Implementation Differences and Underlying Commonalities of Peer Support: Implications for Standardization and Advocacy

- Brian Oldenburg, Australia (Chair)
- Michaela Riddell et al, Victoria, AUSTRALIA
- Xuefeng Zhong et al, Anhui Province, CHINA
- Andrea Cherrington et al, Alabama, USA
- Ed Fisher, USA (Discussant)
Each presentation

- Grantee, American Academy of Family Physicians Foundation Program – Peers for Progress
- Each program has developed, implemented and evaluated a different peer support program to improve diabetes management

- **Four functions of peer support:**
  - Assistance in daily management
  - Social and emotional support
  - Linkage to clinical care
  - Ongoing support
Key Functions of Peer Support

1. Assistance, consultation in applying management plans in daily life
Assistance in applying management plan in daily life

- Problem
- Doctor Educator Nurse
- Plan
- Peer Supporter
- Action/Implementation

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Key Functions of Peer Support

1. Assistance, consultation in applying management plans in daily life
2. Social and Emotional Support
3. Linkage to clinical care
4. Ongoing support, extended over time

Fisher et al. *Family Practice* 2010
27 Suppl 1: i6-16.
Global Standardization with Local Tailoring

KEY FUNCTIONS
- Assist in managing diabetes in daily life
- Social and emotional support
- Link to clinical care
- Ongoing support

Local, Regional, Cultural Influences

Diverse Implementation of Key Functions
4 x 15 minute presentations

- How did your program specifically address each of the four functions?
- How did you evaluate/measure “success” at addressing each of these?
- Results/findings?
- Challenges and implications for dissemination and ‘scale up
- Ed to discuss
- DISCUSSION
The Australasian Peers for Progress Diabetes Project:
Features of a community based program

Michaela Riddell, Project Manager
Brian Oldenburg, Chief Investigator
Conducted in metropolitan and regional locations in the state of Victoria, Australia

RCT of peer led, community based peer group support

Recruitment by post using state based registry of people diagnosed with diabetes (all types)
## Baseline characteristics

<table>
<thead>
<tr>
<th>Participants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>285</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>148 (52% male)</td>
</tr>
<tr>
<td><strong>Regional</strong></td>
<td></td>
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<tr>
<td></td>
<td>116 (41%)</td>
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<tr>
<td><strong>Age (median)</strong></td>
<td>62 yrs (95% CI: 61, 63)</td>
</tr>
<tr>
<td><strong>Age at diagnosis (median)</strong></td>
<td>54 yr (95% CI: 52.3, 55)</td>
</tr>
<tr>
<td><strong>Duration of diabetes (median)</strong></td>
<td>8yr (95% CI: 7, 9)</td>
</tr>
<tr>
<td><strong>Mean BMI ± SD (n=222)</strong></td>
<td>31.8 ± 6.4</td>
</tr>
<tr>
<td><strong>Mean HbA1c ± SD (n=243)</strong></td>
<td>7.2 ± 1.2</td>
</tr>
</tbody>
</table>
Study design

**Peers for Progress INTERVENTION components**

**Peer Leaders**
- 2.5 days group facilitation training
- Resource Manual
- Ongoing support and supervision from the research team:
  - Weekly teleconferences
  - Weekly newsletters
  - Research team available for questions and support at all times

**Participants**
- Group meetings led by trained peer leaders
- Resource Workbook which includes action planning, goal setting, diabetes management information and links to further resources.
- Website
- Additional Resources and Supports:
  - Regular "check in" phone calls from Leader (min. once per month)
  - Monthly newsletter from Project Team
  - Relaxation CD, BeyondBlue depression DVD, Education DVD
  - Opportunistic activities with peers and/or leader between meetings

**Participant Outcomes**

4 KEY OUTCOMES FOR PARTICIPANTS
1. Assistance and consultation in applying diabetes management plan in daily life
2. Ongoing social and emotional support
3. Linkages to and assistance in gaining access to clinical care
4. Ongoing availability of support
Features of Peer leader support

