Enriching Patient-Centered Medical Homes Through Peer Support

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ABSTRACT

Peer supporters are recognized by various designations—community health workers, *promotores de salud*, lay health advisers—and are community members who work for pay or as volunteers in association with health care systems or nonprofit community organizations and often share ethnicity, language, and socioeconomic status with the mentees that they serve. Although emerging evidence demonstrates the efficacy of peer support at the community level, the adoption and implementation of this resource into patient-centered medical homes (PCMHs) is still under development. To accelerate that integration, this article addresses three major elements of peer support interventions: the functions and features of peer support, a framework and programmatic strategies for implementation, and fiscal models that would support the sustained viability of peer support programs within PCMHs.

Key functions of peer support include assistance in daily management of health-related behaviors, social and emotional support, linkage to clinical care, and longitudinal or ongoing support. An organizational model of innovation implementation provides a useful framework for determining how to implement and evaluate peer support programs in PCMHs. Programmatic strategies that can be useful in developing peer support programs within PCMHs include peer coaching or mentoring, group self-management training, and programs designed around the telephone and information technology. Fiscal models for peer support programs include linkages with hospital or health care systems, service- or community-based nonprofit organizations, and partnerships between health care systems and community groups. Peer support promises to enrich PCMHs by activating patients in their self-care, providing culturally sensitive outreach, and opening the way for partnerships with community-based organizations.

Ann Fam Med 2015;13(Suppl_1):S73-S78. doi: 10.1370/afm.1761.

INTRODUCTION

The patient-centered medical home is emerging as the predominant primary care delivery model in the United States.[1-3] In its ideal form, the PCMH tailors health care services to each patient's needs in several ways, such as by increasing access, managing all aspects of care, and providing team-based care led by the patient's personal physician.[4] The care team can include care managers, nurses, family members, and, increasingly, peer supporters.[5,6] Peer supporters are community members who work either for pay or as volunteers in association with health care systems or community-based organizations and who often share ethnicity, language, and socioeconomic status with the mentees they serve.[7]

The majority of peer support is provided by people with a variety of titles—community health workers (CHWs), *promotores de salud*, lay health advisors, health coaches, patient navigators, and doulas.[8-10] For convenience, we use the term *peer supporter* in this paper for anyone who provides such support, whether that support is delivered formally, as in an established health education program, or informally, as in advice and emotional support from a friend. Peer support may be delivered via many channels, such as phone calls, text messaging, group meetings, home visits, and

Conflicts of interest: authors report none.

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even grocery shopping.[8] Peer support can also take the form of mutual support groups developed by dedicated volunteers. These groups can fill unmet needs, particularly for people living with chronic conditions.[8] CHWs and many others who provide peer support to individuals may also be involved in other activities at the community level, such as community organizing or advocacy work.[8-10]

The Patient Protection and Affordable Care Act highlights the growing role of peer support through the inclusion of community health workers as integral participants in a changing health care system.[11] This legislation has specifically earmarked funding for initiatives that use CHWs to promote health behaviors and optimize outcomes in medically vulnerable populations.[11] As a result, many primary care practices that are being transformed into medical homes, especially those with limited resources and those that have patients with complex care needs, may benefit from incorporating peer support interventions into their organizational structure and operations.[12] This legislative interest in peer support is a reflection of its efficacy,[13-18] particularly its cost-effectiveness and success in reaching the "hardly reached"—at-risk groups that preventive service and care management programs often fail to engage.[19]

Despite the face validity of peer support and its growing evidence base, the incorporation of peer support programs into medical homes is still developmental.[20,21] This article introduces the peer support model and outlines approaches to the functional integration of this resource into medical homes. First, we describe the key functions of peer support and provide the supporting evidence. We then introduce an organizational framework for incorporating peer support programs into medical homes. Finally, we present fiscal models for the sustained financial viability of peer support in medical homes.

