Peer Support and Engagement of Patients and Families: Evidence and Key Directions

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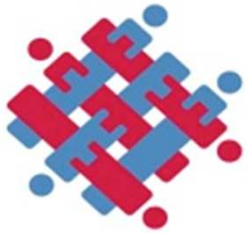
American Academy of Family Physicians Foundation

North Carolina Institute of Medicine

Task Force on Patient and Family Engagement:
Focus on Patient and Practice Level Interventions



Peers for Progress
Peer Support Around the World
A program of the American Academy of Family Physicians Foundation

Fundamental Role of Social Connections and Support

Human beings are more effective and happier when they have someone

- **they can *talk to* about personal matters**
- **who *cares about them***
- **who can *help them* when they need help**

The risk of death associated with social isolation is greater than the risk associated with cigarette smoking

House, Landis & Umberson. *Science*, 1988 *241*: 540-544.

Holt-Lunstad, Smith, & Layton *PLOSMedicine*, 2010, 7: July e1000316 www.plosmedicine.org

Harlow, H.F., & Harlow, M. (1966) Learning to love. *American Scientist* 54: 244-272.


Who We Are
Learn About Peer Support
Promote Peer Support
Get Connected
Take Action
Tools & Training
News & Events
Peers for Progress is a program of the American Academy of Family Physicians Foundation and supported by the Eli Lilly and Company Foundation.
A Learning Community of Peer Support
Peers for Progress is building a Global Network of Peer Support Organizations, and invites you to join in this global endeavor.
>JOIN THE GLOBAL NETWORK
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A summer of Peer Support in Thailand
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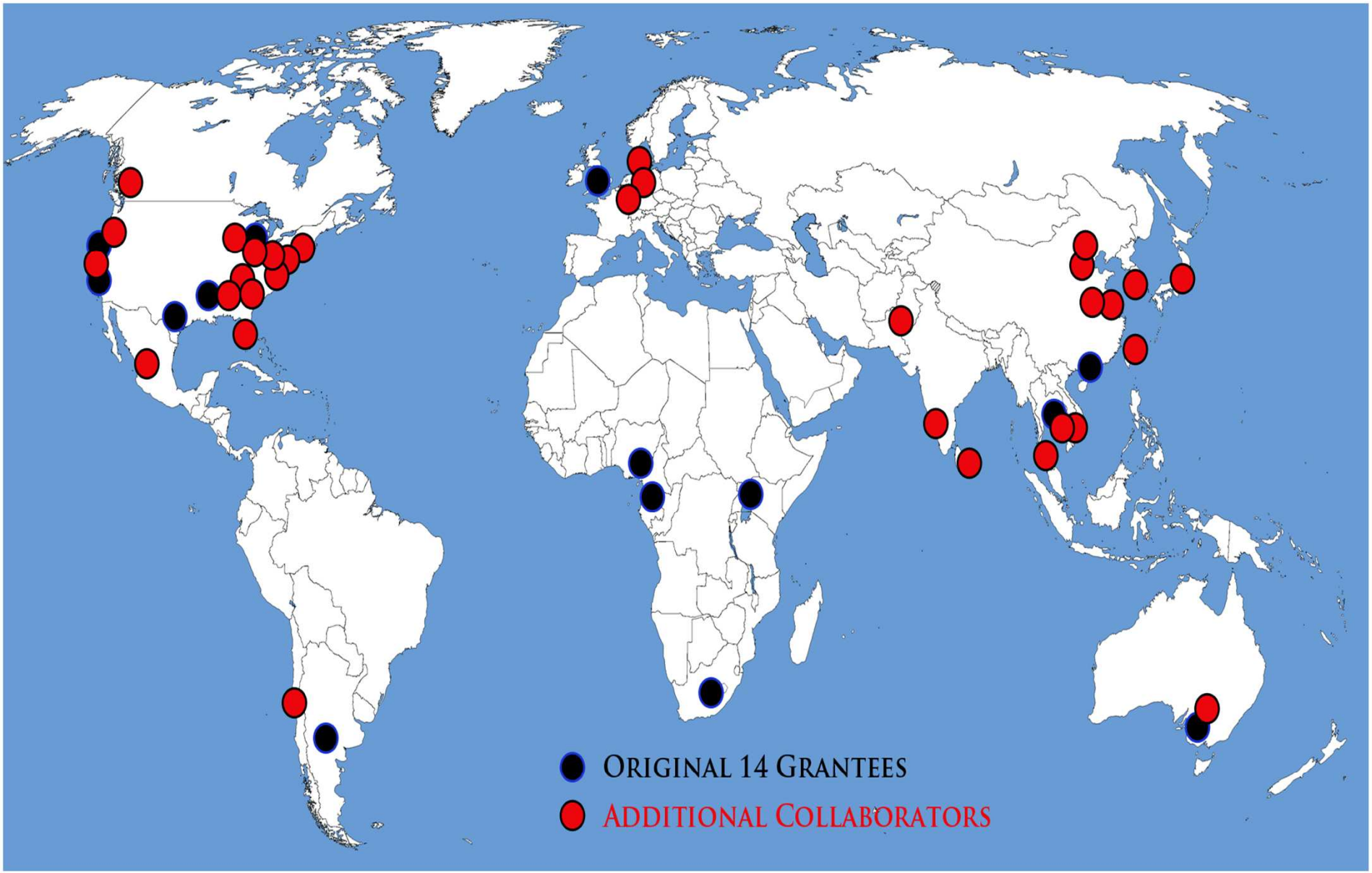


www.peersforprogress.org

Disease Management & Prevention – 8,760

8,766 = 24 X 365.25

6 hours a year in a doctor's office or with other health professional.

8,760 hours "on your own"

- Healthy diet
- Physical activity
- Monitor status
- Take medications
- Manage sick days
- Manage stress – Healthy Coping
- Arrange medical appointments and testing
- Sleep

For Diabetes Self-Management Support*:* Strengths of Peer Supporters

- Not professionals
- Often have the health problem they are assisting with – e.g., people with diabetes helping others with diabetes
- **Share perspectives, experience of those they help**
- **People believe them because they are "like me"**
- Can teach how to implement basic self management plans (e.g., healthy diet, physical activity, adherence to medications)
- ***Have time!!!***

Outcomes of Peer Support – Major Reviews

Dunn, J., Steginga, S. K., Rosoman, N., & Millichap, D. (2003). A Review of Peer Support in the Context of Cancer. *Journal of Psychosocial Oncology, 21*(2), 55-67.

Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annu Rev Public Health, 35*, 399-421.

Swider, S. M. (2002). Outcome effectiveness of community health workers: an integrative literature review. *Public Health Nursing, 19*, 11-20.

