Integrating Peer Support into Primary Care: Rationale & Evidence

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

Who We Are

Learn About Peer Support

Promote Peer Support

Get Connected

Take Action

Tools & Training

News & Events

Peers for Progress is a program of the American Academy of Family Physicians Foundation and supported by the Eli Lilly and Company Foundation.

A Learning Community of Peer Support

Peers for Progress is building a Global Network of Peer Support Organizations, and invites you to join in this global endeavor.

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IDEA EXCHANGE

A summer of Peer Support in Thailand
Note: This is the first in a two part series by two University of North Carolina Masters of Public Health students...

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SCIENTIFIC EVIDENCE

Community Health Workers Assisting with Childhood Asthma
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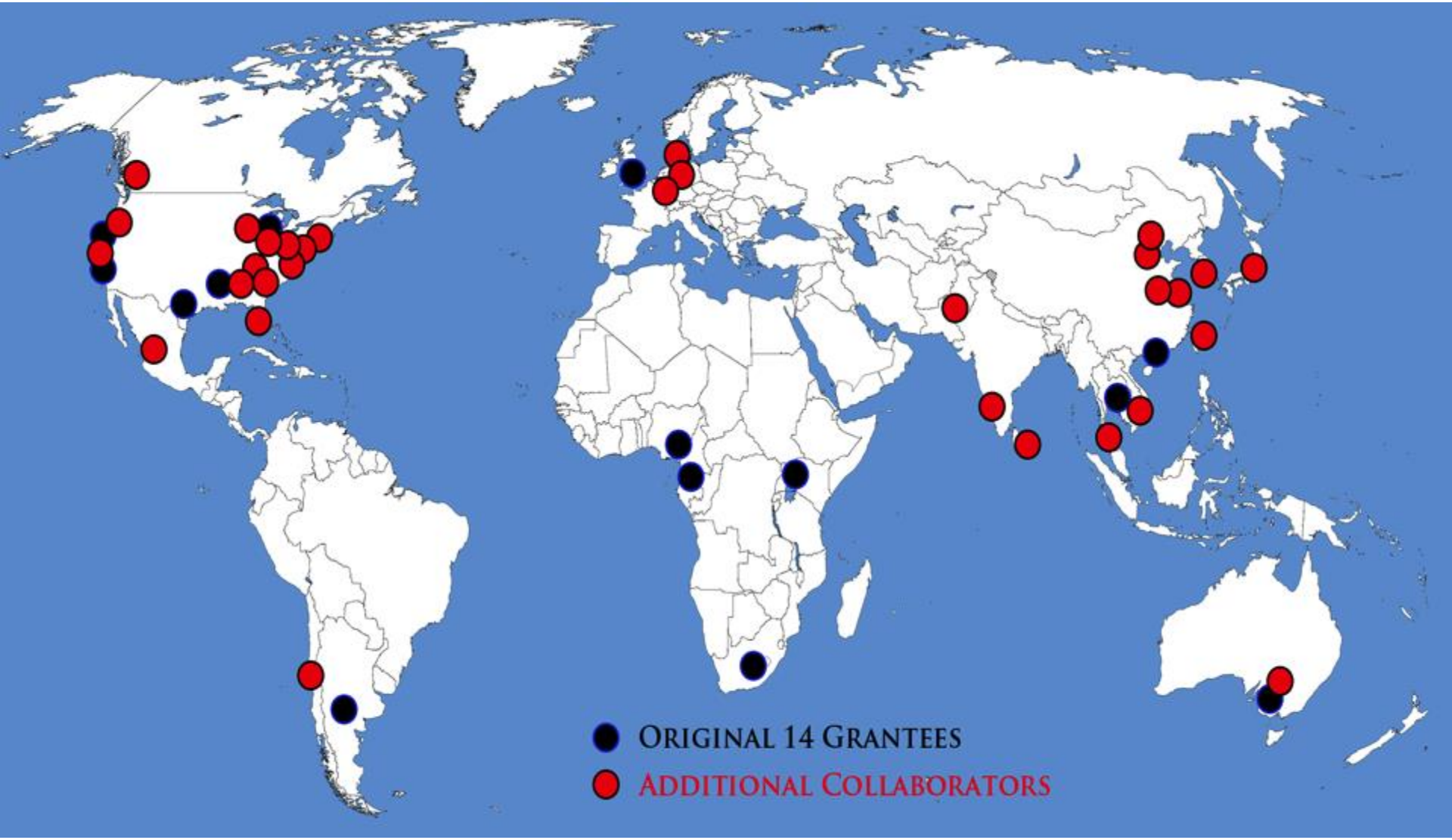

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Definition and Foundations

What is Peer Support

- Community Health Workers, Lay Health Advisors, *Promotores*, Coaches, Navigators….
- Have the problem, have a close relative or friend with the problem, or trained to understand the problem
- Volunteers, reimbursed with stipends, or paid staff
- Community based or clinic based or both
- Four key functions:
  - Assist in daily management
  - Social and emotional support
  - Linkage to clinical care and community resources
  - Ongoing support

Fundamental **Role of Social Connections and Support**

Human beings are more effective and happier when they have someone

- **they can *talk to* about personal matters**
- **who *cares about them***
- **who can *help them* when they need help**

The risk of death associated with social isolation is greater than the risk associated with cigarette smoking

House, Landis & Umberson. *Science,* 1988 *241*: 540-544.

Holt-Lunstad, Smith, & Layton *PLOSMedicine*, 2010, 7: July e1000316 www.plosmedicine.org

Harlow, H.F., & Harlow, M. (1966) Learning to love. *American Scientist* 54: 244-272.

For Prevention & Disease Management: Strengths of Peer Supporters

- Not professionals
- Often have the health problem they are assisting with – e.g., people with diabetes helping others with diabetes
- **Share perspectives, experience of those they help**
- **People believe them because they are "like me"**
- Can teach how to implement basic self management plans (e.g., healthy diet, physical activity, adherence to medications)
- ***Have time!!!***

Evidence

Systematic Review of Evidence Among Publications on Peer Support

- **01/01/2000 – 5/31/2011** : "peer support," "coach," "*promotora*" etc.
- 66 separate studies met criteria of:
  - Provided by nonprofessional
  - Support for multiple health behaviors over time (i.e., not isolated or single behaviors)
  - Not simply peer implementation of class
- Preliminary outcomes:
  - Significant within- or between-group changes: **83.3%** of reports using controlled designs

Elstad et al., Internat Cong Beh Med, Washington, D.C., August, 2010; Fisher et al., in preparation

Results: Diabetes Management

- In 14 studies*
- HbA1c mean
    - Pre: 8.63%
    - Post: 7.77%
    - $p = 0.001$

* Studies from 2000 – July, 2012: Babamoto et al. 2009, Beckham et al.2008, Culica et al. 2008, Dale et al. 2009, Greenhalgh et al 2011, Heisler et al 2010, Mayes et al. 2010, McElmurry et al 2009, McEwen et al 2010, Otero-Sabogal et al. 2010, Ruggiero et al. 2010, Sacco, 2009, Smith, et al. 2011, Walton et al. 2012

Health Affairs Special Issue (January, 2012): *Confronting the Growing Diabetes Crisis*

Cameroon, South Africa, Thailand, Uganda

- Reductions in BMI, BP, HbA1c
- Improvements in exercise, diet, perceived susceptibility to complications, perceived support, and perceived quality of life
- Increased contact with primary care
- Sustained, increased participation 3 years after funding ended

By Edwin B. Fisher, Renée I. Boothroyd, Muchieh Maggy Coufal, Linda C. Baumann, Jean Claude Mbanya, Mary Jane Rotheram-Borus, Boosaba Sanguanprasit, and Chanuantong Tanasugarn

Peer Support For Self-Management Of Diabetes Improved Outcomes In International Settings

ABSTRACT Self-management of diabetes is essential to reducing the risks of associated disabilities. But effective self-management is often short-lived. Peers can provide the kind of ongoing support that is needed for sustained self-management of diabetes. In this context, peers are nonprofessionals who have diabetes or close familiarity with its management. Key functions of effective peer support include assistance in daily management, social and emotional support, linkage to clinical care, and ongoing availability of support. Using these four functions as a template of peer support, project teams in Cameroon, South Africa, Thailand, and Uganda developed and then evaluated peer support interventions for adults with diabetes. Our initial assessment found improvements in symptom management, diet, blood pressure, body mass index, and blood sugar levels for many of those taking part in the programs. For policy makers, the broader message is that by emphasizing the four key peer support functions, diabetes management programs can be successfully introduced across varied cultural settings and within diverse health systems.

www.peersforprogress.org

Fisher et al. *Health Affairs* 2012 31: 130-139.

