The Peer Workforce in Chronic Care: Lessons and Observations from Peers for Progress

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Peer support has contributed to better chronic care and has been utilized as an approach to improve health equity around the world. Growing and improving the peer workforce is a key step toward the broad institutionalization of peer support in the US health care system.

Introduction

A major public health challenge of the 21st century lies in reducing the burden of chronic diseases, especially among populations negatively affected by racism and other social determinants of health. Chronic diseases, including cardiovascular diseases, metabolic disorders, respiratory diseases, cancers, and psychological and mental health problems, are the leading causes of disability, decreased quality of life, and reduced life expectancy. Effective management of chronic diseases is complex and requires coordinated care from medical experts, well-resourced social services, ongoing patient education and support, and a community environment that enables and supports healthy behaviors and lifestyles.

Care transformation models, such as the Chronic Care Model and the Patient-Centered Medical Home, have been shown to improve patient care and outcomes. The success of these models is due in part to the contributions of highly trained and salaried professionals as well as volunteer peer supporters in both clinic- and community-based settings. Going by a variety of names—"community health workers" (CHWs), "lay health advisors," "promotores," "patient navigators"—peer supporters are generally nonprofessionals who share lived experience with recipients. The shared lived experience can be enduring a health problem like diabetes, experiencing a problem through a relative or close friend, or having a shared circumstance, such as being a new parent or living in a food desert. Peers for Progress, a program based at UNC-Chapel Hill dedicated to promoting knowledge-sharing and dissemination of peer support, emphasizes common themes in what peer supporters do, as opposed to what they are called. Based on evidence and experience from across the globe, Peers for Progress has promoted a general model of five "key functions" of peer support: assistance in daily management, social and emotional support, linkage to clinical care and community resources, ongoing support, and simply "being there"—presence or implicit support [1, 2]. This model has shown itself to be versatile in guiding diverse programs and in helping to explain why programs sometimes are unsuccessful [3].

Studies have shown that peers are capable of delivering chronic disease education, screening, and support, with well-documented benefits for cardiovascular diseases, diabetes, cancer, and mental health problems [2, 4]. Visit any major website for a chronic disease association or community and you are likely to find a section dedicated to helping people connect with peer support resources. However, this only highlights the fact that seeking out peer support often relies on individual initiative, due to a lack of integration between the health care system and peer support networks.

Continuum of Peer Support

Peer support has taken many forms across culture and history. Relatively recent manifestations include "barefoot doctors" institutionalized in China in the 1960s, *promotores de salud* in Latin America, "village health volunteers" active in Thailand since the 1960s, "lady health workers" active in Pakistan since the 1990s, Alcoholics Anonymous, mutual support groups such as the Sisters Network among African American women with breast cancer, and advocacy activities among many groups sharing a common identity or concern, such as the National Alliance for the Mentally Ill.

In the United States, extensive studies document that peer support can make important contributions to health, health care, and prevention [5, 6]. The development of the community health worker workforce constitutes an important element of this landscape, emphasizing extensive training and professional identity [7]. Similarly, within behavioral health and services addressing substance use problems, mental health peer support specialists also meet extensive background and training requirements and have emerged both within the Veterans Administration as well as in many programs supported by Medicaid and other funders [8].

Across these many types of peer support programs, there is considerable variety of training and support pro-

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vided. Community health workers certified through authorized training agencies have several core competencies and are qualified to serve as full-time members of health care teams; carry out health education; triage requests for services; and provide emotional and logistical support in dealing with housing, employment, psychological, family, and other stressors and disruptions [9]. On the other end of the spectrum, a volunteer may spend a few hours a week carrying out very specific tasks that may include having nonthreatening conversations with individuals at diverse risks because of social isolation [10, 11].

The continuum of peer support that includes volunteers with modest training and specific contributions reflects the grassroots origins of the field [12]. At the same time, the credentialing and recognition of community health workers, as recommended in the Affordable Care Act, and of mental health peer support specialists, as directed by the Veterans Administration and state Medicaid programs, assures quality of services and appropriate recognition of those providing them. There is a complementarity here. Well-articulated requirements for credentialing, training, and supervision are important for assuring quality and safety of many services. Credentialing also makes peer support "official," thereby conferring recognition and legitimizing the whole field. On the other hand, volunteer approaches facilitate incorporation of peer supporters from the specific church, neighborhood, or other community of those served as well as the development of innovative approaches to problems. The vitality of the field has been advanced by the complementarity among all points of the peer support continuum.