Tyus, N. C., & Gibbons, M. C. (2007). Systematic review of US-based randomized controlled trials using community health workers. *Progress in Community Health Partnerships: Research, Education, and Action, 1*(4), 371-381.

Viswanathan, M., Kraschnewski, J. L., Nishikawa, B., Morgan, L. C., Honeycutt, A. A., Thieda, P., et al. (2010). Outcomes and costs of community health worker interventions: a systematic review. *Med Care, 48*(9), 792-808.

Utility and Benefits of Peer Support

- ***Link people*** to share knowledge and experience
- Provide ***health education*** at the individual as well as community level
- Provide ***practical assistance*** for how to achieve and sustain complex health behaviors that are needed in chronic disease management and prevention
- Provide ***emotional and social support***
- Help people ***cope with the stressors*** that so often accompany health problems
- Help people ***get the clinical care*** and other services that they need; assist in navigating the system
- Build ***individual and community capacity*** for understanding health problems and promoting ways of addressing them
- ***Advocate*** for patients and their communities
- Build ***relationships based on trust*** rather than expertise
- Build ***cultural competence*** through peer supporters that often come from the communities they serve

Brownson, C. A., & Heisler, M. (2009). The Role of Peer Support in Diabetes Care and Self-Management. *The Patient: Patient-Centered Outcomes Research, 2*(1), 5-17

Cherrington, A., Ayala, G. X., Amick, H., Allison, J., Corbie-Smith, G., & Scarinci, I. (2008). Implementing the community health worker model within diabetes management: challenges and lessons learned from programs across the United States. *Diabetes Educ, 34*(5), 824-833.

Colella, T. J. F., & King, K. M. (2004). Peer support. An under-recognized resource in cardiac recovery. *European Journal of Cardiovascular Nursing, 3*(3), 211-217.

Heisler, M. (2010). Different models to mobilize peer support to improve diabetes self-management and clinical outcomes: evidence, logistics, evaluation considerations and needs for future research. *Fam Pract, 27 Suppl 1*, i23-32.

Rosenthal, E. L., Brownstein, J. N., Rush, C. H., Hirsch, G. R., Willaert, A. M., Scott, J. R., et al. (2010). Community Health Workers: Part Of The Solution. *Health Affairs, 29*(7), 1338.

Solomon, P. (2004). Peer support/peer provided services: Underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal, 27*, 392-401.

Systematic Review of Evidence Among Publications on Peer Support

- **01/01/2000 – 5/31/2011** : "peer support," "coach," "*promotora*" etc.
- 66 separate studies met criteria of:
  - Provided by nonprofessional
  - Support for multiple health behaviors over time (i.e., not isolated or single behaviors)
  - Not simply peer implementation of class
- Preliminary outcomes:
  - Significant within- or between-group changes: **83.3%** of reports using controlled designs

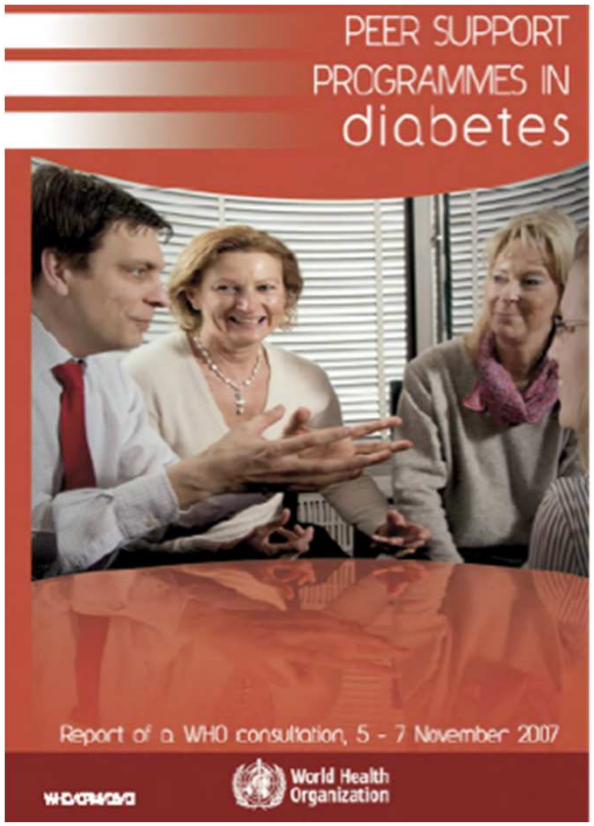
Elstad et al., Internat Cong Beh Med, Washington, D.C., August, 2010; Fisher et al., in preparation

Results: Diabetes Management

- In 14 studies*
- HbA1c mean
    - Pre: 8.63%
    - Post: 7.77%
    - $p = 0.001$

* Studies from 2000 – July, 2012: Babamoto et al. 2009, Beckham et al.2008, Culica et al. 2008, Dale et al. 2009, Greenhalgh et al 2011, Heisler et al 2010, Mayes et al. 2010, McElmurry et al 2009, McEwen et al 2010, Otero-Sabogal et al. 2010, Ruggiero et al. 2010, Sacco, 2009, Smith, et al. 2011, Walton et al. 2012

WHO Consultation, November, 2007



Australia	Mexico
Bangladesh	Netherlands
Bermuda	Pakistan
Brazil	Philippines
Cameroon	Saudi Arabia
Canada	Singapore
China	Switzerland (WHO)
Egypt	Turkey
Gambia	Ukraine
India	United Kingdom
Indonesia	United Republic of Tanzania
Jamaica	United States

1. **Key functions are global**
2. ***How* they are addressed needs to be worked out within each setting**