Peer Support in Vietnam

Dang Tran Ngoc Thanh, R.N., Ph.D., Linda Baumann, R.N., Ph.D., et al.

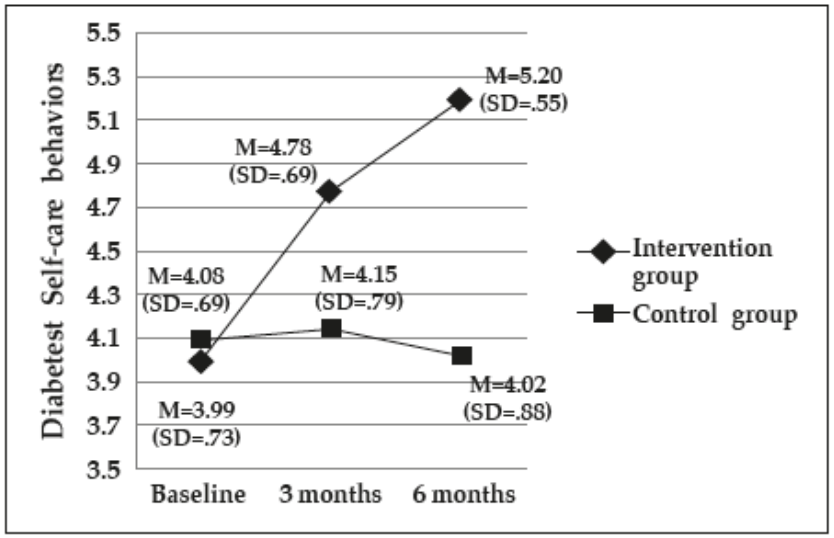
University of Wisconsin – Madison

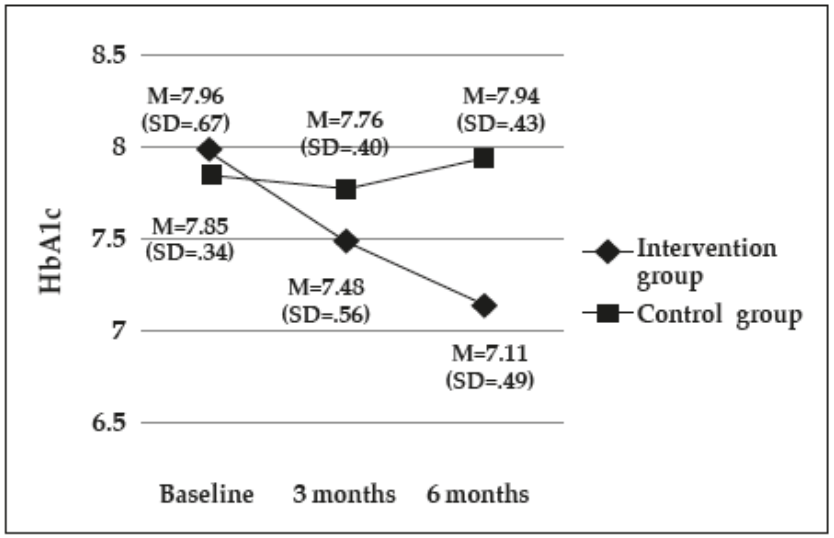
Burapha University, Chon Buri, Thailand

Pham Ngoc Thach University, Ho Chi Minh City, Vietnam

6-Month Intervention:

- 4-week class led by nurse, contracting for specific goals
- Peer leaders attended classes
- Peer leaders matched with participants in 4th class
- Protocol: Weekly contact for 2 months, biweekly for 3 months (averaged 6.5 calls out of expected 14)



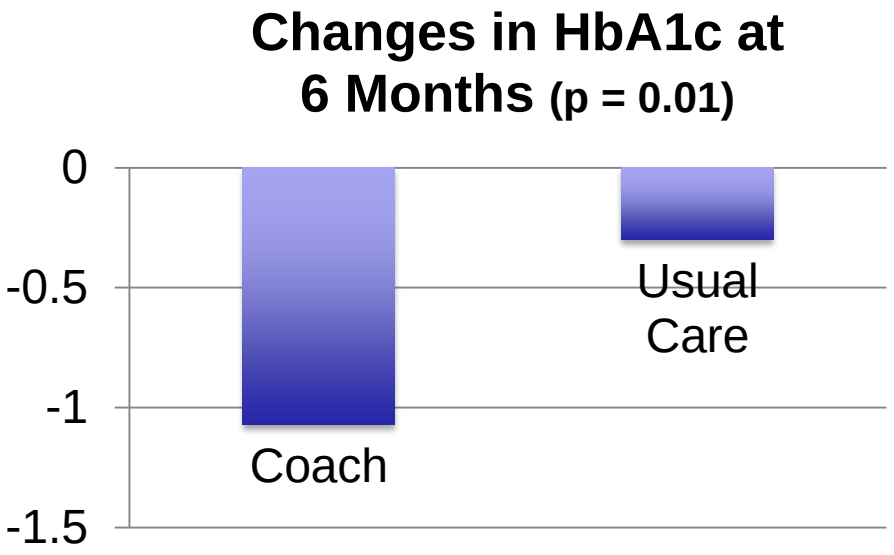


Thanh et al. J. of Science, Technology, & Humanities. 2013 11: 41-79.

Peer Support in San Francisco

Thomas Bodenheimer, University of California, San Francisco

Clinical Setting Six Department of Public Health safety-net primary care clinics serving patients covered by Medicare/Medical or San Francisco's coverage for uninsured residents



- Majority of patients were non-white, ethnically and culturally diverse

Patient Contact Patients had average of 7.02 interactions with their coach, including 5.37 telephoned calls

