NATIONAL PEER SUPPORT
Collaborative Learning Network

APPROACHES AND CHALLENGES TO INTEGRATING PEER SUPPORT AND PRIMARY CARE SERVICES

An Issue Brief Analyzing Integration of Peer Support and Primary Care

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# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACA</td>
<td>Patient Protection and Affordable Care Act</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>DSM</td>
<td>Diabetes Self-Management</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>LHA</td>
<td>Lay health advisor</td>
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<tr>
<td>PCMH</td>
<td>Patient Centered Medical Home</td>
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<tr>
<td>PS</td>
<td>Peer support</td>
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<tr>
<td>Pser</td>
<td>Peer supporter</td>
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<tr>
<td>PDSA</td>
<td>Plan, Do, Study, Act</td>
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<tr>
<td>QALY</td>
<td>Quality Adjusted Life Year</td>
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<tr>
<td>ROI</td>
<td>Return-on-Investment</td>
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I. Background & Purpose

Peer support (PS) is defined as practical, social, and emotional support services that are provided by those who share similar characteristics with those who access the services. Increasingly, PS is intentionally fostered within formal interventions to manage, maintain, or encourage healthy behaviors. Community Health Workers (CHWs), lay health advisors (LHAs), patient navigators, advocates, and promotores de salud are different titles for peer supporters (PSers).1 Some of them perform important functions in community-based programs, clinical settings, or in a combination of both. Through the development of technology, they can also provide support via phone, text messaging, or internet.2

PS is a critical and effective strategy for ongoing health care provision and sustained behavior change for people with chronic diseases and conditions.3,4,6,7,8 When integrated with clinical care, PS programs can reduce use of costly health care services (e.g., emergency department, inpatient stay) and increase utilization of preventive and primary care services.9 Moreover, examples, like those found in the Diabetes Initiative of the Robert Wood Johnson Foundation, demonstrate the potential cost-effectiveness of PS. In the analysis, the cost per Quality Adjusted Life Year (QALY) was $39,563, well below the criterion for good value of $50,000 per QALY.10

In recent years, the U.S. health care system has begun shifting its strategy to be more preventive and primary care focused and promote the uptake of Patient Centered Medical Homes (PCMH).11,12,13 This emerging trend emphasizes patient-centeredness as a key strategy for better care by actively engaging patients in their own medical care.14 The Institute of Medicine (IOM) defines patient-centeredness as: “Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.”15 However, the scope of patient-centered care has evolved from simply improving communication between individual practitioners and their patients to include comprehensive delivery of health services.16 In many cases, PS programs have been used to promote and enhance patient empowerment and engagement, two major characteristics of patient-centered care. Thus, the integration of PS and primary care services provides a route to improve delivery of care.

The passing of the Patient Protection and Affordable Care Act (ACA) in 2010 further encourages integration of PS with primary care services and overall treatment. Specifically, the ACA enables the use of CHWs to reach medically underserved populations through its funding of community health centers and PCMHs, as well as other health and preventative services.17 However, there is little documentation of integration pathways (e.g., process and tools), presenting and analyzing both the costs and benefits of integration, as well as addressing organizational and system factors and how to overcome associated challenges. This issue brief intends to highlight common barriers, facilitators, and considerations to integrating PS and primary care, as well as showcase how some organizations have already done so. The issue brief identified close to 20 PS programs that have attempted to integrate PS and primary care services. Four programs describing integration are detailed and featured throughout the main sections. It is our hope that these lessons learned can be beneficial to those who are in the process of, or interested in integrating PS and primary care.
Roles, Responsibilities & Key Characteristics of Peer Supporters