- 2.5 days training
  - Group facilitation
  - Group maintenance
  - SMART goals
  - Use of the program resources
- Weekly teleconference
- Weekly e-newsletter
- Mentor day
  - Role play for issues confronting leaders in group
  - Presentation on Happiness
  - Presentation on 10,000 steps
Total number of teleconferences = 43
Expectation to attend teleconference at least once every month i.e 12 conference calls (28%)
Mentor day evaluation

- Role play sessions:
  - “…..sessions were spot on, they directly related to issues leaders face and gave strategies on how to handle scenarios many of us have already faced in the group, like how to handle dominant group members and difficult behaviours”

- Goal setting:
  - “…….. our group has really been struggling with goal setting so it was great to discuss and see how other groups have been doing goal setting, and it was good to know we are not the only ones who have been struggling with this.”
Group meetings

- 11 groups + pilot group, 4 groups had leader pair.
- Met for (at least) 90 min once per month (12 meetings by Dec 2011)
- First meeting time/place by consensus participation, subsequent meeting time/day agreed by group
- Leader participated in organising meeting location (local community/neighbourhood house, church hall)
- Meeting topics, themes and visitors driven by group needs/interests
- Leader asked to contact participants
  - Before each meeting
  - After meeting if participant absent
  - Occasionally during the month
- Leader complete & submit contact record
  - After each meeting to record attendance, meeting content
  - For each out of meeting contact
Meeting topics/themes

- healthy diet
- physical activity
- goal setting
- daily management
- problem solving
- motivation
- coping skills
- footcare
- clinical care/medication adherence
- depression/stress
- social issues/eating out
- support outside meeting
- HCP visits

Frequency of meetings:

- Bendigo
- Dandenong
- Geelong 3214
- Geelong 3215
- Glen Waverley
- Richmond
- Wangaratta
- Warragul
- Werribee
Key peer support function # 1

Assistance to apply diabetes management plan in daily life

- Group discussion:
  - Healthy eating/diet
  - Physical activity
  - Taking medication
  - BGL monitoring
  - Setting goals/action planning
  - Getting through social occasions

- Password protected website with vignettes from self management education sessions

- Promote additional group activities such as
  - walking groups
  - going to exercise classes together
Key peer support function # 1

Assistance to apply diabetes management plan in daily life

“Everyone comes to the meeting with their education manual and most of the information we need is in that book so we understand that the information is out there and the group will help us figure out how to use that information and manage better” – peer leader

• Participant feedback about the group:

  “Better control of Diabetes with support and encouragement”

  “Gained knowledge on being healthy”

  “Learning to change my lifestyle”

  “Motivated to attend exercise sessions”

  “Learnt new ideas from peers on better management”

  “Learned useful things- Healthy Eating Booklet”

  “Goal setting to improve my diabetes management”
Key peer support function # 2

Provide social and emotional support

- Group discussion:
  - Coping
  - Depression/anxiety stress
  - Motivation
  - Problem solving
  - Social/family interactions
  - Happiness and well being

- Support outside the meeting (Telephone, email, F2F)
  - Peer leader – participant
  - Participant – participant

- Promote group activities such as
  - walking groups
  - going to exercise classes together
Key peer support function # 2

Provide social and emotional support

- “I phoned the group members to tell them about J…, 3 of us went to the funeral and a card was signed by everyone in the group. Everyone was shocked when they heard but then we talked about her positive contributions to the group and her own positive action towards her diabetes management ”

- “A social contact…a walk around the lake….distance is about 1.5km, flat footpath….but with arthritic hips and bad backs etc it was an achievement for some and easy for others but we were there to do it and the challenge is to do it again”
Linkages to and assistance in gaining access to clinical care