Outcomes

Reduction in HbA1c by > 1 point: 49.6% vs 31.5%
HbA1c < 7.5%: 22% vs 14.9%

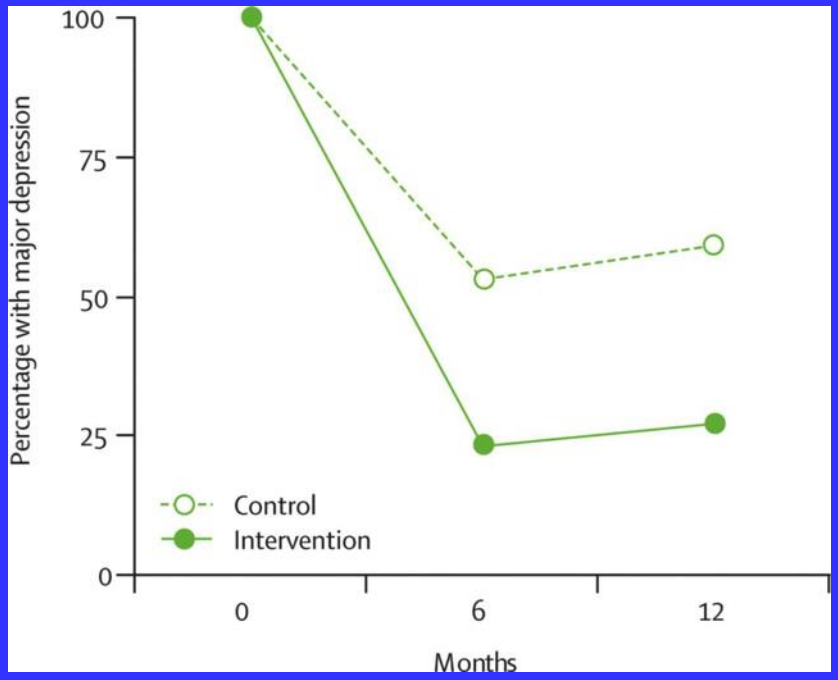
Thom et al., *Annals of Family Medicine* 2013 11: 137-144.

“Lady Health Workers” in Pakistan Reduce Post-Partum Depression

“Lady Health Workers”
Completed 2ndry education
Responsible for ≈ 100 households
Primarily general health education and preventive maternal and child care
Extending to TB and HIV detection and control
≈ 96,000 LHWs cover 80% of Pakistan rural population

Manual based intervention, “Thinking Healthy Programme”

- Promote change in thoughts likely to increase depression
- Practical problem solving
- Collaboration with family



Rahman et al.
Lancet 2008 372: 902-909
Arch Womens Ment Health 2007 10: 211-219.

Cost Effectiveness

In FQHC in Denver, Peer Supporters

- Shifted costs from urgent care, inpatient care, and outpatient behavioral health care
- Increase utilization of primary and specialty care visits.
- ROI = 2.28:1.00.

(Whitley et al. J Hlth Care Poor Underserved 2006 17: 6-15)

Diabetes Initiative of Robert Wood Johnson Foundation

- 3 of 4 projects in cost analysis emphasized peer supporters
- Cost per Quality Adjusted Life Year (QALY) = $39,563
  (well below $50,000 criterion for good value)

(Brownson et al., The Diab Educator. 2009 35: 761-769)

Asthma CHW Project with Medicaid Covered Children in Chicago

- Three to four CHW home visits over 6 mos and liaison with care team
- ROI: $5.58 saved per dollar spent

(Margellow-Anast et al., J. Asthma 2012 49: 380-389)

Lifestyle Modification for Low-Income Latino Adults with Diabetes

- CHWs and nurse educator: home visits, self-mgmt education, individual counseling
- $10,995 to $33,319 per QALY
- Especially cost-effective among those with HbA1c > 9%

(Brown et al., Prev. Chronic Dis. 2012 9:E140)

Preventing Rehospitalization in Schizophrenia, Depression, Bipolar Disorder

- *Recovery Mentors* provided individualized frequency, mode, content of support
- Over 9 mos: 0.89 vs 1.53 hospitalizations, 10.08 vs 19.08 days in hospital ($p < 0.05$)

(Sledge et al., Psychiatr. Serv. 2011 62:541--44)

Reducing Depression and Anxiety Disorders in India

- Education about psychological problems, ways of coping, and interpersonal therapy delivered by lay health counselors with primary care and psychiatric back-up
- 30% decrease in prevalence, 36% in suicide attempts, 4.43 fewer days no work/reduced work in previous 30 days.
- Lowered time costs resulted in Intervention being cost effective and cost saving

(Patel et al. Br. J. Psychiatry 2011 199:459-466; Buttorff et al. 2012 90: 813-821)

Fisher et al., *Ann Rev Public Health*, 2014, in press

Reaching the Hardly Reached

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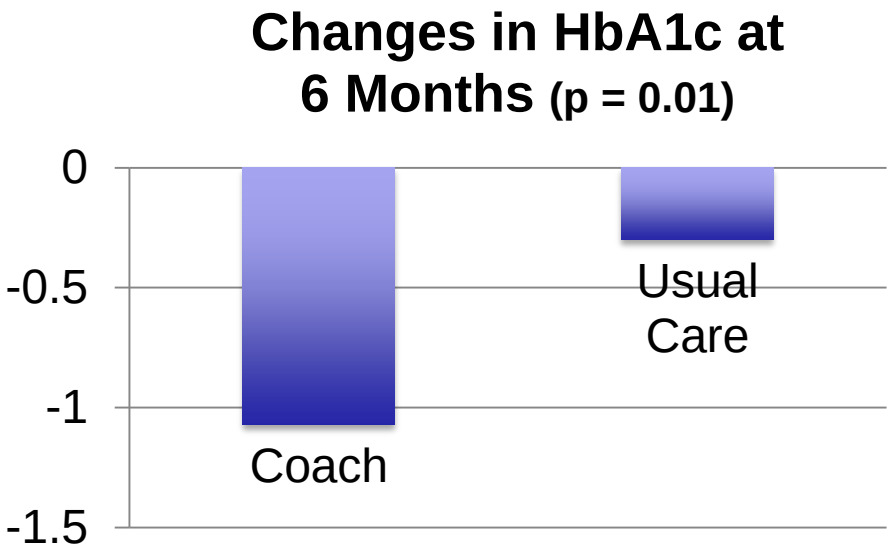

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In San Francisco, Greater Improvements Among Those With Low Initial Medication Adherence

