

A Controlled Evaluation of the Australasian Peers for Progress Diabetes Program (PfP-DP) and Its Transferability to Other Countries

Brian Oldenburg, PhD
School of Population and Global Health
University of Melbourne

and

Formerly,
School of Public Health and Preventive Medicine
Monash University
Melbourne, Australia

The Australasian Peers for Progress Diabetes Program aims to deliver peer support in a community-based group support model. This cluster randomized controlled trial was designed to evaluate the effects of a peer-led program on improving daily management, social and emotional support, and linkage to clinical care for people with type 2 diabetes.

Population & Setting

English-speaking adults with type 2 diabetes living in 1 of 36 specified postcode (zip code) locations in Victoria, Australia.

Who Are the Peer Supporters?

The National Diabetes Services Scheme (NDSS), administered by Diabetes Australia on behalf of the Australian Government, is a national database of Australians diagnosed with diabetes. The NDSS, through Diabetes Australia-Vic (DA-Vic) was used to identify individuals who: a) had been enrolled in the database for more than 12 months, b) indicated a willingness to be contacted for research purposes, c) resided in one of the selected locations, and d) was between the ages of 25 and 75. Potential participants were invited by mail to contact the project team if interested in receiving more information about participating in the study as a peer supporter or as a group member. General Practitioners, community health centres, pharmacies, diabetes clinics, podiatrists,

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living

Peer leaders encouraged group activities, such as walking and exercise classes; a password protected website offered vignettes from self-management education sessions

Social/Emotional Support

Peer leaders provided support outside of meetings via telephone, email, or face-to-face

Linkages to Care

Peer leaders organized group meetings with health care professionals; meetings were driven by group needs

Ongoing Support over Time

Several peer support groups will continue meeting past the intervention period and have established close integration and support from local community health services

optometrists and any active DA-Vic community network group, or other community-based groups within the selected locations were also targeted with posters and brochures to increase study exposure. A total of 285 participants were selected to participate in the study and were randomized by their neighbourhood to a peer support intervention or usual care. Eighteen peer leaders were successfully trained for the intervention.

Peer Supporter Training and Quality Assurance

Peer leaders were given a resource manual and trained over two and a half days by a credentialed diabetes nurse educator experienced in group facilitation training. Training aimed to equip leaders with communication and group facilitation skills so they could help their group members share their stories, set goals, problem solve, increase awareness and linkages with the available health system, optimize self-management behaviours (including glucose monitoring, dietary changes and physical activity), and also provide emotional support. Peer leaders were supported during the intervention period through weekly teleconferences with the project staff, including diabetes educators, dieticians and psychologists. They also received a weekly informational e-newsletter. Peer leaders were asked to attend at least one supportive peer group teleconference with the project staff each month for organizational and informational support, and also as an opportunity for peer leaders to provide experiential, emotional and social support to each other.

Peer Supporter Roles & Responsibilities

One or two peer leaders met once a month with groups ranging from 7-14 participants for a period of 12 months. Meetings were 90 minutes in length and took place within a local community setting. Additional contact in between meetings was encouraged; some groups participated in routine walks, group tai chi classes, or met for coffee. Peer leaders actively followed up with participants who did not attend the monthly meeting.

Unique Features or Strengths

Prior to randomization, all study participants and peer leaders received 1 day of basic diabetes education to account for a lack of basic diabetes knowledge and self-management principles among a number of participants. A dedicated education program was developed in association with credentialed diabetes educators from DA-Vic and delivered to as many participants as possible. The 7-hour program covered basic disease information, good self-management practice including diet and physical activity, disease complications and medications, and included a project-specific education manual. A DVD incorporating video excerpts from the education day along with additional

TRAINING SUMMARY

Duration: 2½ days

Content:

- Setting the scene
- PfP support groups
- Story telling & communication skills
- Goal-setting
- Review goals & problem solving
- Linkage to clinical care
- Group facilitation
- Ethics & self-care
- Peer leader roles & responsibilities
- Putting it all together
- Working with the research group

Approach: Knowledge acquisition, skills building, & role playing

Evaluation: Peer supporters' suitability further assessed during the interactive sessions by training facilitator

Language: English

information and key messages was developed and provided to all participants who were unable to attend a formal education session in-person.