Roles and responsibilities of PSers vary depending on the contexts (e.g., culture, resource, policy) as well as characteristics of the populations they serve. Focusing on the shared functions of PS offers a means of allowing systematic examination while understanding the need for local tailoring and flexibility in implementation. Peers for Progress, a program of the American Academy of Family Physicians Foundation, and colleagues of its funded projects around the world have identified four key functions of effective PS. The functions are assistance in daily management, social and emotional support, linkage to clinical care and community resources, and ongoing availability of support.18 Table 1 summarizes the four studies selected and describes what the four key functions look like in each setting. Interestingly, three of the four programs mainly serve Latino/Hispanic populations. This coincides with a widespread adoption of PS in Latino/Hispanic communities. However, Peers for Progress has found that PS can be effective among a wide range of populations in both international and US-based settings.18,19

Notably, a fundamental characteristic of PSers is the supporters’ proximity to and affinity with the target population. In some cases, PSers are individuals who have the same diagnosis as the recipient of an intervention. In other cases, PSers are chosen because they have learned how to manage their condition effectively and are ready to receive training to provide support to others.20,21 Regardless of the reason, PSers are usually chosen because of their demographic resemblance to the intended audience of an intervention, such as a shared linguistic or cultural background or neighborhood residence.22 Through their shared characteristics, PSers understand the context in which a given population performs health behaviors and are able to help people to overcome barriers to accessing health services and managing their disease. Once integrated with multidisciplinary teams in clinical settings or in communities, PSers can potentially serve as change agents within organizations and communities. They bridge the community-clinical divide by bringing knowledge of community culture and context to decision-makers, resulting in system changes that improve the quality and effectiveness in the delivery of health services.23-25

Given the diverse characteristics and roles of PSers, it is no surprise that there are numerous ways that they are integrated in primary care settings. Some PSers are integrated into the clinical care team, helping patients implement clinical care plans after a visit with a provider or providing health education as part of a regular clinical visit. When integrating PS and clinical practices, the roles of PSers should be clearly defined so as to set realistic expectations for their work and avoid scope of practice conflicts.26
<table>
<thead>
<tr>
<th>Settings</th>
<th>Federally Qualified Health Center (FQHC) in Rural Oregon (La clinica del Carino); PCMH.</th>
<th>5 different Network Diabetes Program (NDP) clinics around Chicago</th>
<th>Inner-city primary care clinic in Minneapolis, Minnesota</th>
<th>Community health center located along the Texas-Mexico border; underserved with high poverty rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance in daily management</td>
<td>Help with individual care plans, action plans, needs assessment</td>
<td>Reinforce clinical instructions and apply physician instructions to diabetes self-management (DSM) behaviors</td>
<td>Assist with applying self-management (e.g., provide education about care, set goals)</td>
<td>Conduct self-management classes according to the curriculum; assist with goal setting and problem solving</td>
</tr>
<tr>
<td>Social and emotional support</td>
<td>Perform active listening; provide warm handoff between the patient and the providers; provide different intensity of support during the follow up to meet individual needs</td>
<td>Act as “cultural bridges” and clarify misunderstanding</td>
<td>Provide culturally-sensitive services; encourage patients to share some things that they are reluctant to tell their doctors</td>
<td>Provide culturally-sensitive services</td>
</tr>
<tr>
<td>Linkage to clinical care and community resources</td>
<td>Assist with accessing community, internal resources, social services, transportation, etc.; assist with recall system (e.g., schedule appts, med adherence and refills)</td>
<td>Emphasize importance of keeping appts, reinforce instructions from physicians</td>
<td>Review information shared by physicians during medical appointments; improve patient contact with provider</td>
<td>Report patient responses and/or symptoms</td>
</tr>
<tr>
<td>Ongoing availability of support</td>
<td>Perform home and hospital visits, telephone contacts</td>
<td>Not specified</td>
<td>Provide flexible contacts (check-in through telephone or in-person) that are set between PSers and patients</td>
<td>Not specified</td>
</tr>
<tr>
<td>Populations</td>
<td>Primarily Latino migrant workers</td>
<td>Limited-English proficient (LEP) Latino</td>
<td>Diverse population (a mix of Black, White and other races based on self-identified race survey) with various immigrant groups</td>
<td>Primarily low-income Latino/Hispanic</td>
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</table>
III. Organizational Factors & Impacts on Integration

Integrating PSers into primary care services is an innovative strategy. While there is no one-size-fits-all model for integration, a few programs document key strategies to facilitate a successful integration process (Table 2). From the four studies highlighted here and other research identified, we suggest four organizational factors to consider when integrating PS and primary care: motives for integrating care, administrative support, clinical staff buy-in, and team-based climate.