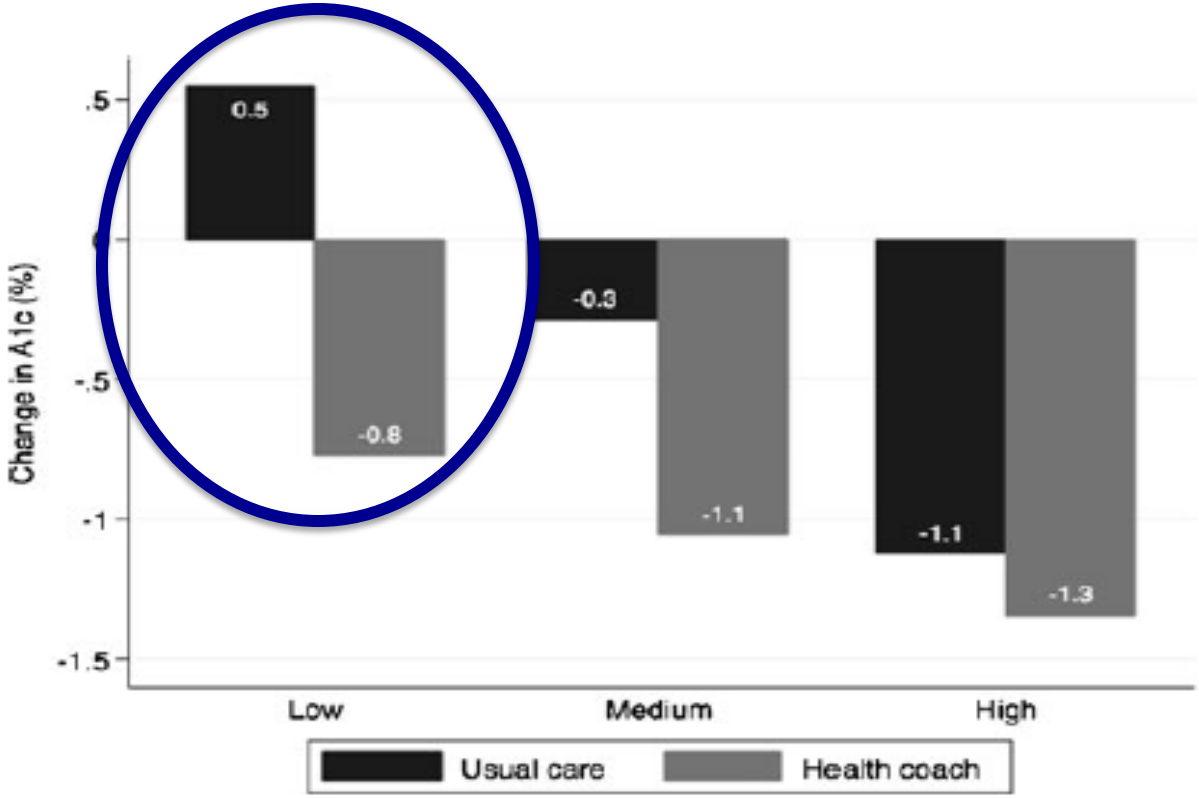


Figure 2. Change in hemoglobin A1c at low, medium and high levels of medication adherence, stratified by study group. Adjusted for age, marital status, hypertension, initial HbA1c, insulin use, body mass index.

Moskowitz et al. J Gen Intern Med. 2013 28: 938-942.

Asthma Coach for Single Mothers of Medicaid-Covered Children Hospitalized for Asthma

Randomized Controlled Trial

- Children, aged 2 - 8
- Hospitalized for Asthma
- Very Low Income; almost all in homes withouth fathers

Enrolment only contingent on willingness to complete reimbursed assessments

- ***Thus, assess reach of intervention to generalizable sample***

Total enrolment = 189

- 96 Asthma Coach, 93 Usual Care

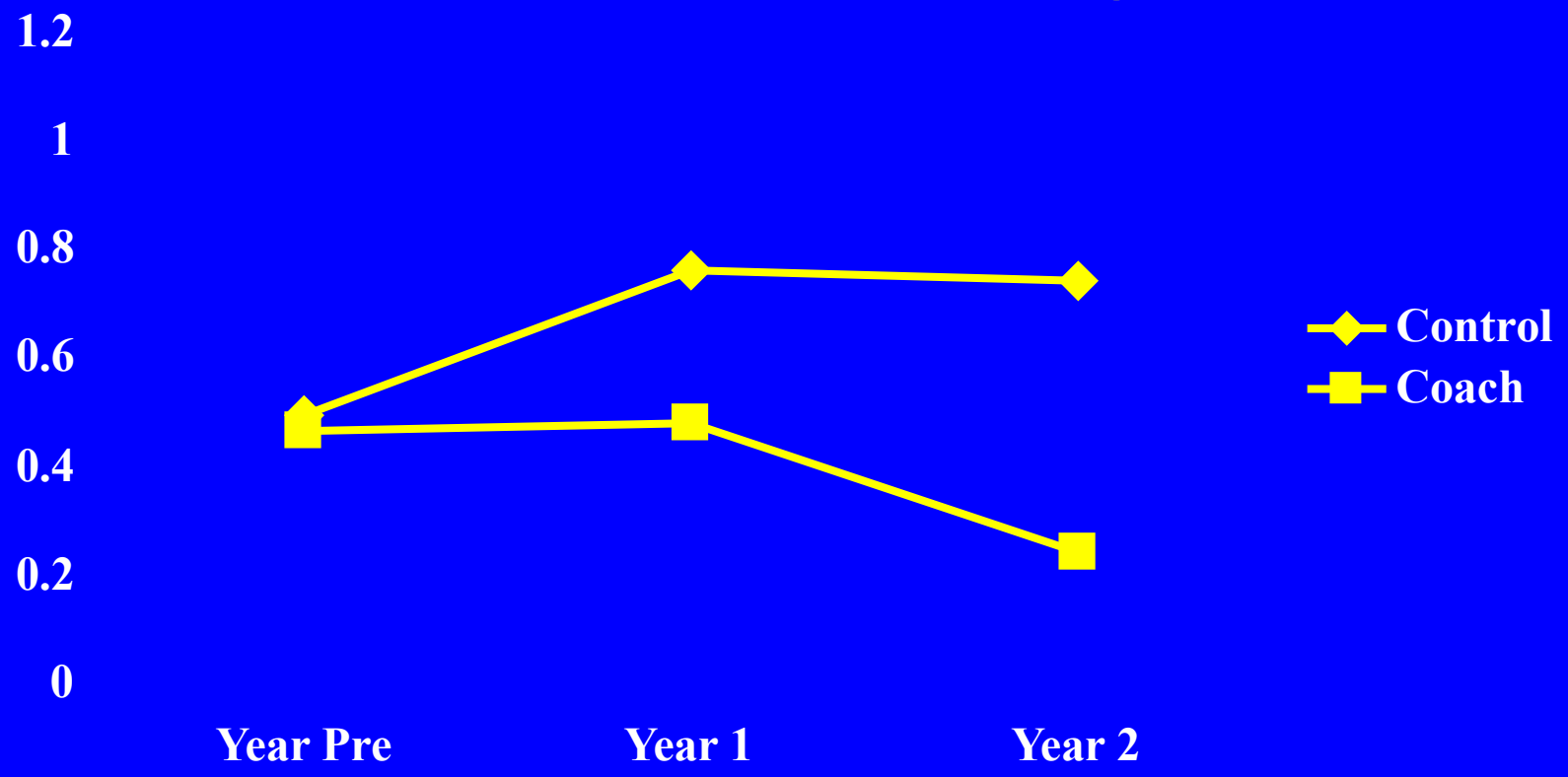
Asthma Coaches Reach "Hardly Reached"

Substantive Contact (Face-to-face or by phone in which at least one key management behavior discussed)

- 35% within 7 days of assignment of Coach
- 63% with 1 month
- 89% within 3 months
- Sustained Engagement: ≥ 1 contact per quarter throughout last year of 2-year intervention

Hospitalizations

Admissions in Year Prior to Randomization (Year Pre) and 1st and 2nd Years of Coach Program



Interaction of Group X Time significant, $p < .02$.

Year 1 is adjusted by subtraction of index hospitalization. Thus Year 1 mean reflects hospitalizations other than index.

Fisher et al. *Arch Ped & Adol Med* 2009 163 (3), 225-232.

Peer Support in Primary Care

Community Outreach is Key Component of Patient-Centered Medical Home

- However, several challenges:
- Time consuming nurturing of community relationships
- Imprecise reach of community outreach:
  - Community programs and activities on weight management
  - Attended by “vegans who run marathons”

Peer Support in Urban Private Practice

- Half-time outreach worker from community coordinated most activities, including individual follow-up with patients
- Increased rates of preventive care (e.g., mammography and childhood immunizations)
- Increased percentage with glycated hemoglobin under 10% from 56% to 77%

Bayer & Fiscella Arch Fam Med 1999 8:546-549

Peer Support for Outreach/Engagement from PCMH

Peer supporters recruited from communities intended to reach

- Community ties then intrinsic to services

Peer supporters can reliably reach those of greatest importance

- e.g., 92% of low-income, single mothers from ethnic minorities in Asthma Coach
  (Fisher et al. Arch Pediatr Adolesc Med. 2009 Mar;163(3):225-32.)