Outcomes and Reach of Peer Support

A major 2014 review in the *Annual Review of Public Health* by Perry and colleagues documented benefits of peer support and community health workers around the world, including in undernutrition; under-5 childhood mortality; case management of childhood illnesses; women's health; HIV/AIDS; malaria; tuberculosis, including directly observed therapy; acute malnutrition; cancer screening; and chronic disease prevention and management, including for hypertension, diabetes, and cardiovascular disease [6]. Benefits have also been noted in mental health, such as with problem-solving, activation, and cognitive behavioral interventions in the Americas, Europe, South Asia, and Africa [13-17]; telephone peer coaching with veterans, police, and other high-risk groups [18]; schizophrenia [19]; and indirect effects on anxiety and depression with peer support interventions for other chronic diseases [20].

A key concern in health care is reaching and engaging those who face a variety of social determinants of health, including racism and discrimination, and for whom conventional prevention and treatment models fail [21]. Peer

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support appears to be a remarkably effective approach with such groups. For example, over two years, an "asthma coach" was effective in engaging 90% of unmarried, low-income mothers of children covered by Medicaid who had been hospitalized for asthma [22]. Relative to randomized controls, the coach intervention reduced subsequent rehospitalization by 50% [22]. In diabetes management, the relative advantage of peer support over controls was greatest among those with low initial scores on self-management and medication adherence as well as on health literacy and social support [23, 24]. Reviewing these and other papers, Sokol and Fisher identified consistent advantages of peer support in reaching, engaging, and benefitting those too often "hardly reached" [21, 22].

Development of the Peer Workforce

From volunteers giving five hours per week to community health workers employed full time, the entire continuum of peer support has made contributions to chronic disease care. In the United States, the task of developing the infrastructure to support the peer workforce is delegated to the states and nongovernmental organizations. This infrastructure supports the training and career development of peers closer to the paraprofessional end of the continuum. One challenge of workforce development is maintaining high standards while preserving "peerness" and avoiding the pitfalls of elevating one type of peer support above the others.

The peer workforce consists of people who are motivated by their desire to do something good for their communities—not necessarily to turn their activities into a career. Recognizing that not every person wants to be a certified community health worker or peer support specialist, with all of the commitments and responsibilities that those roles entail, it's important that training and quality assurance for peers vary depending on the specific organization and program in which they work. Statewide quality assurance initiatives are useful for the training of paraprofessionals, but it is difficult to set training guidelines for informal peers whose training needs are specific to the organization or project. The ways in which organizations might benefit from outsourcing their training needs is not entirely clear, and there are many reasons that organizations might want to retain trainings in-house. Furthermore, from the experiences of Peers for Progress, the emphasis on education and training on the front end can be inefficient and counterproductive. In fact, on-the-job training and ongoing refreshers and enrichment (e.g., sessions on motivational interviewing or action planning or coping with low mood) can be even more valuable than intensive front-end trainings because there are immediate opportunities for practice and application.

In addition to training and certifying individuals in the peer workforce, credentialing programs can be equally important to quality assurance. For many organizations, gaining funders' recognition and approval of the organization's own practices of recruitment, training, supervision/monitoring, and back-up may be much more feasible than managing credentialing—and recredentialing—of a cohort of individuals. Individual credentialling (e.g., of highly trained community health workers) and program credentialing (e.g., of volunteers) might complement each other in many settings, supporting reimbursement for their services [25]. In terms of workforce development and advancement, working under high-quality programs can produce greater impacts, prevent burnout, and nurture a more experienced workforce. The experience of Peers for Progress indicates that peer supporters greatly value monitoring, supervision, and backup from program managers, especially as these actions signal recognition of the importance of the services involved. Furthermore, peer support programs need to network together to collaborate and exchange good practices, including training and support for their peer supporters.

The discussion in this commentary has thus far focused on training a small group of peers to provide support to the larger population. Another approach to developing community peer support is to provide lots of the people in the community with training in good peer support practices to strengthen the community's capacity to support itself. Currently, Peers for Progress is collaborating with over 35 groups on campus at UNC-Chapel Hill to promote a broad approach to peer and community support [26]. This approach recognizes that many people have the experiences and qualities to be a good peer supporter to someone they know—that we can all be peer supporters as we develop a culture of mutuality.

Lessons From COVID-19

When COVID-19 began disrupting community and health care services, there were many unknowns about how the lockdowns and restrictions would affect people living with chronic diseases. Would the pandemic cause lasting changes to the landscape of chronic disease care? Would people with chronic diseases suffer higher rates of morbidity and mortality under the pandemic? What could primary care services do to assist patients who might be homebound and isolated?

