which poses the challenge of balancing evaluation indicators that reflect both the clinic and the community. What would be the appropriate mix of clinical and community team members to conduct such evaluations?

- **The Challenge of Showing Behavior Change –**

**Follow-up Data Collection:** Addressing this challenge requires tracking individuals as their circumstances change over time and following up with individuals who may no longer be receiving services from the organization conducting the evaluation.

- **A Different Model – Dynamic, Rapid Feedback:**

Quality improvement methodologies such as those promoted by the Institute for Healthcare Improvement (IHI) provide sound alternatives to conventional research designs for testing program innovations and using lessons learned for fast-paced program improvement.

- **Moving to Quality Improvement from Research-Based Approaches:**

The goal of quality improvement (QI) is not to prove that something is effective in an absolute sense (leaving aside questions as to whether this is possible). Rather, QI methodology seeks to improve interventions in the settings in which they operate and for the populations they serve, using direct observation of their impacts on valued outcomes in those settings.

# ORGANIZATIONAL & SYSTEM ISSUES

## Identifying Organizational and System Factors and Their Impacts on Peer Support

- **Planning with Systems in Mind – What We Want for the Future:** Planning for PS needs to incorporate health care systems and other community settings and systems through which PS will take place.
- **The Role of Organizational Culture:** Organizational culture is very influential in communities, worksites, housing complexes, and health care organizations. PS needs to be tailored to organizational culture, but in some cases may also need to ameliorate its effects.
- **The Downside of 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.
- **The Problem of Fragmentation:** Fragmentation of services and the health care system is, at once, a problem for PS but also a problem that PS can help address, at least in terms of helping individuals gain a coherent understanding of their health and the services that advance it.
- **Rethinking from a Business Perspective – Ill Health vs. Good Health:** Why approach health promotion and disease prevention from the perspective of “ill health”? Consider developing, marketing, etc. of PS as services 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.
- **The Complexity of Managing Health Care Plans:** Organizational dynamics of health plans are complex. We need to start recognizing such complexity, especially in health care systems. Instead of heroes and villains, “it’s the system!”
- **The Impact of CMS:** Many decisions of PS programs are influenced by the Centers for Medicare & Medicaid Services (CMS). This illustrates the large role of policies, systems, and reimbursements in directing the development of PS programs.

### INTEGRATION EXAMPLES

- **Integrate Behavioral Health and 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 such a big part of many of the problems presented by patients in primary care.
- **Statewide Transitional Care Program:** 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.

Fragmentation of services and the health care system is, at once, a problem for PS but also a problem that PS can help address.

## Integration – Recognizing the Complexity and Need for Good Models

- **Integration and Colocation:** 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”).



- **Effort-Intensive Integration:** Integration is complex and requires great effort, even though policies may incentivize or enable it. It needs to be promoted and executed by those directing and implementing programs, as well as those receiving their services.
- **Identifying Models – What Successful Integration Looks Like:** What are the various models of integration? Is it respectful of CHWs? What policies and procedures should be in place? What has to take place for it to function well?

## Certification – Understanding Why and How to Certify

- **Certifying Organizations Instead of Individuals:** The process of certifying individuals creates barriers for PS programs that seek to recruit peer supporters from underserved communities and respond nimbly to community needs. Recruiting peer supporters may be more complicated and take longer if certification is required. Certification may also prevent those who have not completed secondary education or junior college from becoming peer supporters or may impose unnecessary financial or bureaucratic burdens on would-be peer supporters.

An alternative is to certify organizations or programs that meet quality assurance standards. National Standards for Diabetes Self-Management Education & Support of the American Diabetes Association and American Association of Diabetes Educators address this approach to quality control: “...a system must be in place that ensures supervision of the services they [peer supporters] provide by a ... health care professional and professional back-up to address clinical problems or questions beyond their training” (50).

- **State Certification of Peer Supporters:** Many states have established certification programs for community health workers and peer support specialists. In Georgia, certified peer specialists are eligible for Medicaid reimbursement.