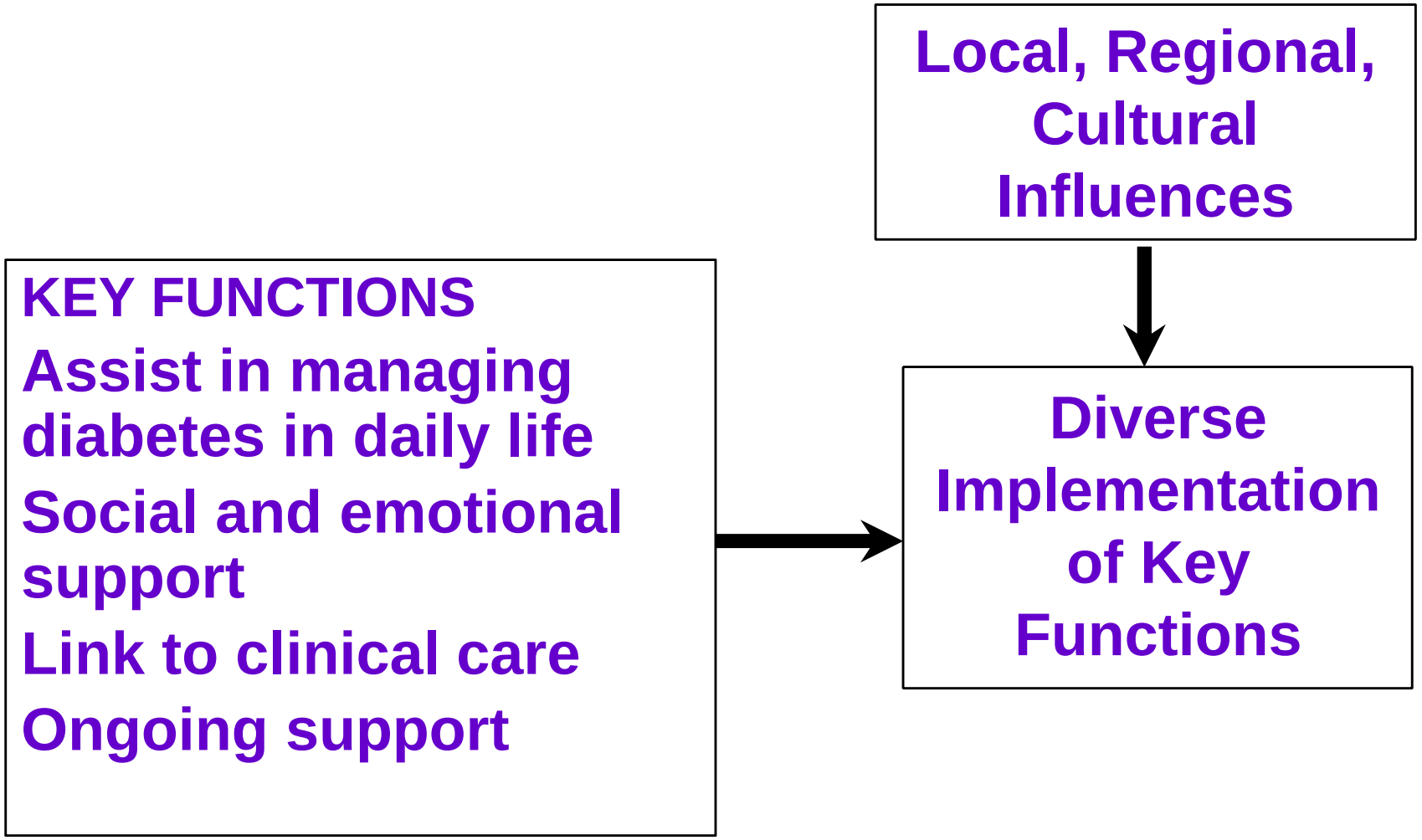
Key Functions of Peer Support

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. Fam Pract 2010 27
Suppl 1: i6-16.

“Standardization by function, not content”

Hawe *et al*. *British Medical Journal* 328:1561-1563, 2004.
Aro *et al*. *Eur J Public Health* 18:548-549, 2008



Peer Support in Cameroon

Jean Claude Mbanya, University of Yaoundé and Central Hospital, Yaoundé

Assistance in Daily Management Group meetings, individual contacts (5 per month), and varied activites, e.g., group meals to demonstrate healthy diet, group exercise

Social and Emotional Support Could discuss with Peer Supporter topics unable to discuss in group or with professionals

Linkage to Clinical Care Peer Supporters not clinicians but motivational link between participants and clinical care;
Accompany patients to clinic visits

Ongoing Support Developed to be continued indefinitely, e.g., convenient locations, only modest honoraria for Peer Supporters

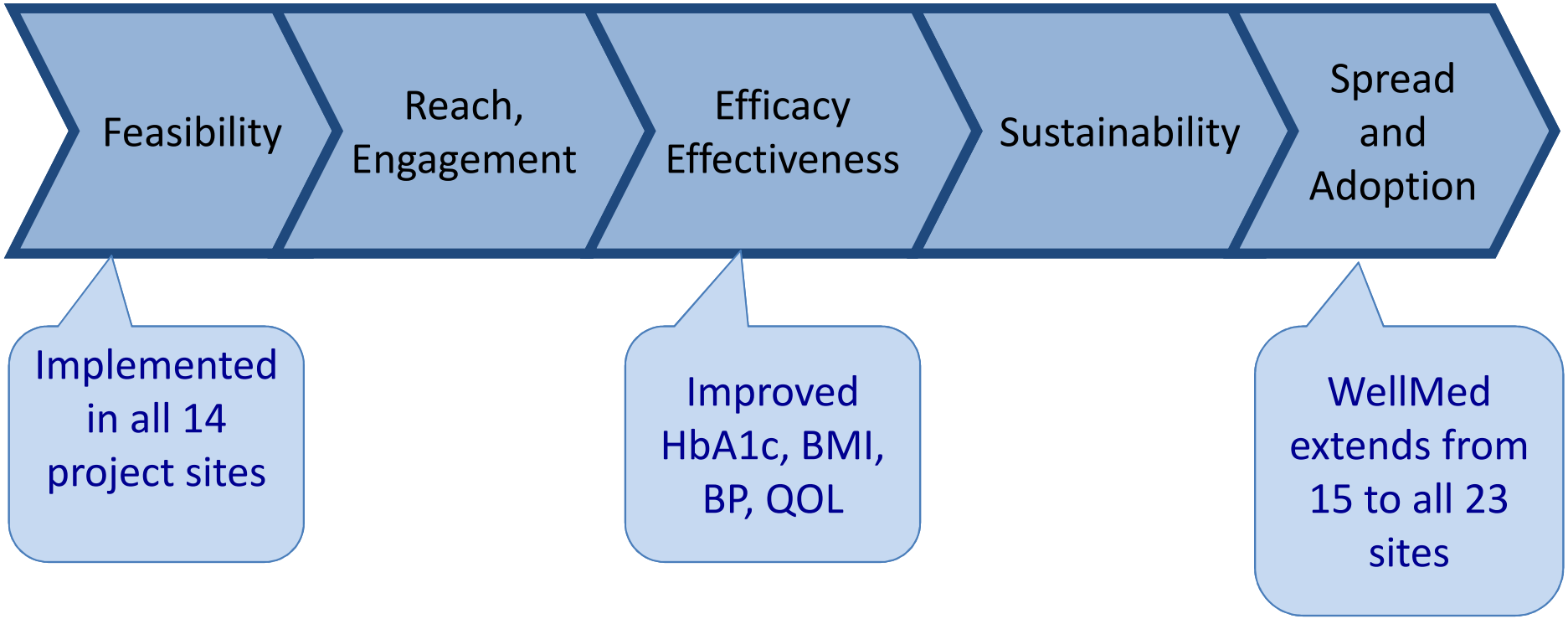
Impacts: over 6 months

BMI: 28.6 - 25.5 SBP: 142 – 124 HbA1c: 9.6 - 6.7%

www.peersforprogress.org

Fisher et al. *Health Affairs* 2012 31: 130-139.