Motives for integrating care

Adopting a new health care delivery model is challenging and can be disruptive in the short term. One way organizations are encouraged to integrate PS with clinical care services is through motivating factors; financial incentives and improved quality of care are important driving forces for motivating change.

Financial incentives often center on reimbursement and cost savings. In addition to ACA funding opportunities for PS programs and services, a few states have also made CHW services Medicaid reimbursable. Evidence of return-on-investment (ROI) also motivates adoption and integration of PSers with clinical settings. While little data exists about the direct cost savings of PS programs, as mentioned earlier, there is evidence that these programs can reduce hospitalizations, visits to specialists, and costly emergency department visits.

Improved quality of care as a motivating factor impacts both individuals and populations. From an individual perspective, PS programs can improve clinical outcomes, such as blood pressure, cholesterol, hemoglobin A1c and BMI and self-management behaviors, such as at home glucose testing for diabetics and medication adherence. From a population perspective, organizations are recognizing PSers’ unique abilities to reach those who could benefit most but are not engaged in services. PSers are especially effective at reaching the “hardly reached” or those who lack adequate access to healthcare because of cultural, linguistic, social and/or economic barriers. For example, benefits of a peer health coach program for adults with diabetes in San Francisco, CA, were most pronounced for those who reported low medication adherence at the start of the program. A recent study conducted in Michigan also showed that low health literacy at the beginning of a dyadic, or one-on-one, support program for veterans with diabetes was associated with greater improvement in glycemic control.

Administrative support

Obtaining support and buy-in from the management level is critical to the success of PS programs and their integration with primary care. Overall, administrative support provides the type of leadership needed for integration, secures resources, establishes protocols, policies and procedures, as well as communicates, advocates, and facilitates buy-in from clinical staff. For example, management must be involved to determine and approve costs for space, trainings, and compensation for PSers. Management governs placement of the PSer as an employee or volunteer, which may influence clinical staff acceptance and expectations of the PSer. Management can also determine the best strategies for reimbursement and charging for services and assess financial benefits of PS programs. Furthermore, management should ensure appropriate supervision and
backup for PSers. Placing the PSer under the supervision of a nurse or other appropriate personnel clarifies a chain of command and provides a source of support and additional training.36

**Clinical staff buy-in**

Once the executives of a health care organization are motivated to initiate the integration of PS with primary care services, the next critical step is obtaining the buy-in of physicians and other members of the clinical team. This can be especially challenging since many health care organizations function as “professional bureaucracies” where decision-making is decentralized into departmental silos where highly trained professionals operate in standardized environments independently from their colleagues, as mentioned above.37-38 This type of organizational structure makes health care settings especially skillful at introducing innovations within a group or department’s responsibility, making it especially difficult to introduce an intervention that cuts across disciplines. Thus, introducing several innovations that require interdepartmental collaborations at once, such as electronic medical records (EMR) and PS programs, can be especially disruptive. Facilitative leadership, which encourages staff to participate in decision-making and problem solving, as well as providing opportunities for staff to provide input such as those described above in Administrative Support can help improve staff buy-in.39

Presenting a summary of evidence-based findings of PS programs to the clinic staff and physicians can capture their attention and begin to add legitimacy to the new approach. Also, data showing trends in client satisfaction, results of community surveys, changes in community advocacy, performance reports of successful PSer referrals, improvement in clinical outcomes in the population, the number of memoranda of understanding (MOU’s) developed with other relevant community-based organizations that were leveraged by PSer, can be shared with the interdisciplinary team to help familiarize them with the many ways in which PSers can contribute to improved patient care.40