Currently testing in collaboration with Alivio Medical Center, Chicago, National Council of La Raza, TransforMED©

Shared Care Plan:

Critical in Linking Patients, Clinical Team, Peer Supporters

Complementarity of Roles

Goals	Objectives	Specific Behaviors
(e.g. Live to 80)	(e.g., lose 10 lb)	(e.g. walk after dinner)

←←←←←←←←←Person with Diabetes→→→→→→→→

Physician →→→→→

Clinical Team→→→→→

Peer Supporter→→→→→→→→→

Alivio Medical Center
Reaching Entire Population of Adults with Diabetes

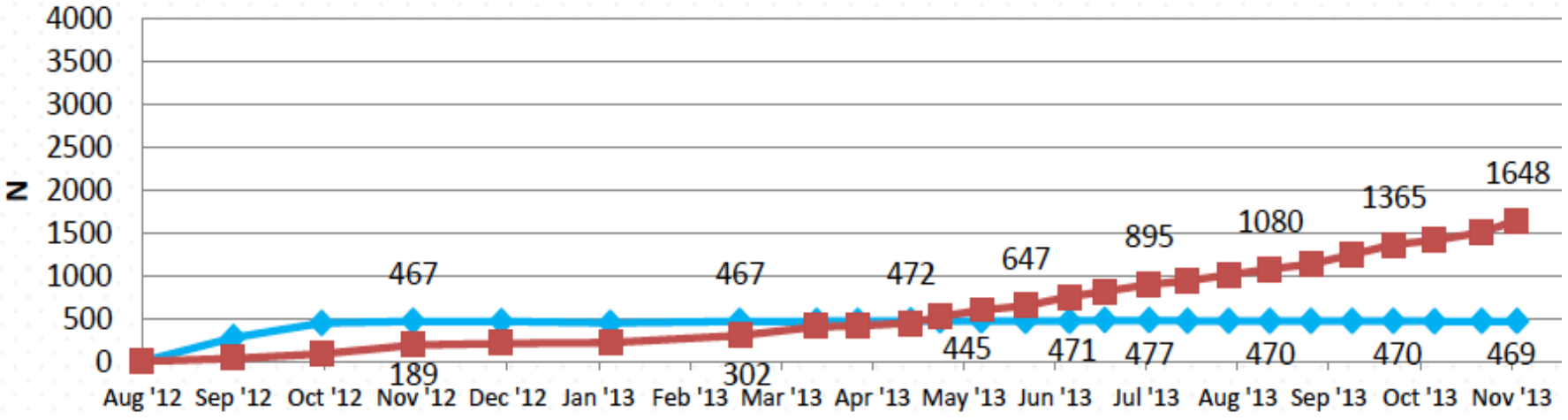
Approximately 4000 with diabetes

High Priority – HbA1c > 8%, Psychosocial Distress, Physician's Referral

- 500 of the 4,500
- Individual contact biweekly, then monthly
- Focus on regular care, diet, exercise, emotional support, assistance with other problems

Normal Priority – Support groups, activities, contacts at clinic visits

Total Contacted by Group: **High Priority** **Normal Priority**



Future Directions

Reducing Rehospitalization

- **Plan for discharge earlier**
- **Offer more intense education for new diagnoses**
- **Flag high-risk patients and provide case management**
- **Multidisciplinary approach to discharge**
- **Check in with patients with chronic conditions**
- **Follow up care**
- **Reconnect with PCPs**

The Revolving Door: A Report on U.S. Hospital Readmissions. RWJF February, 2013.

Reducing Readmissions in CHF

Objectives:

- Reinforce the patient's education
- Ensure compliance with medications and diet
- Identify recurrent symptoms amenable to outpatient treatment

Intervention – Delivered by Research Nurse:

- Education about congestive heart failure and its treatment
- Individualized dietary assessment and instruction by RD
- Consultation with social-service personnel to facilitate discharge planning and care after discharge
- Analysis of medications by a geriatric cardiologist; Elimination of unnecessary medications; Simplification of regimen
- Intensive follow-up through home care services, supplemented by individualized home visits and telephone contact with study team

Results: Significant benefits vs Usual Care in: Total number readmissions and number for heart failure, numbers of participants with > 1 readmission, QOL

Rich et al. NEJM 1995 333:1190-1195.

Reducing Hospitalizations in Medicaid

Intervention Emphases:

1. Coordinated care, responsive to specific patient needs PS
2. Care must continue into the community PS
3. Medical homes and permanent housing essential
4. Integrated, multidisciplinary services and provider teams
5. Care teams serve patients “where they are” – both physically and mentally PS
6. Data sharing and communication among team members for care coordination and tracking progress PS

Results:

- Reduced hospitalizations by 37.5%
- Reduced emergency care while increasing outpatient visits
- Medicaid costs per patient decreased by $16,383 per patient over 12 months.

Raven et al. *BMC Health Serv Res* 2011 11:270

Follow Up After Major Procedures

- Joint replacement
- Transplant
- MIs, other major events

Behavioral Health/Mental Health

- Schizophrenia
- Depression
- Emotional distress complicating other health problems

ACA Health Home Option?

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Patient & family support
- Referral to community & social support services

Harvard Law School Center for Health Law and Policy Innovation. Webinar of National Peer Support Collaborative Learning Network. *Peers for Progress*, American Academy of Family Physicians Foundation, National Council of La Raza, Bristol-Myers Squibb Foundation *Together on Diabetes*. March 2013

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SITEMAP

Integrating Peer Support into Primary Care: Examples from Clinicas de Salud del Pueblo, Inc.

Leticia Ibarra, MPH
Director of Programs
Clinicas de Salud del Pueblo, Inc.

Clinicas de Salud del Pueblo, Inc.

Peers for Progress
Peer Support Around the World | DIABETES

Overview

- Challenges of integrating peer support in primary care settings
- Examples from programs at Clinicas de Salud del Pueblo
- Lessons learned

Challenges

Ensuring a good fit with setting, organization, health issues

1. Culturally acceptable & appropriate
2. Systems/infrastructure in place
3. Paid vs volunteer
4. One-time vs long-term
5. Individual vs group-based
6. On-site vs off-site (community-based)

For Clinicas de Salud del Pueblo

1. Already convinced it is an effective model for our patients
2. Have departments & policies devoted to peer support/community health outreach & education
3. Believe in paying peer supporters for dignity & value they bring, quality, longevity

Biggest questions are the remaining three

Clinicas de Salud del Pueblo, Inc.

Clinicas de Salud del Pueblo, Inc.

Clinicas started in 1970 for farm workers
Today, health centers are open to anyone