Emerging Results from Projects



Emerging Results from Projects

Mean baseline HbA1c = 8.92%
86 of 102 finished program in Vietnam
68% of eligibles participate, 75% retention in Cambridgeshire over 1 year

Emerging Results from Projects

Thailand: Two years after end of funding, VHVs still doing diabetes activities

South Africa: After 2+ years, increased enrollment, local funding

Uganda: Patients scheduled for appointments on same clinic day as their partners

Cambridgeshire, England:

- October, 2013: several hundred peer leaders and participants met to discuss ongoing organizational structure for program
- Diabetes UK has grant to extend to 8 areas in the Eastern region and West Midlands.

Not sustaining ***the program,*** but ***digestion*** into existing routines and activities

Cost Effectiveness

Encourage Program in Alabama (C. Campbell, PhD Dissertation, University of Alabama-Birmingham, 2014)

- 59% probability of being cost-saving
- 55% to 93% probability of being cost-effective, depending on assumptions, inclusion/exclusion, e.g., higher probability for those with depression or poorer baseline clinical status

In FQHC in Denver (Whitley et al. J Hlth Care Poor Underserved 2006 17: 6-15)

- Shifted costs from urgent care, inpatient care, and outpatient behavioral health care
- Increase utilization of primary and specialty care visits.
- ROI = 2.28:1.00.

Diabetes Initiative of Robert Wood Johnson Foundation (Brownson et al., The Diab Educator. 2009 35: 761-769)

- 3 of 4 projects in cost analysis emphasized peer supporters
- Cost per Quality Adjusted Life Year (QALY) = $39,563
  (well below $50,000 criterion for good value)

Asthma CHW Project with Medicaid Covered Children in Chicago (Margellow-Anast et al., J. Asthma 2012 49: 380-389)

- Three to four CHW home visits over 6 mos and liaison with care team
- ROI: $5.58 saved per dollar spent

Lifestyle Modification for Low-Income Latino Adults with Diabetes (Brown et al., Prev. Chronic Dis. 2012 9:E140)

- CHWs and nurse educator: home visits, self-mgmt education, individual counseling
- $10,995 to $33,319 per QALY
- Especially cost-effective among those with HbA1c > 9%

Preventing Rehospitalization in Schizophrenia, Depression, Bipolar Disorder (Sledge et al., Psychiatr. Serv. 2011 62:541--44)

- *Recovery Mentors* provided individualized frequency, mode, content of support
- Over 9 mos: 0.89 vs 1.53 hospitalizations, 10.08 vs 19.08 days in hospital ($p < 0.05$)

Reducing Depression/Anxiety Disorders in India (Patel et al. Br. J. Psychiatry 2011 199:459-466; Buttorff et al. 2012 90: 813-821)

- Education about psychological problems, ways of coping, and interpersonal therapy delivered by lay health counselors with primary care and psychiatric back-up
- 30% decrease in prevalence, 36% in suicide attempts, 4.43 fewer days no work/reduced work in previous 30 days.
- Lowered time costs resulted in Intervention being cost effective and cost saving

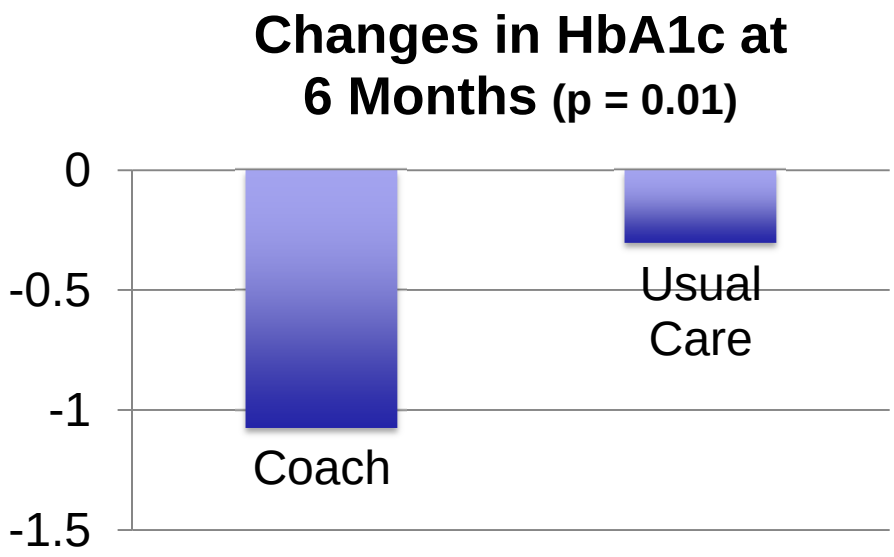
Fisher et al., *Ann Rev Public Health*, 2014, in press

Reaching the Hardly Reached

Peer Support in San Francisco

Thomas Bodenheimer, University of California, San Francisco

Clinical Setting Six Department of Public Health safety-net primary care clinics serving patients covered by Medicare/Medical or San Francisco's coverage for uninsured residents



- Majority of patients were non-white, ethnically and culturally diverse

Patient Contact Patients had average of 7.02 interactions with their coach, including 5.37 telephoned calls

Outcomes

Reduction in HbA1c by > 1 point: 49.6% vs 31.5%
HbA1c < 7.5%: 22% vs 14.9%

Thom et al., *Annals of Family Medicine* 2013 11: 137-144.