# PROGRAM SUSTAINABILITY

## Financial Issues – New Financing Models to Support Funding and Quality

- **Opportunities in the ACA:** Peer support services promote several key objectives of the ACA. Integrated into community-based care, peer support services have the potential to improve the quality of healthcare delivery, lower healthcare expenditures, and reduce health disparities. Emerging payment models such as accountable care organizations, chronic health homes, and community health teams to support the patient-centered medical home offer the possibility of routine reimbursement. However, the details will have to be worked out at the state levels. For more information, please see the Issue Brief “Opportunities for Peer Support in the Affordable Care Act” on the Peers for Progress website.
- **Transition from Funding PS to Financing PS:** To realize fully the potential of PS, we need to move toward financing the infrastructure and delivery of PS rather than reimbursing instances of care that meet specific guidelines.
- **Importance of Funding to Behavioral Health:** Behavioral health funding is very limited. There is a need to expand funding for behavioral health and also determine ways of integrating behavioral health into other channels of care in order to expand funding streams. Regardless of the professional community’s readiness to accept PS in behavioral health, funding is essential.
- **Making More Money by Spending Less Money:** Although the Affordable Care Act (ACA) includes many provisions favorable to extending PS programs, fundamentally, the legislation was designed 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.

## Knowledge Management – Effective Learning and Sharing Mechanisms for QI

- **Underutilization of Good Resources:** CHW Central, funded by the U.S. Agency for International Development (USAID), provides an online resource at the international level. High quality resources on peer support are available but underutilized.

**To realize fully the potential of PS, we need to move toward financing the infrastructure and delivery of PS rather than reimbursing instances of care that meet specific guidelines.**



- **Expanding Knowledge Base of PS through a Multi-National *Promotores* Network:** The *promotora* model extends throughout Latin America. There is a great opportunity for enhancing knowledge through hemispheric cooperation and exchange.



## Needs and Objectives of Advocacy – Overcoming Funding Challenges and Resistance

- **The Disconnect between Dollars and Outcomes – Disproportionate Allocations of Resources to Behavioral Health:** 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 allocation of resources to behavioral health (< 6%) and community health promotion is very small relative to other areas of health care and prevention.
- **Getting U.S. Federal Funders to Invest and Commit to PS:** The organization of the National Institutes of Health around disease categories, the tendency of grant proposals for work that fits into established patterns to do better in grant review than proposals for more novel approaches, and lingering views of peer support as somehow frivolous or insubstantial and therefore unworthy of research support all create barriers for funding.
- **Overcoming Resistance of Managers and Professionals:** Managers have concerns about reporting and job procedures. Professionals are concerned about the spread of misinformation, the mishandling of patients, and the disruption of their relationships with their patients.
- **Capitalizing on Opportunities within Health Care Reform:** Some funding opportunities in the ACA are limited to states that have conducted the appropriate planning and established the necessary protocols (e.g., chronic health homes). Advocacy at the state level is needed to ensure that local communities can benefit from ACA funding.

**The *promotora* model extends throughout Latin America. There is a great opportunity for enhancing knowledge through hemispheric cooperation and exchange.**

follow-up, monitoring of critical adherence (e.g., daily weigh-in in heart failure), and recognizing that PS can provide much of these services, almost always more cheaply and often more effectively than professionals.

## Advocacy Strategies – Focusing on Success Stories and Benefits of Peer Support

- **Peer Supporter Stories:** Stories of program success, examples of individuals helped, and testimonies from peer supporters can be highly effective in promoting programs.
- **Engaging the Skeptics – Showing Win-Win Scenarios:** Show how PS programs are congruent with the goals of professionals and that 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.
- **Marketing Peer Supporters to Payers and Clients by Emphasizing Its Complementary Roles, Effectiveness & Low Costs:** The health care system is placing greater value on 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 these services, almost always more cheaply and often more effectively than professionals.
- **Regulations that Enhance, Not Restrict Peer Support:** Flexible response to individual and community needs and opportunities is often recognized as a key feature of PS (4, 6-9). This flexibility cuts across the mode, content, schedule and other aspects of support. Regulations or guidelines that standardize PS may inadvertently restrict this flexibility. They should be drawn to strike a balance between standardization and flexibility. The four key functions of peer support (7) may provide a useful template for standardization that also provides ample flexibility for adaptation to population, individual, community, cultural, or system features (51).