Major Challenges & How They Were Addressed

- **Reach and engagement:** Soon after support groups began meeting it became clear that getting accurate information from group leaders could be problematic. To accurately and effectively measure what happened during group meetings, the intervention was adapted to a real-world setting with more focus on supporting peer leaders through teleconferences, providing group meeting report templates for simply recording group meeting activities, and sending a weekly e-newsletter with a reminder about reporting. This approach aimed to engage the leaders more supportively and enabled the research team to record teleconferences in order to hear how the group was connecting. The peer leaders also “met” regularly every month via a conference call to review their progress and to problem solve issues that were identified by each of the participants; these calls were supported by the project team, however, the agenda and input for the majority of the calls were provided mainly by the participants.
- **Basic diabetes education:** During pilot training of the peer leader program, it was noted that basic diabetes education and knowledge of diabetes self-management principles were lacking among many participants. In order for intervention groups to provide support, rather than focus on filling the wide knowledge gap, participants received 1 day of basic diabetes education. Those who were unable to attend the face-to-face meeting were sent the education manual and a DVD resource featuring footage from the actual education session supplemented with visual material to reinforce diabetes self-management education messages.

LESSONS LEARNED

- Although collecting real time data requires more frequent follow-ups and dedication, it provides more accurate information
- Group teleconferences and occasional face-to-face meetings are essential for keeping peer leaders engaged & enthusiastic
- Diabetes specific education, including self-management education, is an integral aspect of participant recruitment

Key Results & Major Accomplishments

Eleven of the 12 planned intervention groups continued for the entire trial period. The majority of recruited participants were already quite well controlled with a mean HbA1c of 7.2% at baseline. The main hypothesized outcome of a significant reduction in CVD risk in the intervention arm, using the UKPDS risk score, compared to the usual care arm, was not observed. Significant differences between the intervention and usual care arms for clinical and anthropometric measures (HbA1c, lipids, weight, BMI etc.) were also not observed in the intervention condition compared to control participants. Whilst clinically significant findings were not demonstrated in this study, daily management of diabetes by group members were significantly enhanced in the intervention group with intervention participants reporting increased frequency of daily self-care activities, increased intake of >5 servings of fruit and vegetables, more frequent BGL testing and monitoring as well as some improvements in physical activity intensity and frequency. Recipients of peer support also reported improved medication adherence. They reported increased satisfaction with the support they were receiving from their health care team, suggesting improved linkages with the clinical care

team and/or better understanding of the role of clinical care providers in diabetes self-management. Five of the eleven groups still continue to meet by themselves, most of which are in rural/regional areas. Rural participants also reported higher costs and lower accessibility to both clinical and allied health services associated with ongoing diabetes management. This study demonstrates the feasibility of providing self-directed community-based diabetes support groups; however, we also note the value and requirement for extensive peer leader support to ensure the initiation, strong establishment and long term sustainability of these kinds of groups. The clinical benefits of this kind of program in Australia have not been clearly demonstrated in this study that recruited people with relatively well controlled diabetes; however, it could also be the case be that the intervention and follow-up period may have been too short to detect any significant clinical improvements and/or the prevention of diabetes complications.

RESOURCES	<ul style="list-style-type: none"> ➤ Site & Intervention Characteristics ➤ Peer Support Recruitment Brochure ➤ Peer Leader Selection Interview and Scorecard ➤ Facilitator Handbook ➤ Peer Leader Manual and Participant Workbook ➤ Sample Newsletter ➤ Group & Individual Contact Notes
PUBLICATIONS	<ul style="list-style-type: none"> ➤ Rawal, LB et al. Utilization of general practitioner services and achievement of guideline targets by people with diabetes who joined a peer-support program in Victoria, Australia. <i>Australian Journal of Primary Health.</i> 2014 Mar 12. ➤ Gordon, LG et al. A cost-effectiveness analysis of a telephone-linked care intervention for individuals with Type 2 diabetes. <i>Diabetes Research and Clinical Practice.</i> 2014 Apr;104(1):103-11. ➤ O'Neil, A et al. Telephone-delivered, health coaching improves anxiety outcomes after myocardial infarction: the 'ProActive Heart' trial. <i>European Journal of Preventive Cardiology.</i> 2014 Jan;21(1):30-8. ➤ Sathish, T et al. Cluster randomised controlled trial of a peer-led lifestyle intervention program: study protocol for the Kerala diabetes prevention program. <i>BMC Public Health.</i> 2013 Nov 4;13(1):1035. ➤ Daivadanam, M et al. Lifestyle change in Kerala, India: needs assessment and planning for a community-based diabetes prevention trial. <i>BMC Public Health.</i> 2013 Feb 1;13:95. ➤ Riddell, MA et al. Cluster randomized controlled trial of a peer support program for people with diabetes: study protocol for the Australasian Peers for Progress Study. <i>BMC Public Health.</i> 2012 Oct 4;12(1):843. ➤ Williams, ED et al. Randomised controlled trial of an automated, interactive telephone intervention (TLC Diabetes) to improve type 2 diabetes management: baseline findings and six-month outcomes. <i>BMC Public Health.</i> 2012 Aug 3;12:602.

FOR MORE INFORMATION, PLEASE CONTACT:

Michaela Riddell, PhD
 Project Manager
 Monash University
 Email: michaela.riddell@monash.edu