KEY FUNCTIONS OF PEER SUPPORT

From randomized trials to community-level interventions, a substantial body of research provides compelling evidence for the value of peer supporters in promoting healthy behaviors and managing chronic disease.[6,8,22] Although much of this work has focused on diabetes, peer support interventions have been shown to be powerful in other disease states, particularly in resource-limited environments. Such interventions enhance linkages to care and attend to the dynamic "real world" circumstances influencing health behavior.[14,15,23,24] In developing and disseminating models for promoting peer support, Peers for Progress has identified 4 key functions of peer support that provide a structure for standardization of peer support programs while allowing for their adaptation to various community environments and organizational settings[6,8]:

- Providing assistance in the daily management of health-related behaviors. Peer supporters help individuals translate what physicians and other health care providers recommend into specific, actionable plans.[6,8]
- Providing social and emotional support for those whose motivation for self-management may falter. Peer supporters can provide an opportunity for patients to share moods and feelings.[6] Social and emotional support may also help individuals cope with the distress that can accompany chronic disease and can involve providing problem-solving and other self-management strategies.[25]
- Linking the patient to clinical care and community based resources. Peer supporters help patients recognize when they should access health care and often facilitate timely linkages to medical services.[8]
- Offering longitudinal support. Preventive and self-management skills are needed throughout life, and ongoing peer support can develop into a sustained relationship.[8]

By sharing, and successfully managing, the same chronic disease as their mentees, peer supporters can serve as role models. In addition, they often share demographic characteristics or reside in the same communities as those they serve and can provide an understanding of and perspective on medical conditions that help patients work complex treatment regimens into their daily routines.[17,26] Because peer supporters often live with comorbid disease, they share knowledge and experience invaluable in practical and emotional support of behavior change—knowledge and experience that professional health care staff frequently do not have.[27] Studies of patients living with chronic conditions such as diabetes, cancer, cardiovascular disease, mental illness, and HIV/AIDS have shown ongoing peer support to be a key element in sustaining meaningful health behavior change.[28,29] Strategies based on peer support offer emotional, social, and practical assistance in achieving and sustaining the complex behaviors that are essential for managing chronic conditions and staying active and healthy.[30-32] Peer support can also complement and enhance existing health care services to help patients adhere to care management plans, stay motivated, cope with the stressors of chronic illness, and maintain continuity with their primary care providers.[33]

In addition to addressing the behavioral and psychological factors that contribute to health, peer supporters—often CHWs—also attend to the social determinants of health in many resource-limited com-

munities.[34] This benefit reflects the historical linkages of CHWs with their communities and their dedication to community development and empowerment.[35] The positive effects that CHWs have had on strategies to promote public housing[36] and reduce community violence[37] have been documented. And at the individual level, emerging evidence indicates that peer support is effective in reaching those whom traditional health services fail to engage.[38]

CHWs are increasingly recognized for their value in facilitating care delivery and are being incorporated within health care systems. For CHWs to preserve their value, however, they will need to preserve a community orientation and ongoing commitment to building community capacity through advocacy and organizing to address the larger social factors affecting health.[34] CHWs are often identified through a demonstrated commitment to and cultural understanding of the communities they serve. Additionally, they may have basic administrative skills that allow them to organize groups, marshal area resources, and report on their activities.[17] CHWs can have training in specific health-related areas (eg, physical activity promotion) and receive ongoing support and development from professional sources, such as public health programs such as county health departments, nonprofit advocacy groups, and nurses affiliated with health care organizations.[17,26]

A FRAMEWORK AND PROGRAMMATIC STRATEGIES FOR IMPLEMENTING PEER SUPPORT

Limited but emerging work addresses the adoption of peer support interventions in patient-centered medical homes.[20,21] Three recent, largely qualitative studies support the feasibility of peer recruitment and training and the capacity of peer supporters to connect with patients in medical homes.[21,39,40] Unfortunately, the organizational factors and programmatic strategies that contribute to the successful implementation of peer support programs in this context are not well understood.[15,41,42] An organizational theory of innovation implementation provides a useful framework for determining how best to implement and evaluate peer support programs in PCMHs.[43] In brief, this theory posits a series of factors, including among others organizational readiness for change, the fit between an innovation and the values of the organization where it is being implemented, and the efficacy of the innovation, that enable predictions of the success of an innovation implementation.[43]

Several programmatic strategies for peer support can be applied in PCMH settings:

- Clinicians or other members of the health care team can identify patients who have intrinsic coping and disease self-management skills as potential peer supporter candidates.[17,26]
- Operationally, peer supporters may be deployed as a part of a comprehensive care team or may be extenders of clinical care managers.
- Organizing peer support as a continuation of professionally led group programs may be an effective way of introducing peer supporters and of sustaining the benefits of those programs[45] Group self-management training combines the benefits of evidence-based disease self-management programs (eg, the Chronic Disease Self-Management Program)[44] with peer group support in order to promote health behaviors.[17,26] After training, peer leaders convene group sessions with a structured format that facilitates the dissemination of health information as well as small-group discussion and peer exchange. Once the formal group training period has ended, peer leaders can also maintain contact via individual meetings or telephone follow-up with participants to provide ongoing support.[17]
- Designing peer support programs around telephone or information technology (IT) is an effective and cost-efficient way to extend the reach of peer supporters.[17,26] One approach combines elements of peer support groups with support via telephone or IT in which patients receive support through regular contacts. Many patients prefer telephone or IT communication since it eliminates access barriers (eg, transportation problems) and provides a level of anonymity that some patients prefer and that is not found in meeting-based approaches.[17,26] Interactive voice response exchange platforms, for example, are a low-cost technology that can generate automatic reminder calls without requiring participants to share phone numbers, thereby ensuring privacy.[17,26,46,47]

A major challenge for PCMHs that seek to implement peer support interventions will be in balancing the competing demands of adaptation and fidelity.[48,49] This ongoing task involves allowing the intervention to be modified during implementation in order to meet practice needs and circumstances, yet discouraging adaptations that undermine the intervention's "active ingredients"—the core elements of the intervention that produce its main effects.[48,49] Peer support programs at the community level have allowed for considerable local flexibility, but have maintained fidelity to the four key functions of peer support, described above.[8] PCMHs that develop peer support programs will need to ensure fidelity to these key functions. In addition, to avoid potential harms or drawbacks of emerging programs, such as the dissemination of incorrect health information, PCMHs will need to attend to

the organizational factors specific to implementation, which are listed in Table 1.

FISCAL MODELS FOR SUPPORTING PEER SUPPORT

A growing body of evidence establishes the cost-effectiveness of community-based peer support interventions.[50,51] In the United States, peer support programs, primarily involving CHWs, have been organized on three predominant fiscal models:

- Peer support programs developed as extensions of hospital or other health care systems. This model integrates peer supporters with professional disease management or care teams from health care systems that focus on specific disease states, such as asthma or HIV/AIDS. CHWs extend the reach of hospitals and other care entities and are the primary points of contact for patients and their families, providing health education and facilitating access to social and community-based services.[11]
- Peer support programs embedded in community-based nonprofit organizations. Community-based nonprofit organizations are the traditional base for programs involving CHWs. These organizations may be faith-based or advocacy groups that are rooted in their communities and often provide a host of social and health-related services.[11] In this model, CHWs may or may not have linkages with health care professionals but serve as sources of information regarding health behaviors and access to care.[11]
- Peer support programs managed by entities that interface between health care systems and communities.[11] The management entities involved here are CHW organizations that are integrated with clinical and community groups and have a goal of managing populations and developing the local workforce.[11] Here, a network of CHWs provide protocol-guided services that target chronic disease risk assessment, self-management support, and coordination with primary care providers.[11] This model represents a hybrid of the historical roles of CHWs as extensions of health care systems and as community activists. It provides opportunities for scalability as well as financial sustainability.[11]

The lack of fiscal models to support the sustained integration of CHWs has limited the widespread expansion of the peer support programs beyond time-limited funding, such as grants. However in light of the Affordable Care Act and with the ongoing transformation to value-based health care, payment models are evolving to support CHWs.[20] For example, in 2008 the Centers for Medicare and Medicaid Services (CMS) approved a Minnesota plan that authorized payment for CHWs who worked under Medicaid-approved providers.[20] Managed care organizations in New Mexico and Colorado have also used federal Medicaid funds to provide CHW services for targeted populations.[20] In each case, states have specified a scope of services that includes promoting disease self-management, facilitating access to care, and engaging hard to reach patients.[20] Several value-based payment models currently being tested—shared savings, bundled payment, and capitation—have the potential to provide a business case for peer support interventions as part of reorganized care that is predicated on care coordination, efficiency, and ultimately, quality.[20] In addition, CMS is rolling out incentives in fee-for-service Medicare that would allow providers to bill for care coordination activities, creating a per beneficiary benefit for care coordination.[52]