# ARGUMENTS FOR PEER SUPPORT

## PS increases access to care, improves quality of care, decreases costs, and increases reach to populations

### Growing Peer Support is Cost Effective

Growing evidence of the cost effectiveness of peer support includes a study in a Federally Qualified Health Center in Denver. A peer support program encouraging a variety of healthy patterns, from routine mammography to diabetes management, showed a return on investment of \$2.28 to \$1 (47). In the Robert Wood Johnson Foundation Diabetes Initiative, programs that emphasized peer support showed a cost per quality adjusted life year of \$39,563 (48, 52).

### Peer Support Reduces Hospitalizations

An “Asthma Coach” intervention reduced rehospitalization by 50% over a 2-year period. In a program for people with serious mental illness (schizophrenia, depression, bipolar disorder), Recovery Mentors provided individualized support and, compared to controls, achieved lower rates of hospitalization: 0.89 vs. 1.53 hospitalizations per person over 9 months, 10.08 vs. 19.08 days in hospital (49).

### Peer Support Reaches those Too Often Missed

In the same intervention an “Asthma Coach” engaged 89% of unmarried, low-income mothers of children covered by Medicaid who had been hospitalized for asthma and held their engagement for 2 years (44). In a successful peer coaching intervention for low-income patients of safety net clinics in San Francisco, the added benefit of peer support was greatest for those who reported lowest levels of medication adherence at the start of the program (41). Rather than cherry picking within a patient population, these programs reach and engage those that are missed by other approaches (52).

### Peer Support is Traditional Care

Peer Support is as old as humankind and engrained in many cultures, such as the *promotora* tradition in Latin American cultures. Further, it rests on the fundamental importance of social support, the absence of which is as lethal as smoking cigarettes (5, 48). Thus, PS should be understood as a traditional bedrock of care and community health (52).

# RECOMMENDATIONS AND AREAS FOR FUTURE WORK

At the conclusion of the conference, participants had a chance to reflect and identify priorities for the field to address. Collectively, what emerged was this concept of a patient centered, population focused, community oriented peer support model.

The momentum of the Affordable Care Act (ACA) is pushing health care toward population approaches, offering a continuum of care. This environment is incredibly encouraging for CHWs/peer supporters, who have a track record of operating at the individual, community, and population levels.

The suggestions listed under the categories below will shape the activities of the National Peer Support Collaborative Learning Network in 2014.

## Definition of Peer Support, Certification, Quality Control, and Workforce Development

There was wide consensus that defining the core functions and competencies of peer support is an important step that will help improve organizational uptake, program development, training, backup, and advocacy efforts for funding and reimbursement. A standard definition of peer

support would be built around common features, while allowing for flexible response to individuals and communities. Agreement on a particular name or a set of common titles for peer supporters (e.g., CHW) would be helpful in specifying their contributions and making a case for sustainable funding. Establishing national standards for CHW/peer supporter skills and core competencies would clarify their roles and strengthen quality assurance. At the same time, peer support programs must consider the competencies of CHWs/peer supporters in the process of setting clinical expectations and training curricula.

Lessons from existing peer support programs highlight the importance of workforce development. Identifying effective approaches to recruiting and deploying peer supporters, as well as nurturing them to prevent burnout are critical for workforce retention. From experience, it is clear that CHWs/peer supporters thrive when they are given vertical and lateral (e.g. volunteer, part-time, full-time) career development opportunities.



Finally, continuing discussions on issues around certification is crucial from a quality control perspective. Though consensus around whether or not certification should be required and how to certify continues to be elusive, a key challenge is striking a balance between assuring quality and maintaining the essence of peer support. While some states have opted to certify individual CHWs, some experts in the field strongly recommend looking into models of certifying organizations, especially those that have a long history of working with CHWs/peer supporters.

## Financial Models

Overreliance on grant funding is limiting the dissemination and sustainability of peer support programs. Programs need to develop innovative payment models that finance entire systems as opposed to services delivered. New opportunities available through the Affordable Care Act may provide funding for CHWs/peer supporters as part of health management teams, as patient navigators, and as behavioral health specialists. One avenue that can be explored is a business model that is owned and operated by peer supporters.