In San Francisco, Greater Improvements Among Those With Low Initial Medication Adherence

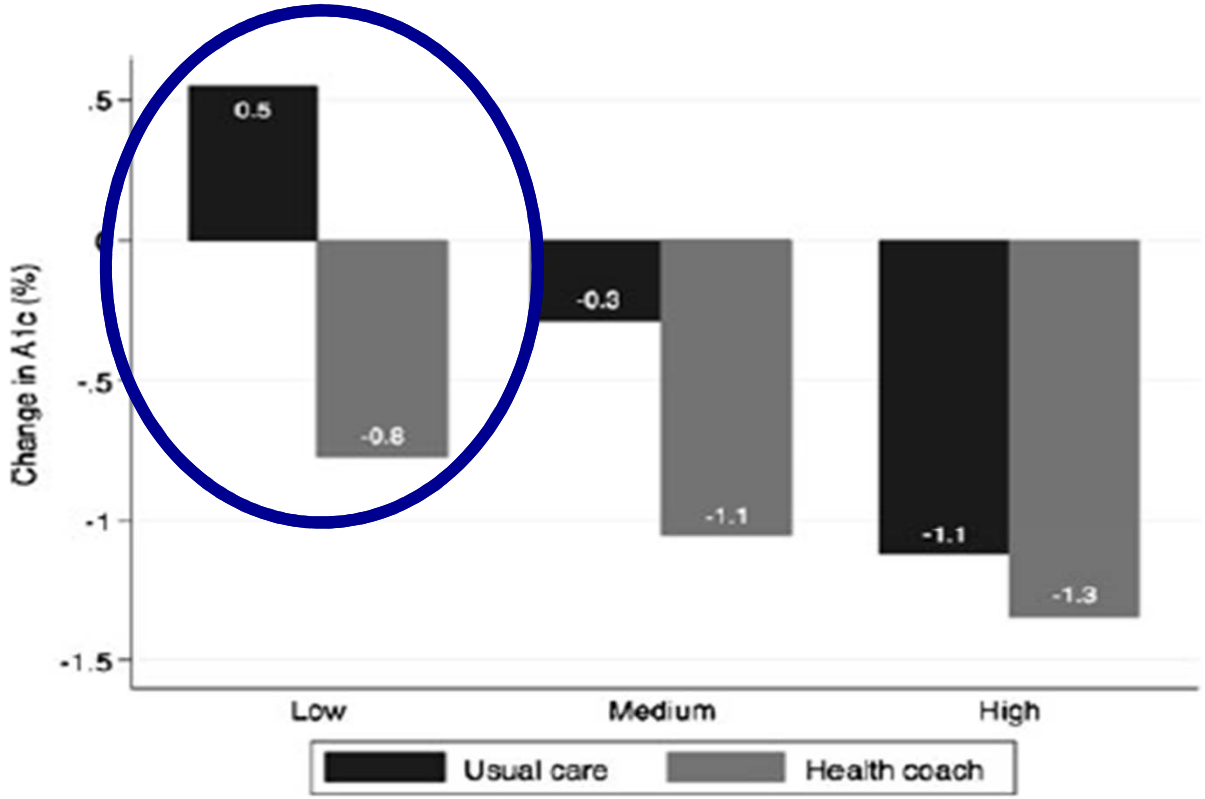


Figure 2. Change in hemoglobin A1c at low, medium and high levels of medication adherence, stratified by study group. Adjusted for age, marital status, hypertension, initial HbA1c, insulin use, body mass index.

Moskowitz et al. J Gen Intern Med. 2013 28: 938-942.

Reaching the "Hardly Reached"

PS ***more*** effective among those low in self-reported **medication adherence and/or self management** (Moskowitz et al. J Gen Intern Med. 2013 28: 938-942.)

PS ***more*** effective among those with **low baseline diabetes support or literacy** levels (Piette et al. *Chron Illn* 2013 Dec;9(4):258-67)

PS ***more*** effective in reducing post-partum depression among women with **household debt and/or lower levels of economic empowerment** (Rahman et al. *Br J Psychiatry* 2012 Dec;201(6):451-457.)

PS more cost-effective among those with **depressed mood or poorer baseline clinical status** (C. Campbell, PhD Dissertation, University of Alabama-Birmingham, 2014)

PS effective in reaching 89% of **low-income, unmarried mothers of Medicaid-covered children** hospitalized for asthma and in reducing rehospitalization by 50% (Fisher et al. *Arch Pediatr Adolesc Med* 2009 Mar;163(3):225-32.)

PS effective in reaching 87% of **"High Need"** adults with diabetes (HbA1c > 8%, Psychosocial Distress, Physician's Referral) at Alivio Medical Center, FQHC in Chicago

PS effective in reaching and significantly reducing HbA1c among low-income Latino patients of FQHC, **43% of whom had 6th-grade education or less.**

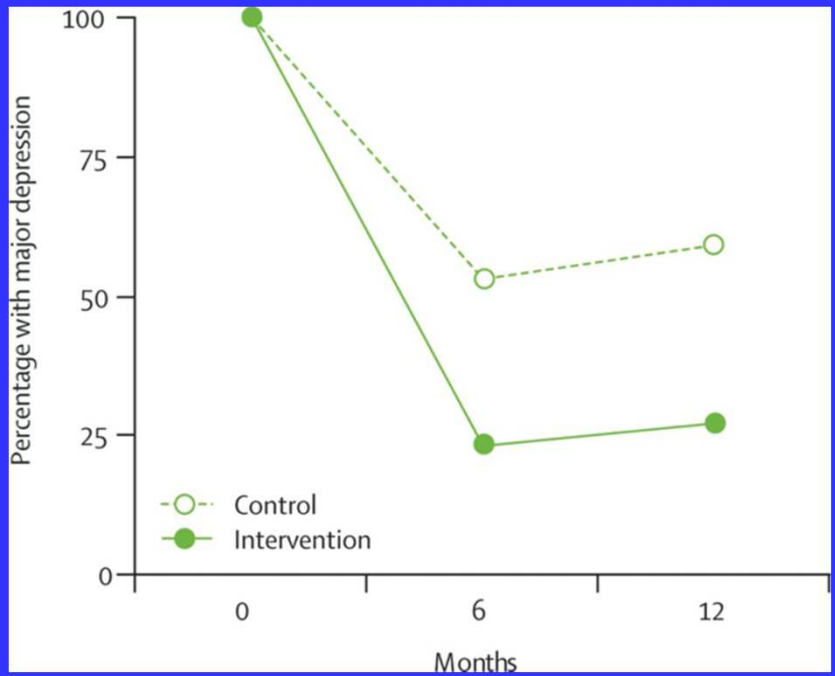
Peer Support and Multimorbidity

“Lady Health Workers” in Pakistan Reduce Post-Partum Depression

“Lady Health Workers”
Completed 2ndry education
Responsible for ≈ 100 households
Primarily general health education and preventive maternal and child care
Extending to TB and HIV detection and control
≈ 96,000 LHWs cover 80% of Pakistan rural population

Manual based intervention, “Thinking Healthy Programme”

- Promote change in thoughts likely to increase depression
- Practical problem solving
- Collaboration with family



Rahman et al.
Lancet 2008 372: 902-909
Arch Womens Ment Health 2007 10: 211-219.

What is the intervention?

What are we treating?