- 99% of participants have own physician
- 62% of participants at baseline had GP management plan
- 53% of participants have private health insurance
- Health care professionals attended group meetings
  - HCP visits organised by peer leader
    - Driven by group needs
    - Promotes/enables contact and connection with local providers and community health services
      - Service available to group members, how to access the service,
      - Questions from group members

<table>
<thead>
<tr>
<th># grps</th>
<th>GP</th>
<th>DE</th>
<th>Dietician</th>
<th>Psychologist</th>
<th>Podiatrist</th>
<th>Exercise physiologist</th>
<th>Pharmacist</th>
<th>Supermarket tour</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>9</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>
“Quite a few members have struggled with their own GPs in terms of giving the support and encouragement and direction I guess that they needed and in fact a couple of them have finally bitten the bullet in the last few meetings and decided to go to another practitioner and have actually found that to be a positive move, .............. for some people that’s been really difficult as they’ve been with the GP for most of their life and to have to make that move is quite a difficult thing to do but with support from the group members are realising it has been for their own benefit.”
Ongoing sustainable groups

- Six groups wish to continue meeting, five of which are from regional locations
  - Most will invite new members to join, talked about sustainability and need for new ideas and experiences

- Several have established close integration and support from the local community health services.
  - Program to supplement and support their management strategies relieving demand on scant public resources for self-management assistance
  - Provide advice and clinical support to group members at meetings and thus increase the reach of their clinical advice to a wider audience.

- Diabetes Australia – Vic has undertaken to support groups who wish to continue meeting
  - Group funds & public liability insurance, promote continued use of regular teleconferences between leaders and opportunities for them to mentor new leaders
Challenges

- Recruitment of peer leaders and participants
  - Use of registry helpful to identify potential participants
  - Mail recruitment strategy yielded approximately 8% response rate with 4% successful enrolment rate

- Goal setting and follow up actions in group meetings
  - Leaders need to understand behaviour change before they can support it

- Participation of local health providers at meetings
  - Evening meetings = payment or agreed time in lieu from employer

- Tracking intervention fidelity and outcomes of group meetings
  - Goal setting/achieving/problem solving
  - Contact record submission by leaders
Conclusions

- **Group meetings**
  - Discussed and promoted key behaviours for effective diabetes self management strategies
  - Community based group
    - Facilitated linkages and relationships with local health providers
    - Support community based activities
    - Provide social and emotional support to members

- **Additional resources**
  - Education manual, participant workbook provided up to date information for access during group meetings
  - Website provided additional information based on requests from participants as well as education vignettes for review and revision

- **Regular teleconference support of the peer leaders may increase sustainability of the groups**

- **Organisational involvement of Diabetes Australia – Vic enhances wider community based opportunity for scaling up of the intervention**
Reciprocal Cooperation between Peer Supporters and Community Health Centers in China

Dr Zhong Xuefeng
Institute of Health Education, Anhui
CDC
Project Objectives

• To evaluate feasibility of peer support group approach for individuals with type 2 diabetes in community settings in Anhui province, China

• To evaluate effectiveness of peer support approach for individuals with type 2 diabetes self-management practices
- Total population 68.62 million (2010).
- Area: 139,600km²
- 105 counties and 17 main cities
Overview of Program & Evaluation

• a community randomized controlled trial study in three sub-community, three cities in Anhui Province, China

• **726** eligible participants with type II diabetes being recruited from CHC diabetes-managed records

• **365** intervention group, **351** comparison group

• **19** peer group were organized and based on buildings/complexes

• **19** peer supporters were nominated/recruited by CHC

• groups consisted of **10 to 15** individuals
Program outline

726 individuals with type 2 diabetes have been recruited by CHC for the evaluation trial.

365 patients recruited to 19 peer support groups (Intervention Condition).

19 individuals with type 2 diabetes were recruited as Peer Supporters/Group leaders.