Involving clinical providers in the planning, delivery and/or review of PSer training is an effective way to increase clinical staff buy-in. In a program where nurse and provider acceptance of the PSers’ role as patient educators was their “largest hurdle to overcome,” establishment of a working committee of nursing director, certified diabetes educator, physicians and the lead promotor to review the promotores training helped the providers begin to “feel comfortable with the quality of the course and teaching ability of the promotores.”33

Providing regular updates on improvements in clinic performance resulting from PSer activities can increase buy-in of clinic staff over time. Several internal processes to focus on include: increases in percentage of kept appointments, decrease in time providers spend on routine patient education, better navigation of patients through health care system and improvement in culturally- and linguistically-competent health education.27

**Team-based climate**

Another factor vital to integration is inclusion of PSers in a team-based care approach. A team-based approach emphasizes interdependence, care coordination, and parity amongst all members of the clinic team. In a health care system that values “professionalism”, there will be hurdles for the clinic team to accept and recognize PSers being part of the professional “team”. Both the problems and their solutions center on clarity of the PSer’s role, effective team communication, as well as
confidence of the PSer’s ability to help patients and work with other team members. For example, to demonstrate how the PSers interface with patients and other members of the organization (RNs, schedulers, etc.), IOM recommends integrating the peer into the organizational chart, as well as developing pathway flowcharts.\textsuperscript{41} To enhance team communication, PSers should be also included in the setting’s internal communication systems, such as staff meetings and discussions regarding patients. After case presentations, clinic representatives (RNs, nutritionists, PSers, etc.) comment on the medical, social needs, and other care needs of the patient to facilitate open communication, a team approach to care, and optimal patient outcomes. Because reliance on the Electronic Medical Record (EMR) is becoming increasingly relevant to care coordination between members of a team, PSers should have access to the EMR to document relevant information to help other members of the team deliver quality care.\textsuperscript{42-43}

An important consideration is whether or not PSers have the relevant training to operate effectively within a team-based setting. Often, PSers receive training on relevant health content (HIV, diabetes, prenatal care, etc.) and effective strategies for engaging in didactic relationships with patients. While these skills prepare PSers to engage patients, they do not necessarily prepare them to interact with an interdisciplinary team. Beyond content training, PSers also need training on providing team-based care\textsuperscript{26,33} and orientation to their team. It is important to familiarize PSers with standard operating procedures in the clinic setting, including flow of referrals, chain of command, roles of other staff members, and communication methods.

Likewise team-based training also benefits other clinic team members. The team training process can help other team members identify the bridging roles of the PSer within the clinic setting and outside the walls of the clinic. An environment that supports ‘360 degree’ communication and transparency among team members, minimizes territorialism, helps prepare team members to work together, and facilitates communication and coordination of care.
Table 2: Examples of Challenges and Effective Strategies of Integration

<table>
<thead>
<tr>
<th>History of PS programs prior integration</th>
<th>Evidence of integration</th>
<th>Challenge(s)</th>
<th>Effective strategies/Solutions</th>
</tr>
</thead>
</table>
| Two CHW programs had been established for many years but didn’t functions the “new” duties. | PSers as members of the clinical care team via a case management model | The clinic staff didn’t know what PSers did outside of staff’s area of work | ● Creation of patient pathway flowcharts to show the roles of PSers  
● On-the-job training and formal learning experience to help PSers to adopt their new roles and function competently  
● EMR to facilitate patient-PSer and provider communication- a care contract, periodic report card for patients (to be printed), and quarterly report for providers  
● 2 wk training plus ongoing supervision and support by a RN  
● Creation of protocols  
● Careful selection of PSers who have warm, outgoing personalities, as well as can respect privacy issues and practice boundaries | ● Obtain administrative support and resources through separate meetings with administration, providers, and CDEs.  
● Emphasize PSer training by establishing a working committee of key clinical staff and the lead PSer  
● Develop a clear job description for each team member  
● Develop and use progress notes approved by providers and medical records |
| Has a community-based Health Promoter program in the community | Working relationship with healthcare providers; opportunities to provide feedback at monthly staff meetings | Initial training did not prepare PSers to work with providers, thus they reported frustration at first | N/A—Pilot study |
| PSers were employed by the clinic to assist in outreach and community education needs | Physicians’ recognition of PSers’ roles in helping their work; shared goals within the triad of patient, PSer, and provider |
| PSers as educators within the clinic | Providers were skeptical initially |
| Clinical staff initially didn’t accept PSers as educators due to concerns about the lack of quality assurance |