Dissemination

Key Functions and Mental Health

1. **Assistance, consultation in applying management plans in daily life**
   - **Carry out "homework"**
   - **Problem solving**
2. **Social and Emotional Support**
   - **Empathy, encouragement, "nonspecific factors" of psychotherapy**
3. **Linkage to clinical care and community resources**
   - **Specialty care**
   - **Community programs**
4. **Ongoing support, extended over time**
   - **Mental health problems are chronic, relapsing**
   - **Encourage maintenance of problem solving and effective behaviors**
   - **Identify need for renewed primary or specialty care**

Common Ground of Problem Solving

- Self management – problem solving - central to diabetes and chronic disease management
- Common self management/problem solving steps:
  1. Specific objective
  2. Identify possible steps to achieve objective; Choose one
  3. Learn key skills, rehearse, plan application
  4. Try it – monitor results
  5. Revise plan in light of results
  6. Repeat 2 – 5 until objective achieved

Example of Physical Activity

- **Set objective of moderate physical activity 150 min per week**
- **Over one month, achieve objective**
- **Effects:**
  1. **Improved mood**
  2. **Improved metabolism**
  3. **Modest weight loss**
- **Was this management of diabetes or depression?**

Example from Rahman's Lady Health Worker Intervention for Post-Partum Depression

"… case where poverty and the husband's chronic unemployment were an underlying issue in the mother's depression, the LHW used CBT techniques to motivate her to take a small loan from the government's micro-credit scheme. The money was used to ***purchase a buffalo*** to sell its milk for profit (the LHW had personal experience of such a venture and was able to guide her). The woman was able to return the loan, gained tangibly from the intervention, both materially and in self-worth and confidence, and this led to marked improvement in her depressive symptoms"

Rahman, A. Challenges and opportunities in developing a psychological intervention for perinatal depression in rural Pakistan – a multi-method study. *Archive of Women's Mental Health*. 2007 10: 211-219. p 217.

What is the intervention?

What are we treating?