Program outline
Characteristics of peer supporters

- retired people (100%)
- average age 64 years old
- 84.2% of them are males (16/19)
- 100% have middle or high educational level
- suffering diabetes average age 9.3 years
- good communication skills (1/3 of them used to be teachers/administration staff/health worker/salesman)
- compliance to community health professionals and workers
- 36% of them used to be leader before retired
- have positive personality and be social
- to be volunteer, no pay
Peer support intervention

- a community-and primary care-based model
- face to face meetings/activities twice per month
- group meeting/activities co-led by CHC staff and PS (peer group leaders) monthly
- sub-group informal meeting/activity (Taji group, Fishing, shopping, jogging) led by peer group leaders at unscheduled time (daily or weekly)
PROGRAM DELIVERY

PEER GROUP MEETING/ACTIVITIES

CHC
- co-led meetings
- providing clinical cares
- facilitating activities
- led sub-group activities

PEER SUPPORTER
- co-led meetings
- link group members with CHC

4 KEY OUTCOMES:
- Daily self-management
- Social and emotional support
- Linkages to primary care
- Ongoing support

- Learning problem solving skills
- Getting knowledge
- Sharing experience
- Modeling
- Verbal persuasion and encouragement
- Closed relationship
How the 4 key functions of peer support were delivered?

1. Assist with daily self-management
   - get information and leaning new skills about self-management
   - learn good modeling from group members
   - sharing experience of daily self-management
   - sub-group activities (exercises and shopping, food)

2. Provide social & emotional support
   - “second-home” / “common language” and could talk about their feelings and concerns
   - "group belongs"/"social belongs", feel helped and supported each other
   - "encouraged by peer supporters and group members when felt depression and stress"
3. Link to clinical care

- peer supporters become bridge of CHC and diabetes patients in the community
- CHC providing clinical services based on peer group member needs (discussion in group meeting)

4. Ongoing support (after 6 months)

- sub-peer group keep activities
- PS keep closed relationship with CHC staffs
- CHC continue to provide clinical services to patients based on their needs proposed through PS
Results
1. Self-management

Diabetes self-management practices

1. Healthy diet
• The mean score increased 0.44 and -0.53, sig. (P<0.01)

2. Physical activities
• The mean score increased 2.22 and 1.03, sig. (P<0.01)

3. Monitoring glucose
• The mean score increased 0.27 and -0.79, sig. (P<0.001)

4. Medication adherence
• The mean score increased 1.11 and 0.37, no sig. (P>0.05)
2. Psychosocial factors

Psychosocial factors

1. Knowledge
   • Mean score increased 1.57 and 0.75, sig. (P<0.01)

2. Attitude
   • Mean score increased 8.0 and 7.5, no sig. (P>0.01)

3. Self-efficacy
   • Mean score increased 2.42 and 1.32, sig. (P<0.01)

4. Social support
   • Mean score increased 2.15 and 0.21, sig. (P<0.01)
3. Emotional support

Qualitative evaluation outcome:
A 61 year old woman commented,
“...I became sick two years ago, and when I found out I had diabetes, I felt upset, and thought that my life was meaningless. When I joined the peer support group, I discovered that many people had the same illness as me, and some people in our group had been living with diabetes for more than 20 years. They lived very well, and now they are more than 80 years old, so it encouraged me to believe that I too can live a long and healthy life if I can control my blood sugar and manage my life suitably.” (Chao Jin-lan, female, housewife, 61 years old, Da Qiong community)
4. Clinical outcomes

1. BMI
   • The mean score decreased 1.12 and 0.16

2. Systolic blood pressure (SBP)
   • The mean score decreased $-2.59 \pm 7.89$ and $-1.03 \pm 10.2$, sig. (P<0.01)

3. Fasting Plasma Glucose (FPG)
   • The mean score increased -0.99 and 0.06, sig. (P<0.05)

4. Two-hour postprandial plasma glucose (2hrPPG)
   • The mean score increased -0.96 and -0.15, sig. (P<0.05)
Conclusions

• The results demonstrate that, when adapted, PLSP is culturally acceptable and feasible in China when delivered according to a community-and primary care based model and integrated into the routine of community government organizations and community health services.
Future Challenges

• How to deliver this model to China rural areas?