The establishment of wellness trusts is another approach that has the potential to sustain community-based peer support programs. Wellness trusts have been proposed as a governance and fiscal approach that would pool assets and create an administrative infrastructure

Table 1. Organizational Factors to Consider When Implementing Peer Support Initiatives in Medical Homes

Structure
Uniform guidelines for determining eligibility, recruitment, and selection of peer support candidates.
Clear standards that define responsibilities, scope of work, competencies, performance standards, and reporting relationships that are tied to licensed professionals, such as nurses or social workers, in the medical home.
Operating procedures and back-up plans that allow peer supporters direct access to professional staff in the event of urgent or life threatening circumstances.
Clinical information systems that allow effective communication, at the appropriate level of patient health information, between peer supporters and professional staff.
Process
Orientation and ongoing training for peer support workers in interpersonal and communication skills, documentation and other administrative skills, and content and teaching skills for specific health promotion areas.
Effective dissemination of peer support services to medical home staff, area health care affiliates, and community stakeholders.
Ongoing monitoring of peer support services provided, with appropriate supervision.
Communication and documentation of peer support activities in a database that is accessible to medical home staff and retrievable for reporting and evaluation.
Outcomes
Clear and measurable goals and objectives in the following short-term and intermediate areas: patient-level outcomes, such as health and functional status measures; biometric and other disease state measures; patient-centered and other individual care process measures; organizational-level outcomes, such as access to care, health care utilization, costs of care and savings; and community-level outcomes, such as social capital.

Table 2. Research Areas of Study Regarding Peer Support Initiatives in Medical Homes

Comparative effectiveness
What are the differential effects of peer support interventions that are targeted to patient disease states (eg, diabetes, depression), medical comorbidities, and demographic characteristics?
What is the incremental benefit of peer support interventions for patients who are already engaged in behavior or self-management programs?
How can peer support interventions interface effectively with emerging health information technologies to improve care?
Cost-effectiveness
What is the cost-effectiveness of peer support programs compared with other behavior and disease management programs?
What are the indirect benefits of peer support programs to medical homes?
What are the financial models that can provide for the sustained viability of peer support programs in medical homes?

to support health promotion and disease prevention activities whose rates of return are not large enough or rapid enough for commercial insurers.[53,54] Operationally, a community health trust would determine which services, such as CHWs, have the most promising long-term value and offer incentives for members to use them.[53,54] Through the formation of a "health utility," health care providers in a specified geographic region would be linked to area social and public health services, providing shared services and support that would improve the horizontal integration of care and create a community-level platform for evolving high-performing, integrated health care systems.[53] Fiscally, a collaboration of federal and state sources (eg, Medicaid), private insurers, employers, and health care systems could collectively provide a diversified funding stream that would sustainably support a community health trust for a defined population.[53,54]

FINAL COMMENTS

Peer support is a robust strategy for health promotion and a powerful complement to team-based care, which is a core element of the patient-centered medical home.[5] The adoption of peer support interventions in PCMHs, however, is still in its infancy. Research is still needed into the the comparative effectiveness and cost effectiveness of these initiatives in medical homes. Table 2 suggests some important areas for research. Nevertheless, peer support and the PCMH share a common focus on promoting access to care, encouraging patients to assume more active roles in their health care, enhancing communication between patients and providers, providing culturally-sensitive outreach and follow-up, and partnering between health care and community-based organizations.[55] As the US health care system continues to evolve toward value-based purchasing, the evidence base and cost-effectiveness of peer support programs virtually ensure that they will enrich medical homes of the future.

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Submitted July 22, 2014; submitted, revised, November 17, 2014; accepted December 3, 2014.

Key words: peer support, medical home, community health worker, primary care

Funding support: Funding for this research was provided by the American Academy of Family Physicians Foundation through the Peers for Progress program with support from the Bristol Myers Squibb and Company Foundation.

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