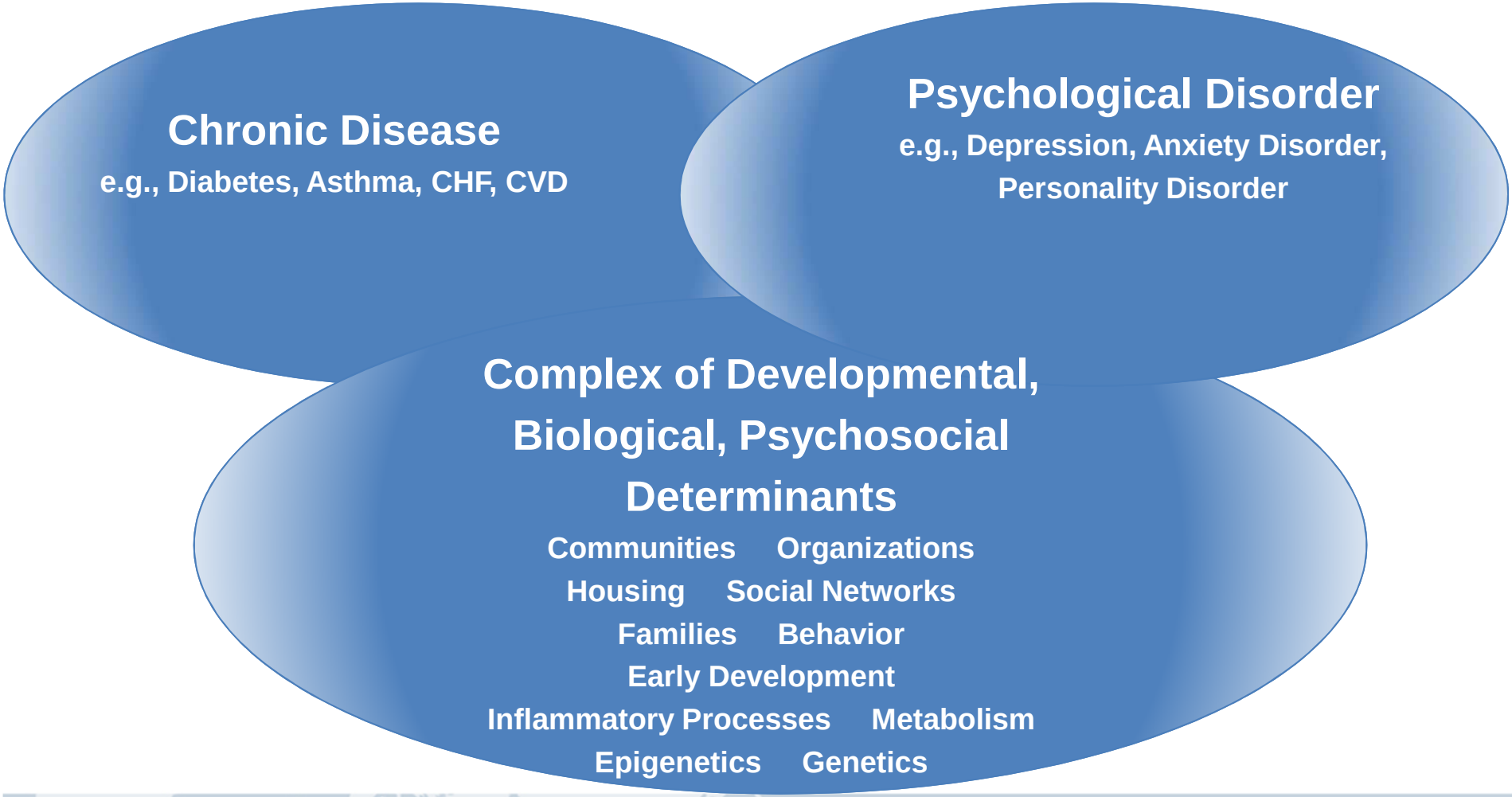
Dissemination

Simple Model of Comorbidity

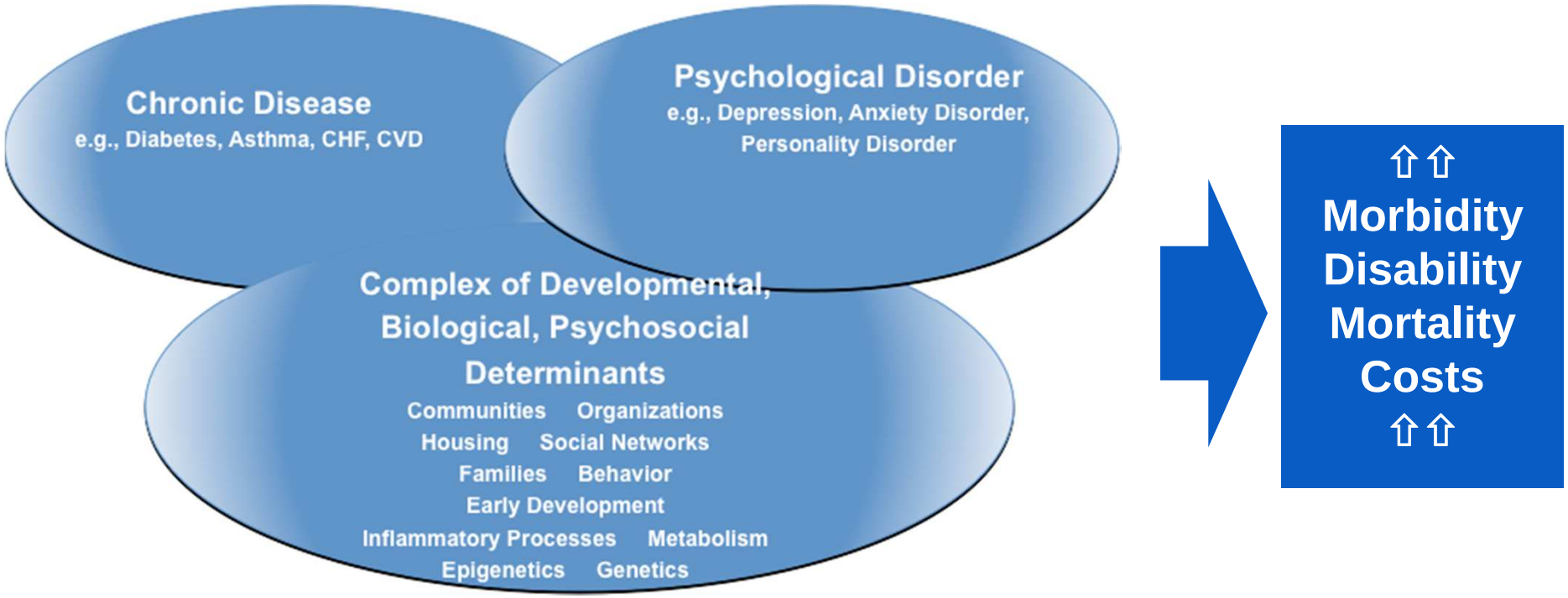
Clinical Reality

A Familiar Individual Case History:
2 YO: Low family income, single parent, disadvantaged, poor diet, compromised nurturance, epigenetic changes in stress mediators
8 YO: Hx abuse, overweight, discouraged, poor grades
16 YO: obese (HBP? IGT?), poor grades in school, limited social development, inflammatory changes
35 YO: BMI = 35, HBP, IGT, frequent depressed mood and general suspiciousness, frequent sleep disturbance, variable employment,
50 YO: Type 2 diabetes, HBP, BMI = 38, joint problems, ADL impacts, Dx depression, variable employment, sleep disturbance, hospitalization in previous year, Rx for DM, HBP, Depression, Joint pain, sleep disorder …

Chronic Disease and Psychological Disorders as Expressions of Complex Biological, Psychological, and Socioeconomic History



The Face of 21st Century Illness Burden



Fisher, Chan, Kowitt, Nan, Sartorius, & Oldenburg, (In Press). In: N. Sartorius, M. Maj, & R. Holt (Eds.), *Comorbidity of Mental and Physical Disorders*. Basel: Karger

Jade and Pearl in Hong Kong

Juliana C. Chan and colleagues, Hong Kong Institute of Diabetes and Obesity; The Chinese University of Hong Kong; Prince of Wales Hospital

JADE – Structured Care Management (Chan et al. *Diabetes Care* 2009 32: 977–982.)

- Algorithm and registry based care
- Initial appraisal and report to PCP
- Quarterly reports, including to patient
- Initial patient education session

Nota Bene: JADE is the Control Group

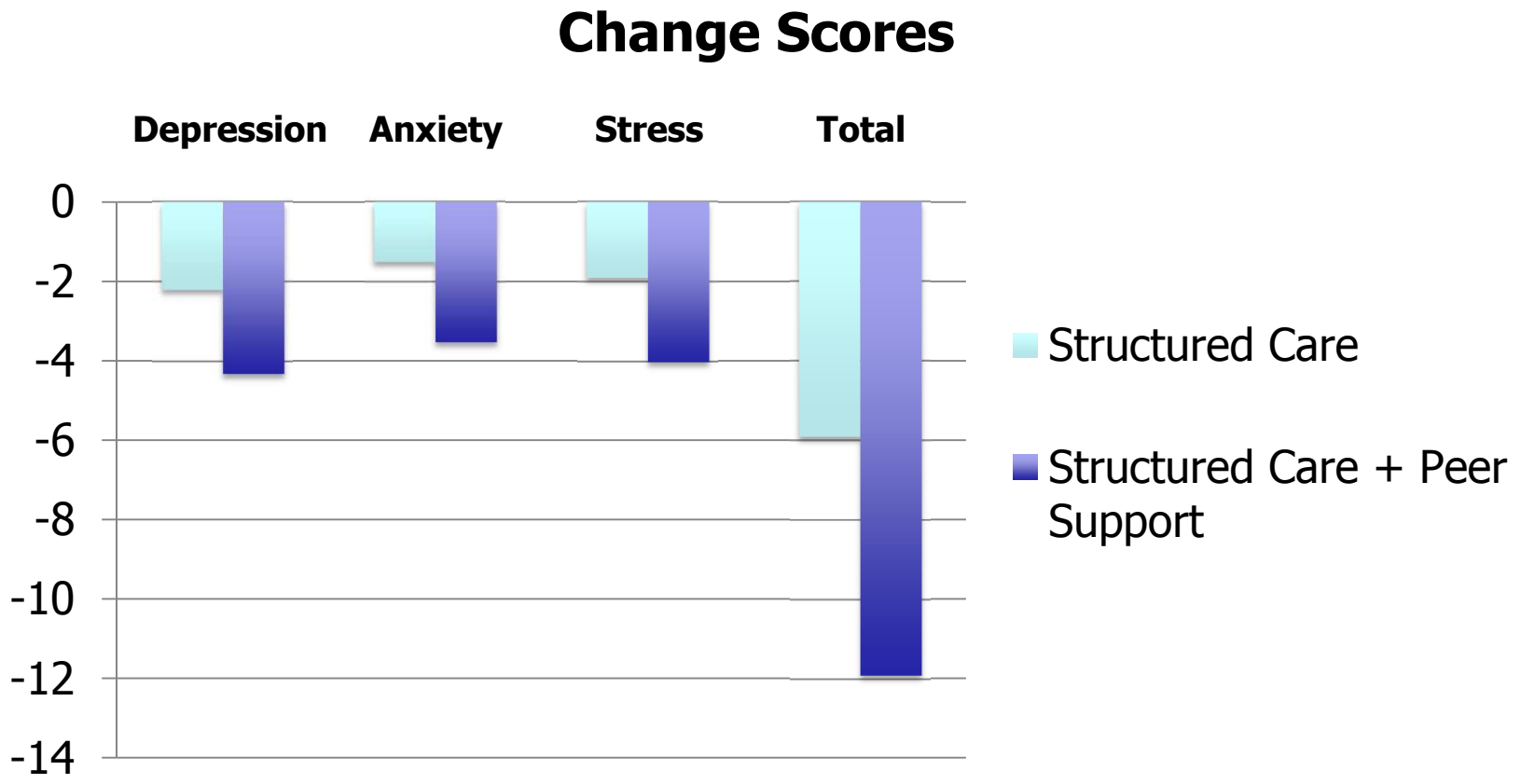
PEARL – Peer Support (Chan, Am Diab Assoc, June, 2012)