• How to use group peer support for young individuals with diabetes?

• CHC capacity building

• How to integrate into the routine of health organizations(such as CDC) and community primary health services?
Acknowledgements

This project was conducted in partial fulfillment of the requirements for the doctoral degree in health education and behavior science at Mahidol University in Bangkok. Dissertation chairs were: Profs. Chanuantong Tanasugarn and E. Fisher

Administration organization (funder): Anhui Provincial Bureau of Health

Executive organization: Health Education Institute of Anhui Provincial Center for Disease Prevention and Control

Partner organizations:
- Hefei Municipal Bureau of Health
- Hefei City's Center for Disease Prevention and Control
- Heyidi Community Health Service Center
- District Bureau of Health, District CDC
- Tongling Municipal Bureau of Health
- Tongling City's Center for Disease Prevention and Control
- Yangguan Community and Rendong Community Health Service Station
- District Bureau of Health, District CDC
- Bangbu Municipal Bureau of Health
- Bangbu Center for Disease Prevention and Control
- Daqing Community Health Service Center
- District Bureau of Health, District CDC
The ENCOURAGE Study: Implementation of a volunteer diabetes peer support intervention in rural Alabama

Andrea Cherrington, MD MPH
Assistant Professor, Dept of Medicine
University of Alabama, Birmingham
SBM: April 11, 2012
ENCOURAGE Study -Overview

• Group randomized controlled trial in rural Alabama
• Determine the effectiveness of a volunteer peer support + education vs. education alone in improving diabetes outcomes
• Outcomes: A1c, health-related quality of life, cost effectiveness
Residents: 86,614
54% female
72% African American
Median household income $25,563
31% residents live below poverty line
1 in 3 adults > 50 have diabetes
Health care access is limited
- One Certified Diabetes Educator
Large variation between practices
- Size, staff & services
Peer Support Intervention

1. Assist with daily self-management
   - Weekly telephone calls for 8-12 weeks
   - Emphasis on setting “SMART” goals, problem solving & overcoming barriers

2. Social & emotional support
   - Active listening to provide emotional support, encourage participants to engage social network

3. Link to clinical care
   - “Raise the BAR (Be prepared; Ask and learn; Reflect and reach out)” on your health care provider office visit

4. After 8-12 weeks, monthly calls to provide ongoing support

www.peersforprogress.org
<table>
<thead>
<tr>
<th></th>
<th>Overall N = 424</th>
<th>Intervention n = 198</th>
<th>Control n = 226</th>
<th>p-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c, %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean ± SD</td>
<td>8.0 ± 2.0</td>
<td>8.1 ± 2.1</td>
<td>7.9 ± 1.9</td>
<td>0.32</td>
</tr>
<tr>
<td>HbA1c ≥ 7.0%, n (%)</td>
<td>61%</td>
<td>62%</td>
<td>60%</td>
<td>0.79</td>
</tr>
<tr>
<td><strong>Age, years</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mean ± SD</td>
<td>59.6 ± 12.8</td>
<td>59.4 ± 12.2</td>
<td>59.8 ± 13.3</td>
<td>0.74</td>
</tr>
<tr>
<td><strong>Gender, n (%)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>24%</td>
<td>21%</td>
<td>27%</td>
<td>0.20</td>
</tr>
<tr>
<td>Female</td>
<td>76%</td>
<td>79%</td>
<td>73%</td>
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<tr>
<td><strong>Race</strong>, n (%)</td>
<td></td>
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<tr>
<td>African American</td>
<td>87%</td>
<td>95%</td>
<td>80%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Caucasian</td>
<td>13%</td>
<td>5%</td>
<td>20%</td>
<td></td>
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<tr>
<td><strong>Education, n (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>30%</td>
<td>32%</td>
<td>28%</td>
<td>0.06</td>
</tr>
<tr>
<td>GED‡, high school, or 12th grade</td>
<td>44%</td>
<td>47%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>More than high school</td>
<td>26%</td>
<td>21%</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Annual Household Income, n (%)</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>&lt;$10,000</td>
<td>34%</td>
<td>37%</td>
<td>32%</td>
<td>0.03</td>
</tr>
<tr>
<td>$10,000-$20,000</td>
<td>18%</td>
<td>19%</td>
<td>17%</td>
<td></td>
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<td>$20,000-$30,000</td>
<td>15%</td>
<td>13%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>&gt;$30,000</td>
<td>18%</td>
<td>13%</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Don’t know, refused, missing</td>
<td>14%</td>
<td>18%</td>
<td>11%</td>
<td></td>
</tr>
</tbody>
</table>
Evaluation of Peer Support