We learned that the pre-COVID peer workforce and clinic-community connections can be mobilized rapidly in response to public health emergencies. The peer workforce is highly elastic and fully capable of assisting in community-based relief efforts. In a Peers for Progress project in Shanghai, peer leaders from a diabetes peer support initiative were redeployed to assist clinical staff in local COVID response activities, such as temperature screening, package deliveries, contact tracing, and community education. Furthermore, these peers continued to engage with participants in the diabetes project through social media posts encouraging them to maintain healthy lifestyles during the pandemic. In interviews conducted at a peer support call center in the early months of the pandemic in the United States, peer supporters responded that their roles increased and became more complicated amidst the pressing demands for food, housing, safety, and economic assistance [27]. In addition to emotional and social support, they were also providing a great deal more informational and instrumental support to address very concrete challenges [27].

Peers for Progress has observed that the emphasis on mental health during the pandemic has provided an opportunity for peer support to demonstrate its value to chronic disease care. Peers have been a lifeline for isolated people during the pandemic as programs transitioned to telephone and digital health platforms. This adds to the evidence that peer support should be a strategy for the growing epidemic of loneliness and social isolation that will persist long after the pandemic is over. For people experiencing social isolation, including many who are disabled due to chronic diseases, even relatively brief interactions with someone they enjoy talking to can make a big difference in their emotional well-being and quality of life. These types of light contacts require only minimal training and would be appropriate for peers across the entire continuum of peer support.

Conclusion

A society's health infrastructure is put to the test by its ability to care for those with chronic diseases. Peer support can help address gaps in our health care system and alleviate the strain on professional health care providers. Peer support addresses health equity, but this often leads to the impression that it is cheap care for poor people. Instead, research shows it is good care for all people. When it comes to the sustained behavior and lifestyle changes that are so critical to chronic disease management, peers have a strong record of effectively nudging people in the right direction. For its role in chronic care, peer support deserves more recognition and resources to ensure that these valuable programs are well-established for the long term. Since chronic diseases are often "for the rest of your life," why shouldn't peer support have a place as a trusted companion on that journey? NCM