**Programs need to develop innovative payment models that finance entire systems as opposed to services delivered.**

## Integration of Peer Support and Primary Care

The flexibility and patient-centeredness of peer support enable it to have a place within many diverse models of care integration. In the rush to integrate, efforts must be made to preserve “peerness” due to the tendency toward professionalization in health care settings. Nevertheless, we should emphasize models that are multilevel (individuals, communities, systems), team-based, non-fragmented, and respectful of CHWs/peer supporters. Respectful, in this sense, refers to 1) the recognition of their unique role on the health care team, 2) the recognition of their value to patients and providers, 3) the provision of appropriate compensation, and 4) the preservation of their peer identity, or peerness.

**The systemic integration of peer support in behavioral health is well underway, which makes the peer supporter a natural conduit for integration between behavioral health and primary care.**

Integration of peer support in primary care typically increases patient-centeredness, reduces care fragmentation, and improves the comprehensiveness of care. Furthermore, the systemic integration of peer support in behavioral health is well underway, which makes the peer supporter a natural conduit for integration between behavioral health and primary care. Recognized models for integrated care include the patient centered medical home and accountable care organizations.





## Building the Evidence Base

Considering the scope of the potential impact of CHWs/peer supporters, innovative research methods may be useful for evaluating the impact of peer support. Those in the field need to encourage partnerships between research and practice for evaluation. These partnerships would produce valuable program-oriented evidence that addresses issues in implementation and dissemination.

Some of the most promising research is emerging from behavioral health and chronic disease management. To capitalize on the increasing number of published articles on peer support, more systematic reviews are needed to synthesize the findings and address “what works well for whom and when.” Furthermore, the field would benefit from an online database that catalogs all scientific reports on peer support.

## Reaching Diverse Communities and Focusing on Populations

The current trend favors clinic-based peer support programs focused on individual care. However, there are many community settings that would be suitable for the expansion of peer support, such as rural communities, high-risk settings, and schools. Adopting a population focus would mean targeting families and social networks rather than individuals. CHWs/peer supporters have also shown their ability to impact population health by directly addressing the social

determinants of health and reducing health disparities. In the future, peer support may benefit from shifting to an emphasis on the wellness of individuals and communities, as opposed to an orientation around the prevention and management of disease.

## Advocacy

Attaching peer support to the definition of comprehensive health care would help secure political support and long-term financing. With respect to the Affordable Care Act, advocating for more flexibility in the grant-making process should open up opportunities for peer support demonstration and dissemination projects. At the same time, state level guidelines must be in place to guide ACA implementation in the direction of peer support.

Recognition of peer support as a key part of comprehensive health care would advance political and policy support and long-term financing of programs. The Affordable Care Act includes numerous provisions for peer support and funding of peer support programs. Enabling regulations and guidelines at the federal and state levels (such as through state regulations for Medicaid expansion) will shape the growth and evolution of peer support over the next decade. They must entail quality control, reimbursement, and certification standards that advance the ability of peer support to respond to individual and community needs and that expand opportunities for diverse groups to become peer supporters.

**At the forefront of advocacy efforts should be the mainstreaming of peer support in health care as good care for all people, not cheap care for poor people.**



## NPSCLN Next Steps

Participants' comments coincide with the challenges and issues that have been identified through the work of Peers for Progress and the National Council of La Raza (NCLR). Their recommendations indicate an emerging interest in and need for scalable, stable, and far-reaching programs that can be implemented through comprehensive yet flexible approaches. The National Peer Support Collaborative Learning Network (NPSCLN) was established to address these challenges and facilitate the adoption and dissemination of quality peer support programs across the country. Moving forward, the NPSCLN will continue its role in developing and sharing evidence, practice resources, as well as methods and models pertinent to organizational uptake and system-wide change.