- Contact logs
  - To capture number of contacts & content
- Qualitative feedback from peer advisors
- Questionnaires at 6 and 12 months
Contact Logs

- 2410 Contact logs received
  - Range 0-58, median 12
  - 160 office visit forms

- Categories for first goals set
  - Diet, Exercise, or Diet & exercise, 50%
  - Weight loss, 35%
  - Stress management, 8%
  - Medication Adherence, 3%
  - Doctor’s Visit, 2%
  - Other, 2%
    (monitor blood sugar, quit smoking, eye care)

61% of the goals set met 3 to 4 of the four SMART criteria

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Results – “Daily Management”

<table>
<thead>
<tr>
<th>Has your peer advisor…</th>
<th>not at all</th>
<th>little</th>
<th>moderate amount</th>
<th>great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>…asked you what would be helpful to you in managing your diabetes?*</td>
<td>7%</td>
<td>11%</td>
<td>29%</td>
<td>53%</td>
</tr>
<tr>
<td>…helped you set specific goals to manage your diabetes?*</td>
<td>11%</td>
<td>13%</td>
<td>24%</td>
<td>52%</td>
</tr>
<tr>
<td>…helped you learn skills or improve your skills to achieve your goals?**</td>
<td>7%</td>
<td>15%</td>
<td>27%</td>
<td>51%</td>
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</tbody>
</table>

*N = 143, missing = 55

**N = 142, missing = 56
## Results – “Emotional Support”

<table>
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<tr>
<th>Has your peer advisor…</th>
<th>not at all</th>
<th>little</th>
<th>moderate amount</th>
<th>great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>…helped you solve problems that arise in managing your diabetes?</td>
<td>10%</td>
<td>15%</td>
<td>27%</td>
<td>48%</td>
</tr>
<tr>
<td>…helped you figure out how to deal with stress?</td>
<td>18%</td>
<td>14%</td>
<td>22%</td>
<td>46%</td>
</tr>
<tr>
<td>…helped you become confident to manage your diabetes?</td>
<td>10%</td>
<td>12%</td>
<td>25%</td>
<td>53%</td>
</tr>
</tbody>
</table>

*N = 143, missing = 55*
## Results – “Social Support”

<table>
<thead>
<tr>
<th>Has your peer advisor…</th>
<th>not at all</th>
<th>little</th>
<th>moderate amount</th>
<th>great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>...helped you get support from family?*</td>
<td>20%</td>
<td>13%</td>
<td>19%</td>
<td>48%</td>
</tr>
<tr>
<td>...helped you get support from friends?*</td>
<td>20%</td>
<td>17%</td>
<td>18%</td>
<td>45%</td>
</tr>
<tr>
<td>...helped you get support from others?**</td>
<td>20%</td>
<td>17%</td>
<td>19%</td>
<td>44%</td>
</tr>
</tbody>
</table>