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References

1. Fisher EB, Earp JA, Maman S, Zolotor A. Cross-cultural and international adaptation of peer support for diabetes management. Fam Pract. 2010;27(Suppl 1):i6–i16. doi: 10.1093/fampra/cmp013
2. Evans M, Daaleman TP, Fisher EB. Peer Support for Chronic Medical Conditions. In: Avery J, ed. Peer Support in Medicine: A Quick Guide. New York: Springer; 2020.
3. Fisher EB, Ballesteros J, Bhushan N, et al. Key features of peer support in chronic disease prevention and management. Health Aff (Millwood). 2015;34(9):1523–1530. doi: 10.1377/hlthaff.2015.0365
4. Tang PY, Fisher EB. Enhacing Peer Support Interventions in Diabetes Care. In: Delamater AM, Marrero DG, eds. Behavioral Diabetes: Social Ecological Perspectives for Pediatric and Adult Populations. Springer International Publishing; 2020.
5. Fisher EB, Bhushan N, Coufal MM, et al. Peer Support in Prevention, Chronic Disease Management, and Well Being. In: Fisher EB, Cameron LD, Christensen AJ, et al., eds. Principles and Concepts of Behavioral Medicine: A Global Handbook. New York: Springer; 2018.
6. Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health. 2014;35:399–421. doi: 10.1146/annurev-publhealth-032013-182354
7. Allen CG, Brownstein JN, Cole M, Hirsch G, Williamson S, Rosenthal EL. Building a framework for community health worker skills proficiency assessment to support ongoing professional development. J Ambul Care Manage. 2018;41(4):298–307. doi: 10.1097/JAC.0000000000000251
8. Daniels AS, Bergeson S, Fricks L, Ashenden P, Powell I. Pillars of peer support: advancing the role of peer support specialists in promoting recovery. J Ment Health. 2012;7(2):60–69. DOI:10.1108/17556221211236457
9. George S, Silva L, Llamas M, et al. The development of a novel, standards-based core curriculum for community facing, clinic-based community health workers. Front Public Health. 2021;9:663492. doi: 10.3389/fpubh.2021.663492
10. Kahlon MK, Aksan N, Aubrey R, et al. Effect of layperson-delivered, empathy-focused program of telephone calls on loneliness, depression, and anxiety among adults during the COVID-19 pandemic: a randomized clinical trial. JAMA Psychiatry. 2021;78(6):616–622. doi: 10.1001/jamapsychiatry.2021.0113
11. Steptoe A, Shankar A, Demakakos P, Wardle J. Social isolation, loneliness, and all-cause mortality in older men and women. Proc Natl Acad Sci U S A. 2013;110(15):5797–5801. doi: 10.1073/pnas.1219686110
12. Eng E, Parker E, Harlan C. Lay health advisor intervention strategies: a continuum from natural helping to paraprofessional helping. Health Educ Behav. 1997;24(4):413–417. doi: 10.1177/109019819702400402
13. Chowdhary N, Anand A, Dimidjian S, et al. The Healthy Activity Program lay counsellor delivered treatment for severe depression in India: systematic development and randomised evaluation. Br J Psychiatry. 2016;208(4):381–388. doi: 10.1192/bjp.bp.114.161075
14. Rahman A, Malik A, Sikander S, Roberts C, Creed F. Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. Lancet. 2008;372(9642):902–909. doi: 10.1016/S0140-6736(08)61400-2
15. Chibanda D. Reducing the treatment gap for mental, neurological and substance use disorders in Africa: lessons from the Friendship Bench in Zimbabwe. Epidemiol Psychiatr Sci. 2017;26(4):342–347. doi: 10.1017/S2045796016001128
16. Lyons N, Cooper C, Lloyd-Evans B. A systematic review and meta-analysis of group peer support interventions for people experiencing mental health conditions. BMC Psychiatry. 2021;21(1):315. doi: 10.1186/s12888-021-03321-z
17. Pfeiffer PN, Heisler M, Piette JD, Rogers MA, Valenstein M. Efficacy of peer support interventions for depression: a meta-analysis. Gen Hosp Psychiatry. 2011;33(1):29–36. doi: 10.1016/j.genhosppsych.2010.10.002
18. Evans M, Tang PY, Bhushan N, Fisher EB, Dreyer Valovcin D, Castellano C. Standardization and adaptability for dissemination of telephone peer support for high-risk groups: general evaluation and lessons learned. Transl Behav Med. 2020;10(3):506–515. doi: 10.1093/tbm/ibaa047
19. Evans M, Barker H, Peddireddy S, et al. Peer-delivered services and peer support reaching people with schizophrenia: a scoping review. In press at the International Journal of Mental Health.
20. Yeung RO, Cai JH, Zhang Y, et al. Determinants of hospitalization in Chinese patients with type 2 diabetes receiving a peer support intervention and JADE integrated care: the PEARL randomised controlled trial. Clin Diabetes Endocrinol. 2018;4:5. doi: 10.1186/s40842-018-0055-6
21. Sokol R, Fisher E, Hill J. Identifying those whom health promotion hardly reaches: a systematic review. Eval Health Prof. 2015;38(4):518–537. doi: 10.1177/0163278715605883
22. Fisher EB, Strunk RC, Highstein GR, et al. A randomized controlled evaluation of the effect of community health workers on hospitalization for asthma: the asthma coach. Arch Pediatr Adolesc Med. 2009;163(3):225–232. doi: 10.1001/archpediatrics.2008.577
23. Moskowitz D, Thom DH, Hessler D, Ghorob A, Bodenheimer T. Peer coaching to improve diabetes self-management: which patients benefit most? J Gen Intern Med. 2013;28(7):938–942. doi: 10.1007/s11606-013-2367-7
24. Piette JD, Resnicow K, Choi H, Heisler M. A diabetes peer support intervention that improved glycemic control: mediators and moderators of intervention effectiveness. Chronic Illn. 2013;9(4):258–267. doi: 10.1177/1742395313476522
25. Center for Health Law and Policy Innovation at Harvard Law School, National Council of La Raza (NCLR), Peers for Progress. Recommended Model Guidelines for Credentialing Community Health Worker Programs and Community Health Workers. CHLPI; 2015. Published 2013. Accessed July 26, 2021. https://www.chlpi.org/wp-content/uploads/2013/12/PATHS-Credentialing-Guidelines-Final-070815.pdf
26. Luu SL, Barker HE, Tang PY, Fisher EB. Community building for university peer support. Under review at the Journal of American College Health.
27. Fisher EB, Miller SM, Evans M, et al. COVID-19, stress, trauma, and peer support-observations from the field. Transl Behav Med. 2020;10(3):503–505. doi: 10.1093/tbm/ibaa056