204,665 Visits to 56,331 Unduplicated Patients, 9% are Farmworkers

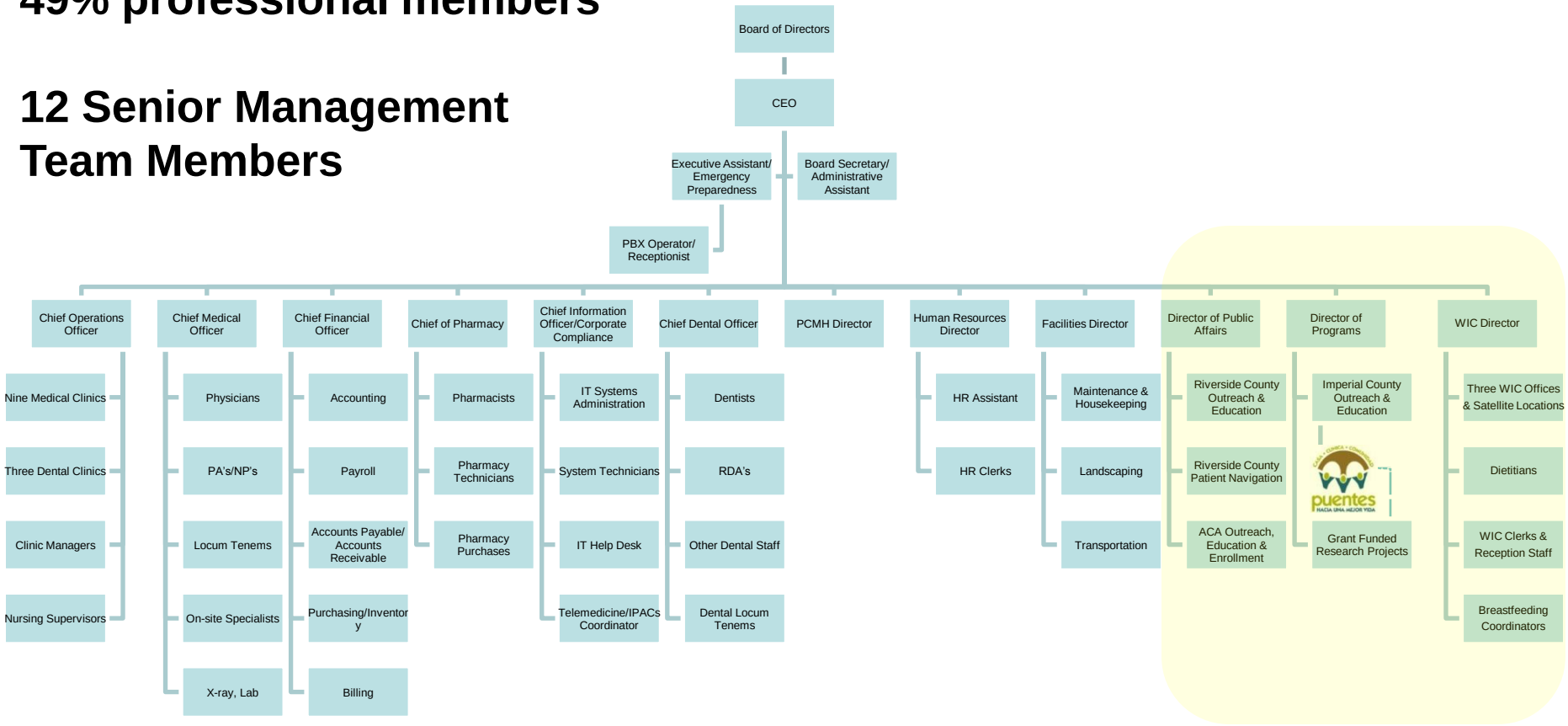
11 Comprehensive Health Centers
3 Dental Clinics
3 Women, Infant and Children (WIC) Programs
2 Community Health Outreach Departments
350 Dedicated and Professional HealthCare Staff

- 52 physicians, dentists and mid-level clinicians

15 Board of Directors:
51% consumer members
49% professional members

12 Senior Management Team Members

Clinicas de Salud del Pueblo, Inc.



COMMUNITY HEALTH OUTREACH (CHO) DEPARTMENT

More traditional Promotora Models

For Prevention

- Pasos Adelante (diabetes)*
- Entre Familia (cancer)*
- Hablando Claro (teen pregnancy)
- Mantenga Su Mente Activa (alzheimers)

Chronic Disease Management

- Puentes (diabetes)*
- Tomando Control de Su Salud*

Health Care Access/Coordination

- Farmworker Outreach Project
- Farmworker Flu Surveillance

**long-term interventions*

Other Peer-to-Peer & Mixed Models

For Prevention

- CCG Teen Pregnancy Program*
- TeenSMART (teen pregnancy)

Chronic Disease Management

- Our Choice/Nuestra Opción (obesity)*
- **Asthma Program***
- **HIV Care Program***

Health Care Access/Coordination

- Immunization Program
- Breast Care Coordination
- Pediatric Outreach Program
- United for Health Action
- **Patient Navigation Program***

For a Better Life

Peer Supporters/promotores are empowering our patients and building social capital

Home	Clinic	Community
FAMILY CONTACTS	CLINIC VISITS	GROUPS/OUTREACH
- Opportunity for all to have a say and bring up issues most relevant for self - Okay to address emotions - Appraise immediate social network for influence on individual, clinic & community - Identify issues for improvement of personal environment	- Learn how to navigate a system of care - Increase comfort level with resources for care - Improve patient – provider exchange & communication - Maximize encounter - Contact with leaders who can advocate for you - Propose ideas for improvement of the institution	- Build a sense of belonging, community - Effective means for sharing values and knowledge - Release tension in safe environment - Accountability - Change agents - Organize actions - Contact leaders to propose ideas to improve community

CASA • CLINICA • COMUNIDAD

puentes

HACIA UNA MEJOR VIDA

Project developed by IBACH-SDSU and Clinicas de Salud del Pueblo
One of 13 projects funded by Peers for Progress program of the AAFP Foundation

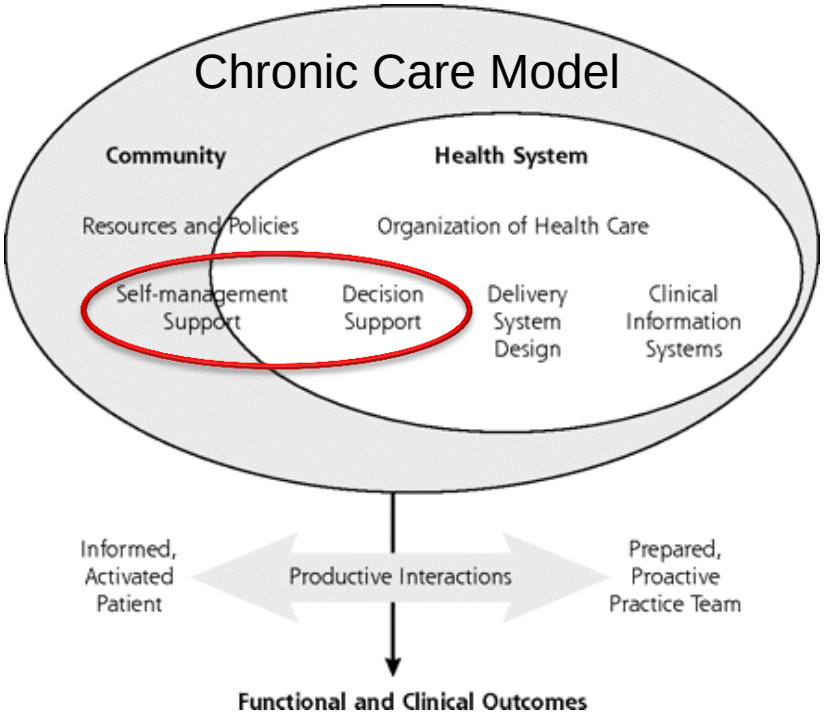
Clinicas de Salud del Pueblo, Inc.

www.peersforprogress.org

Aim: Improve diabetes control for Spanish-speaking patients from Clinicas

By: Working with peer supporters with four core functions for diabetes management:

1. Assistance in daily management
2. Social and emotional support
3. Linkage to clinical care
4. Ongoing support





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HACIA UNA MEJOR VIDA

Ecological Model

Design:	On-going individualized support for 1 year with at least 8 contacts during first six months
Modes of delivery:	Home contacts, clinic visits, & support groups
Delivered by:	3 groups of 10 peer supporters based in 3 main communities of Imperial Valley
Integrated with clinic:	Peer support reports placed in patient health records, quarterly updates at clinician meetings, case-review with clinicians as needed