Volkmann K, Castañares T (2011)  
McElmurry B.J et al. (2009)  
Adair R et al. (2012)  
Sixta CS, Ostwald S. (2008)
|--------------------------------------|---------------------------------|-----------------------------|------------------------|-----------------------------|
| **Major outcomes**                   | ● ↑ Satisfaction of ALL participating providers: Clinic efficiency and quality of care  
● ↓ Hospitalization  
● ↓ ED visit  
● ↑ Self-mgmt  
● ↑ Access to care  
● ↑ Self-care behaviors  
● ↑ Blood glucose control  
● ↓ No-show rates. (12%)  
● ↑ % of achieving care goals (i.e., tobacco use, blood pressure, pneumonia vaccination, eye testing)  
● A net savings of $102,065 over 2 years  
● High patient satisfaction  
● 80%+ of doctors and other clinic staff feeling PSers helpful  
● ↑ Providers’ support to patient self-mgmt  
● ↑ Patient understanding and implementation of self-mgmt (i.e., self-report levels of knowledge, skills, ability, and confidence in managing diabetes)  
● Patient DE course retention and graduation rate of 80%  
● High patient satisfaction | | | ● Has clear policy and procedures for documentation, referral and communication  
● Has providers monitor PSer training and program |
IV. Common Facilitators & Barriers to Integration

The four studies highlighted in Table 2 note communication, mistrust, and undefined roles as challenges to integrating PSers within clinic settings and offer potential solutions for addressing these challenges.

**Intra-organizational communication and trust**

Promoting collaboration between PSers and clinical staff may present significant challenges in clinical settings, where non-clinical staff may not be entrusted by providers to provide patient care. The value of PS should be emphasized among administrators and providers when bringing PSers into a clinical context. Staff and providers should be instrumental in creating the process by which the PSers will be integrated, thus facilitating additional buy in and trust. By explaining the specific skills and knowledge that PSers bring to a clinical setting, leaders of PS integration can encourage understanding of ways in which clinical staff can rely on PSers, for example, by drawing on their knowledge of cultural and social factors impacting the community.25

Communication is key when bridging departments that are not accustomed to collaborating. A review of PCMH demonstration projects yielded a concept of “healthy relationship infrastructure” which is characterized by “effective communication and trust.”39 There are various approaches to promoting healthy relationship infrastructure, ranging from strategic hiring of clinical staff members who demonstrate effective communication, to retreats in which staff can focus on building teamwork and trust. Regular, formal case conferences or meetings in which clinical providers and PSers can discuss patient care can help to promote teamwork between PSers and providers.31,36,44 Promoting a climate in which participation and learning are encouraged across departments, employees may feel safer to try out an unfamiliar process without fear of making mistakes.

In addition to regular meetings and case conferences, clinics can develop tools to help facilitate communication and trust-building among members of the extended care team, involving PSers and key members of the clinic staff. The EMR or electronic health record (EHR) can serve as a hub of communication for the care team. Development of a shared care plan with input from the patient, providers and PSers can be a valuable tool for ongoing improvement in care. Adair and colleagues developed several tools within their EMR, including a shared “care contract” signed by the patient, PSer and physician.56 The contract included recommended care goals catered specifically to each patient. Volkman & Castañares also used a patient care plan involving an individualized action plan and ongoing coordination with PSer, physician and nurse.27 This type of shared decision-making can set the stage for building trust and enhancing communication as each person involved has a role in helping to meet the agreed upon goals.