Unlike the approach taken in the previous year, in 2014 the NPSCLN will leverage the expertise and connections of Network members to strengthen its resource development, networking, and advocacy efforts. Through their participation on advisory committees, Network members will guide several projects that aim to address definitional/certification issues, special audiences (e.g., hardly-reached populations, minorities), integration challenges, financial models, networking and dissemination, and federal and state advocacy. From the tremendous enthusiasm and expertise shown at this conference, we are confident that the NPSCLN will continue to thrive and be able to advance peer support as a regular part of health, health care, and prevention.

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# APPENDIX A.

## CONFERENCE 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, <i>LUNCH</i>
1:00 pm	Individual Work Group Meetings
3:00 pm	Members of all Work Groups: Lessons Learned/Moving Forward
4:00 pm	<i>ADJOURN</i>

### 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, <i>National Council of La Raza</i>
<b>Dinner &amp; Conference Kick-Off</b>	
<i>Dinner and opening remarks from the National Council of La Raza, the American Academy of Family Physicians Foundation and Peers for Progress.</i>	
<b>Venue:</b> Mayflower Renaissance Hotel, Senate Room, Lobby Level	
7:00 pm	Group Dinner & Discussion
9:00pm	<i>ADJOURN</i>

# Appendix A. CONFERENCE AGENDA

Wednesday, November 13, 2013 - All Attendees	
<b>Venue:</b> National Council of La Raza, 1126 16th Street, NW, Suite 600 Washington, DC 20036, ABC Conference Room, Lobby Level	
07:30am	<b>BREAKFAST</b> <i>*Reminder, hotel check out time is 12:00pm</i>
08:00am	<b>Overview of Peer Support, National Peer Support Collaborative Learning Network</b> Edwin Fisher, PhD Global Director, Peers for Progress
08:45am	<b>PANEL 1:</b> <b>Peer Support and Behavioral Health</b> Serious mental illness, multi-morbidity, psychosocial factors in chronic disease management <i>Facilitator:</i> Justin Nash <i>Panelists:</i> E. Lee Rosenthal, Katherine Nordal, Jeanne Gabriele
10:00am	<b>COFFEE BREAK</b>
10:30am	<b>PANEL 2:</b> <b>Audiences and Communities</b> Reach, engagement, emerging needs and special populations served by peer support programs <i>Facilitator:</i> Martha Funnell <i>Panelists:</i> Hector Balcazar, J. Nell Brownstein, Aida Giachello, George Rust
11:45am	<b>LUNCH</b>
12:45pm	<b>PANEL 3:</b> <b>Organizational and System Issues</b> Systems and staffing models, integration models, Patient-Centered Medical Homes, Accountable Care Organizations, and other settings for Peer Support <i>Facilitator:</i> Charlie Alfero <i>Panelists:</i> Gertrudes Holder, Bert van den Bergh, Maggie Morgan
02:00pm	<b>BREAK</b>

**CROSS-CUTTING THEMES**

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Health Care Reform and other funding sources for peer support

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Advocacy

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Preserving peer support as a humanizing force in a system oriented toward objective and financial outcomes

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Retention, certification, quality improvement, and related issues in peer support programs

## Appendix A. CONFERENCE AGENDA

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



# APPENDIX B.

## INTRODUCTORY COMMENTS FROM PANELS

### PANEL 1:

#### 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

### 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

### PANEL 3:

#### Organizational and System Issues

Tools and systems, staffing models, integration models

**Facilitator:** Charlie Alfero

**Panelists:** Gertrudes Holder, Maggie Morgan, Bert van den Bergh

## APPENDIX B. INTRODUCTORY COMMENTS FROM PANELS

### 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.

## APPENDIX B.

### INTRODUCTORY COMMENTS FROM PANELS

- 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 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.

## APPENDIX B. INTRODUCTORY COMMENTS FROM PANELS

### 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



## APPENDIX B. INTRODUCTORY COMMENTS FROM PANELS

### Aida Giachello

- Living in rural communities. There are a growing number of Hispanics / Latinos 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. The elderly is the fastest growing population group within Hispanics / Latinos. 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

- 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.
- 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.
- 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.
- 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 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).

## APPENDIX B. INTRODUCTORY COMMENTS FROM PANELS

### 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

## APPENDIX B. INTRODUCTORY COMMENTS FROM PANELS

- 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”

# APPENDIX C.

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