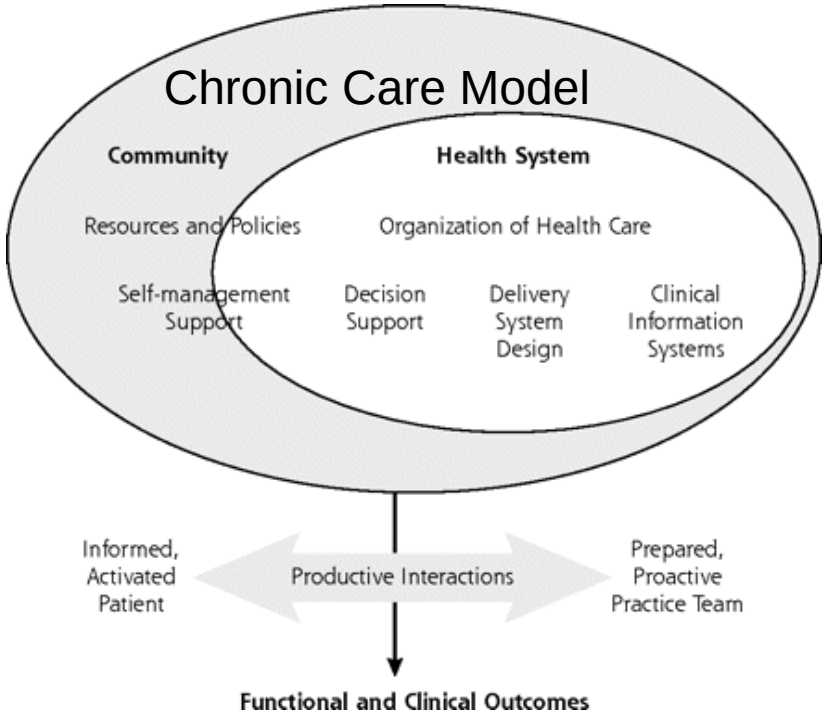
HIV Care Program

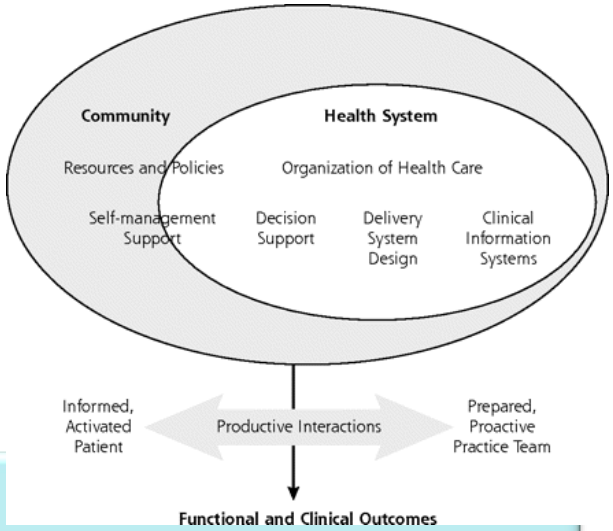
Program developed by Clinicas de Salud del Pueblo and the Imperial County Public Health Department

Aim: Long-term Care for HIV positive individuals in Imperial County

By: Working with a multidisciplinary team following a chronic care model

1. Peer health educators
2. Nutritionist
3. Pyscho-social services provider
4. Case-managers
   - Medical appts, labs, drug assistance
   - Housing, social services, transportation
5. Physician/HIV specialist





Population:	125 HIV+ adults, mostly male, 30% Spanish-speaking
Design:	On-going support with 2+ contacts with each provider per year
Modes of delivery:	5 night-time comprehensive HIV Clinics per month, all services offered on-site during night clinics, team meets before each night clinic for case-review
Delivered by:	Peer support mostly offered by 1-2 bilingual peer health educators and 1-2 bilingual case-managers
Integrated with clinic:	All services offered on-site, all services documented in patient health records, case-review with clinicians required

Lessons learned

Peer support integration…

- Doesn't always have to look the same
- Look for BEST FIT for setting and issue
- Anything needing ≥ 4 visits/year, should include home or community-based intervention
- Becoming a broader reality with ACA, PCMH
- Essential:
  - ✓ Helping to meet goal of bridging primary care practice with the larger community, better life for our patients

Thank you!
¡Gracias!

For more information, please contact:
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at 760-960-4234 or Leticiai@cdsdp.org