**Clearly-defined roles and responsibilities**

Lack of understanding of the concept of PS and the functions of a PSer can lead to initial mistrust or reluctance in collaborating. Developing carefully defined job descriptions including specific roles and responsibilities for PSers, as well as the other members of the integrated care team, is an important first step in facilitating integration. For example, a program developed to help patients improve diabetes self-management behaviors developed job descriptions for all members of the care team explaining their roles and responsibilities in the diabetes self-management program, which...
included PSers (known as promotoras), a PSer’s supervisor, a provider, a certified diabetes educator, and a nurse/program director. By specifying the roles of the entire care team, all team members can become familiar with the specific skill sets and actions needed to collaboratively provide high quality care to patients. Additionally, it takes the focus off the role of PSer or clinician and places emphasis on the patient’s health and well-being allowing each member of the care team to contribute in their own way. In other words, tools that facilitate communication and coordination of care highlight the complementarity of the role of the PSer related to clinical team members which can reduce territoriality and increase acceptance of the PSer.

In a team-based care environment, a team member’s understanding of the role of the PSer may naturally be limited to the activities in which the team member interacts with the supporter. For example, the scheduler sees the impact on patient scheduling while the nurse sees the changes in A1C levels. Workflow mapping such as patient pathway flowcharts can illustrate the activities of the PSer both inside the clinic setting and in the community, and can therefore help all staff members to better understand the role of the PSer. Workflow mapping also helps clarify how PSers should interact with EMRs as members of the clinical team, as others have used this strategy to delineate PSer responsibilities.

When first integrating PSers and clinicians, one recommended practice is to identify a liaison that is familiar with both the healthcare setting and the PS program. This person can help supervise and support PSers, as well as help to orient them to the new clinical setting. To be effective, the liaison must have a solid grasp of not only the clinical setting but also the community in which the PSer will work. An effective liaison could also help to address concerns and misunderstandings about the role of PSers. As clinical tasks have historically been outside the scope of the PSer role, it is important to consider additional training that PSers will need in order to work more closely with clinical providers.
V. Sustainability of Peer Support in the Provision of Primary Care Services

PSers play an important role in the provision of services in the care of persons with infectious and chronic diseases and/or conditions. PSers also provide support in interventions that include environmental, health systems, and community-clinical linkages for the prevention and control of both chronic and infectious conditions. The need for health delivery systems to provide comprehensive, continuous care in and outside of the hospital and acute settings, with accountability for the populations they serve, warrants a sharper focus on cost savings.\textsuperscript{9,45} For persons with chronic diseases and conditions, continuous care is ongoing, every day, and a fact of life. The continuity and sustainability of services provided by PSers for persons with chronic conditions or any other disease at the community level, or in a primary care setting should become an important aspect of the care process provided in all populations.\textsuperscript{7,8,18,25,46}

The results of the PS projects mentioned previously in this report has drawn the attention of policymakers because of their success in improving health care quality and outcomes, in reducing health care costs, or both (Hacker 2013).\textsuperscript{1} Sustainability as defined for this brief is “the continued use of program components and activities for the achievement of desirable program or population goals.”\textsuperscript{47} To scale up and sustain PSers as an integral part of the primary care workforce, the following are areas that need further research and evidence:\textsuperscript{46,48}

1) Definition and importance of community fit - Currently most PSers are recruited from the community in which they work. How important is this selection criteria to the success of the PSer? How important is community trust in defining fit, how is this achieved and measured?
2) What is the best approach for integrating the PSers in the larger health system (this includes social services). Are there evidence based assessment tools or training tools for achieving this goal?
3) Given the general scarcity of resources, what has proven to be the most successful/effective revenue stream for supporting this category of worker?\textsuperscript{48,49}
4) What are the most effective strategies for improving recognition and the sustainability of the PSer? Who will advocate for the PSer?\textsuperscript{48,50} How can we expand opportunities for PSers to participate in regional, national, and international opportunities to discuss their work?

The development and support for the implementation of viable policy proposals for the scaling up and sustainability of PS interventions should be supported by a strong evidence base in order to achieve full acceptance and integration in the health delivery system.
VI. Considerations & Implications

This section includes our reflections from reviewing the literature on integrating PS and primary care. These reflections summarize key considerations when taking steps toward integration, as well as identify areas for further research and improvement.