*N = 143, missing = 55

**N = 141, missing = 57
## Results – “Linking to Care”

<table>
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<th>Has your peer advisor…</th>
<th>Not at all</th>
<th>little</th>
<th>moderate amount</th>
<th>great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>...encouraged you to get regular diabetes care?*</td>
<td>7%</td>
<td>8%</td>
<td>24%</td>
<td>61%</td>
</tr>
<tr>
<td>...helped you get the care you need from doctors and nurses?**</td>
<td>12%</td>
<td>15%</td>
<td>23%</td>
<td>50%</td>
</tr>
<tr>
<td>...helped you find other resources in your community to help you take care of your diabetes?**</td>
<td>25%</td>
<td>12%</td>
<td>19%</td>
<td>44%</td>
</tr>
<tr>
<td>...helped you communicate effectively with your doctor or nurse about your diabetes?**</td>
<td>12%</td>
<td>12%</td>
<td>19%</td>
<td>57%</td>
</tr>
</tbody>
</table>

*N = 142, missing = 56

**N = 143, missing = 55
Ongoing support

- 68/198 participants had 16 or more contacts
  - Typically turned in 1 form per week
  - Range was 0 to 58, median 12
- Number of contacts (and perhaps duration of support) depended on whether individuals knew each other previously or not
Support & prior relationship

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First time meeting</td>
<td>59%</td>
</tr>
<tr>
<td>Family member</td>
<td>4%</td>
</tr>
<tr>
<td>Neighbor</td>
<td>5%</td>
</tr>
<tr>
<td>Friends &gt; 5 years</td>
<td>16%</td>
</tr>
<tr>
<td>Friend 5 years or less</td>
<td>6%</td>
</tr>
<tr>
<td>Acquaintance</td>
<td>9%</td>
</tr>
</tbody>
</table>

N = 161, missing = 27

Mean # of contacts
11 if no prior relationship vs.
14 if prior relationship (p=0.01)
Challenges

• Contact forms don’t always reflect what did or did not occur in an encounter
  – May not capture emotional support provided “off topic”

• Many participants did not move to 2\textsuperscript{nd} goal
  – More emphasis on intensifying intervention & monitoring
  – Specific barriers to diet & physical activity

• Difficult to link to community resources
  – Depends heavily on what is available, this varies by region
## Linking to Care by Area

<table>
<thead>
<tr>
<th>Has your peer advisor…</th>
<th>Area 1</th>
<th>Area 2</th>
<th>Area 3</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>...encouraged you to get regular diabetes care?</td>
<td>57%</td>
<td>64%</td>
<td>57%</td>
<td>.423</td>
</tr>
<tr>
<td>...helped you get the care you need from doctors and nurses?</td>
<td>36%</td>
<td>56%</td>
<td>50%</td>
<td>.385</td>
</tr>
<tr>
<td>...helped you find other resources in your community to help you take care of your diabetes?</td>
<td>29%</td>
<td>52%</td>
<td>43%</td>
<td>.331</td>
</tr>
<tr>
<td>...helped you communicate effectively with your doctor or nurse about your diabetes?</td>
<td>45%</td>
<td>62%</td>
<td>57%</td>
<td>.587</td>
</tr>
</tbody>
</table>

Area 1 = Western Black Belt  
Area 2 = Southern Black Belt  
Area 3 = Central Black Belt
Challenges

• Sustainability & Scaling up
  – Need reliable funding stream to support formal, ongoing peer support programs
    • To date, programs have been largely research grant funded
    • Potential funding for CHWs through the Affordable Care Act promising
  – Limited resources & staff combined with unfamiliarity with peer support programs present challenges for integration of this model with clinical care
The Encourage Team

- Monika Safford, MD, PI
- Andrea Cherrington, MD, Co-PI
- Jewell Halanych, MD; Michelle Martin, PhD; Annette Wright, RN, PhD
- Susan Andreae, Lynn Andreae, Marquita Lewis
- Debra Clark, Ethel Johnson, Sheree Stallworth
- Our peer volunteers
- Our participants
- Numerous Black Belt community businesses and groups who supported the study through donations of space, time and enthusiasm