Co-Occurring Chronic Disease and Psychological Disorder

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-o-
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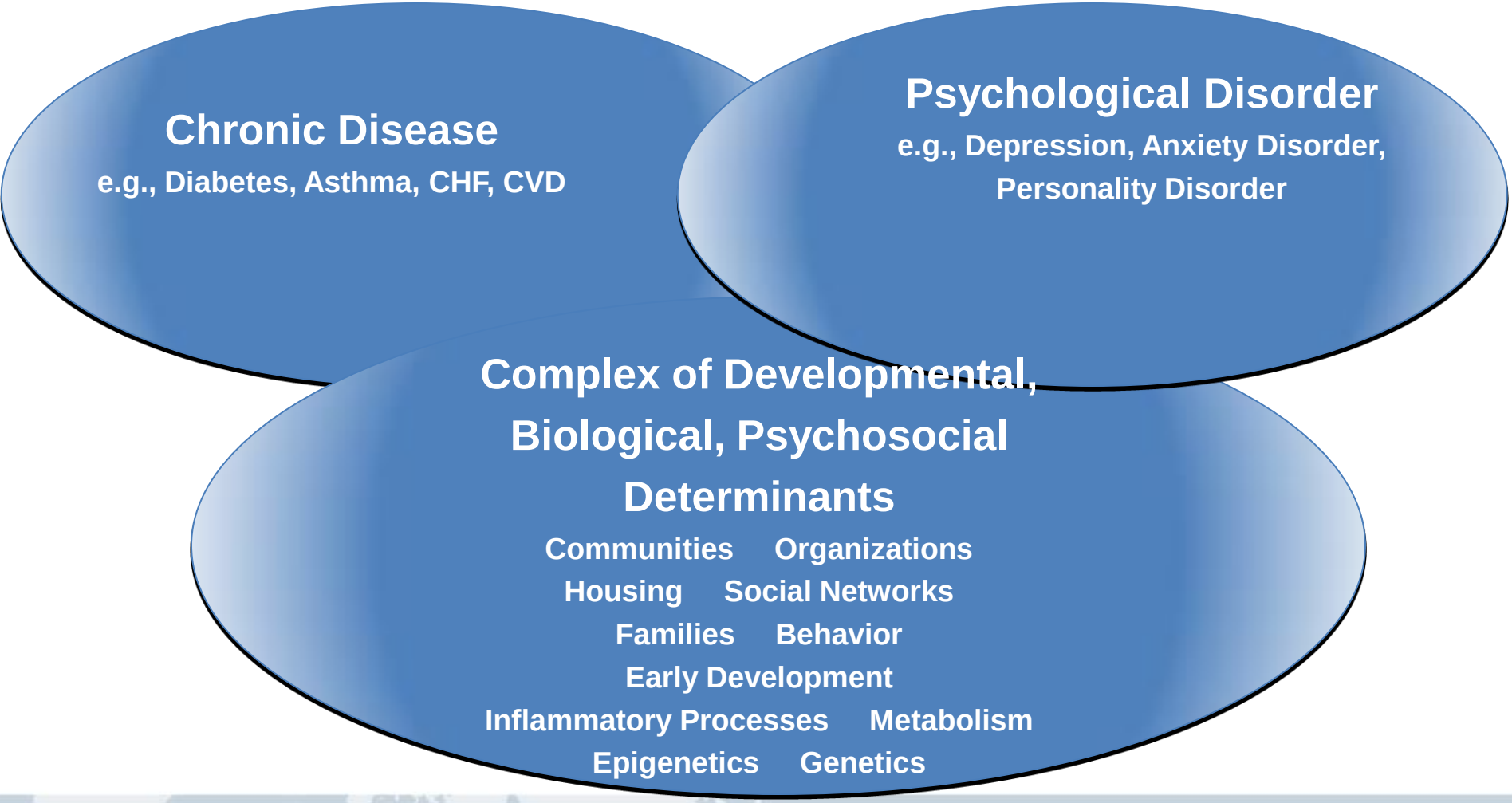
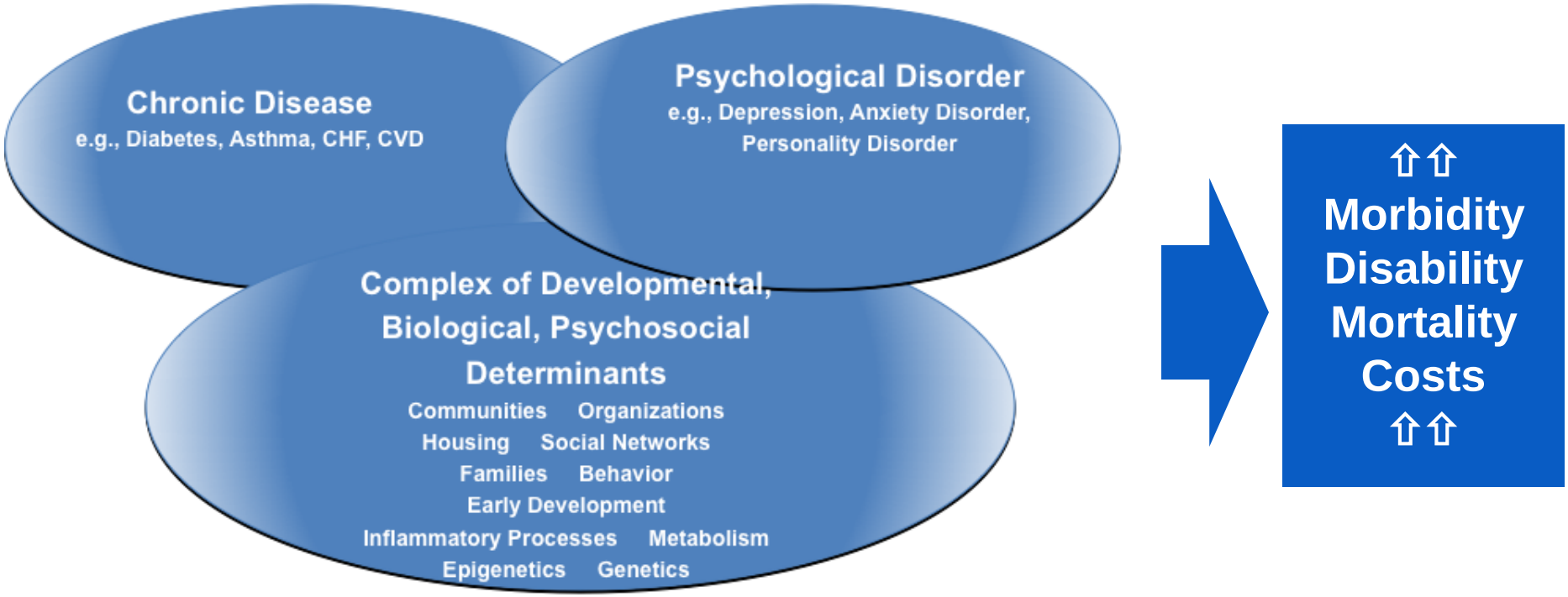
Clinical Reality

A Familiar Individual Case History:
2 YO: Low family income, single parent, disadvantaged, poor diet, compromised nurturance, epigenetic changes in stress mediators
8 YO: Hx abuse, overweight, discouraged, poor grades
16 YO: obese (HBP? IGT?), poor grades, limited social development, inflammatory changes
35 YO: BMI = 35, HBP, IGT, frequent depressed mood and general suspiciousess, frequent sleep disturbance, variable employment,
50 YO: Type 2 diabetes, HBP, BMI = 38, joint problems, mild ADL impacts, Dx depression, variable employment, sleep disturbance, hospitalization in previous year, Rx for DM, HBP, Depression, Joint pain, sleep disorder …

Chronic Disease and Psychological Disorders as Expressions of Complex Biological, Psychological, and Socioeconomic History



The Face of 21st Century Illness Burden



Peer Support Can Help!!!

Reducing Depression and Anxiety Disorders in India

- Education about psychological problems, ways of coping, and interpersonal therapy delivered by lay health counselors with primary care and psychiatric back-up
- 30% decrease in prevalence, 36% in suicide attempts, 4.43 fewer days no work/reduced work in previous 30 days.
- Lowered time costs resulted in Intervention being cost effective and cost saving

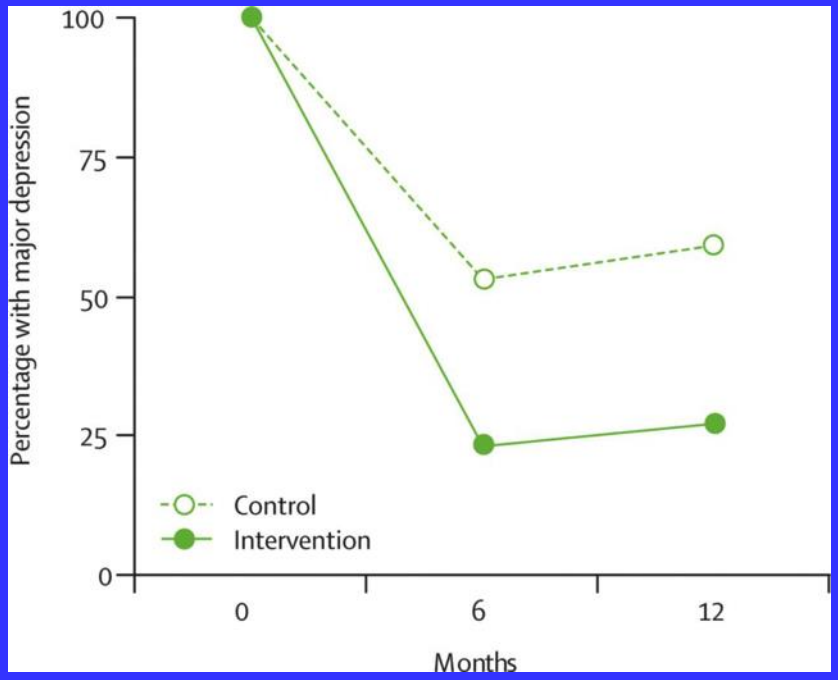
(Patel et al. Br. J. Psychiatry 2011 199:459-466; Buttorff et al. 2012 90: 813-821)

“Lady Health Workers” in Pakistan Reduce Post-Partum Depression

“Lady Health Workers”
Completed 2ndry education
Responsible for ≈ 100 households
Primarily general health education and preventive maternal and child care
Extending to TB and HIV detection and control
≈ 96,000 LHWs cover 80% of Pakistan rural population

Manual based intervention, “Thinking Healthy Programme”

- Promote change in thoughts likely to increase depression
- Practical problem solving
- Collaboration with family



Rahman et al.
Lancet 2008 372: 902-909
Arch Womens Ment Health 2007 10: 211-219.