- Given current efforts to improve the health of the nation and to reduce the costs associated with achieving this goal, the clinical and public health community should recognize the need to improve communication between the health care delivery system and the populations it serves. PSer is a category of health worker that can bridge this divide. If fully integrated, they can influence changes in the community and in clinical settings to improve the quality and effectiveness of health care delivery.

- Integrating PS and primary care services can be beneficial, although there is no one-size-fits-all approach to do so. The process is rarely easy since integration requires both an organizational change and a shift towards team-based care. PSers and organizational leaders should embrace a collaborative, holistic care model.

- Efforts should be made to maintain the PSer’s proximity to and relationships with the community. A PSer that is working only within the clinic walls may lose some of their effectiveness for working with patients. Additionally, efforts should be made to utilize PSers understanding of community context and social and cultural factors that influence the use of preventive and clinical services. The use of phone-based support or technology, such as mobile applications, can be effective tools for ongoing support and connecting with the community. Strategies to preserve peeriness could include selecting a special name/title for PSers or creating specific goals to leverage the value of this peer relationships. When taking steps toward integration, consider a flexible quality or performance improvement model that allows for real-time monitoring and revision, such as Plan, Do Study, Act (PDSA) or rapid-cycle quality improvement. Documenting the process and major outcomes ensure accountability, timely trouble-shooting and problem-solving, and knowledge management of “what works”. Due to the nature of change, expect resistance and frustration, but seek and celebrate “small wins” while ensuring that champions of the integration process continually communicate with the team. To overcome hurdles, it is important that management and associated leaders and provider champions/liaisons consistently recognize and reinforce the complementary roles between clinical staff and PSers. Throughout the process, it is critical to provide opportunities for direct communication and problem-solving. Neither clinicians nor PSers alone can provide all of what the patient needs to be healthy.

- As mentioned in the earlier sections, government reimbursement and cost-savings/effectiveness are often financially motivating factors for integration. Although ACA encourages integration of PS and primary care services, a need for clarification regarding the funding streams by the government and other third party payers exists. Demonstration projects throughout the nation are starting to produce tangible outcomes for cost savings and reimbursement reform. Additionally, the adoption of integration services may be hindered by the shortage of detailed operational costs as well as the structuring of staffing models (e.g., employee, volunteer or a blend of both). For example, among the four studies
highlighted in the tables, only the one by Adair and colleagues gave an estimated a cost of $392 per patient per year which only included PSer salaries and benefits plus a small amount of direct supervision. In other cases, operational costs may include space, training, and even staff time from other clinical staff. Costs can vary over time due to different stages of development into the integration model. Further research and practice reports should closely document and examine costs as well as associated benefits that better evaluate and sustain such efforts.

- In evaluating the effectiveness of PSers, the public health and clinical community should come together to develop measures that are relevant to both clinicians and the public health community. More studies are needed to develop and implement the appropriate measures and indicators for measuring the effectiveness of PSers and related services provided by the organization.

- More research needs to be done to identify the indicators of the successful/effective management or supervision of PSers. a) Should they be supervised by a clinical, community-based or an independent entity? b) Should there be core competencies, a minimum/national standard, for the training and certification of PSers? c) What role could relevant government departments play in defining standards for certification of PSers?

- PSers are not in place to replace the roles of independent practitioners. Therefore, they need and appreciate ongoing support and supervision such as continuing education and on-the-job training. Evidence by Kash and colleagues also suggests that on-the-job training is linked to improved retention rate. However, lack of time and educational readiness are common barriers to workforce development. Primary care practices should assess what supports PSers need and ensure that they are able to provide that support.

- Team-based care and organizational culture are critical for integrating PS and primary care. In addition to the needs for more research on training and certification of PSers, there is also need for research and discussion on organizational capacity to utilize and support PS related activities. An open question remains as to whether this should be done through establishing national guidelines or organizational certification criteria.
References