- Peers work through and trained by nurses
- Peer support classes
- Individual contacts:
  - Protocol: 12 over 12 mos
  - Average of 17

Chan, J. et al. *JAMA Internal Medicine.* Online First, 29 April, 2014

20% Above Cut-Off for Appreciable Distress

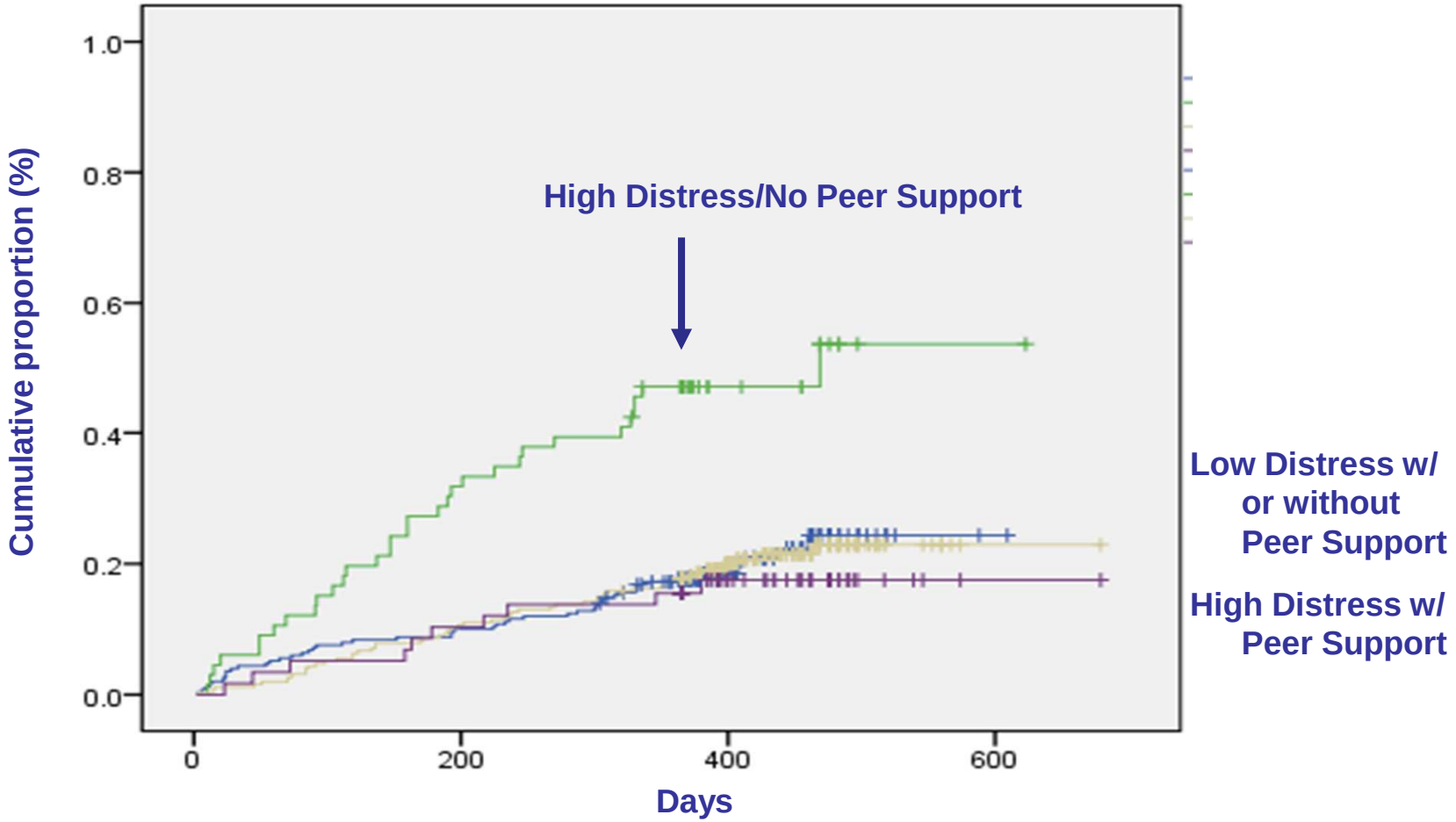
(Total Score on Depression, Anxiety and Stress Scale > 17)



DASS – Depression Anxiety Stress Scale All *ps* < 0.05
(*Adjusted for DASS_Depression_Pre, DASS_Anxiety_Pre, and DASS_Stress_Pre)
DDS – Diabetes Distress Scale

Chan, J. et al. *JAMA Internal Medicine.* Online First, 29 April, 2014

20% Who Are Distressed → 40% of Hospitalizations



Chan, J. et al. *JAMA Internal Medicine.* Online First, 29 April, 2014

What is the intervention?

What are we treating?

Dissemination

Broad Commonalities of Mental Health Rather Than Diagnostic Singularities

Substantial implications for ***dissemination*** to populations

Several projects show noteworthy ***benefits on emotional distress/quality of life*** which interventions were ***not designed*** to address

Self management interventions in general, e.g., in diabetes, improve emotional status (The Diab Educ'or: Fisher et al. 2007 33: 1080-1103; Thorpe et al. 2013 39: 33-52)

Provision of Informational and Instrumental implicitly entails emotional support (Kowitt et al. in preparation)

Thus, diverse deployment of peer support for many health and social purposes may contribute to overall reduction of mental health burden

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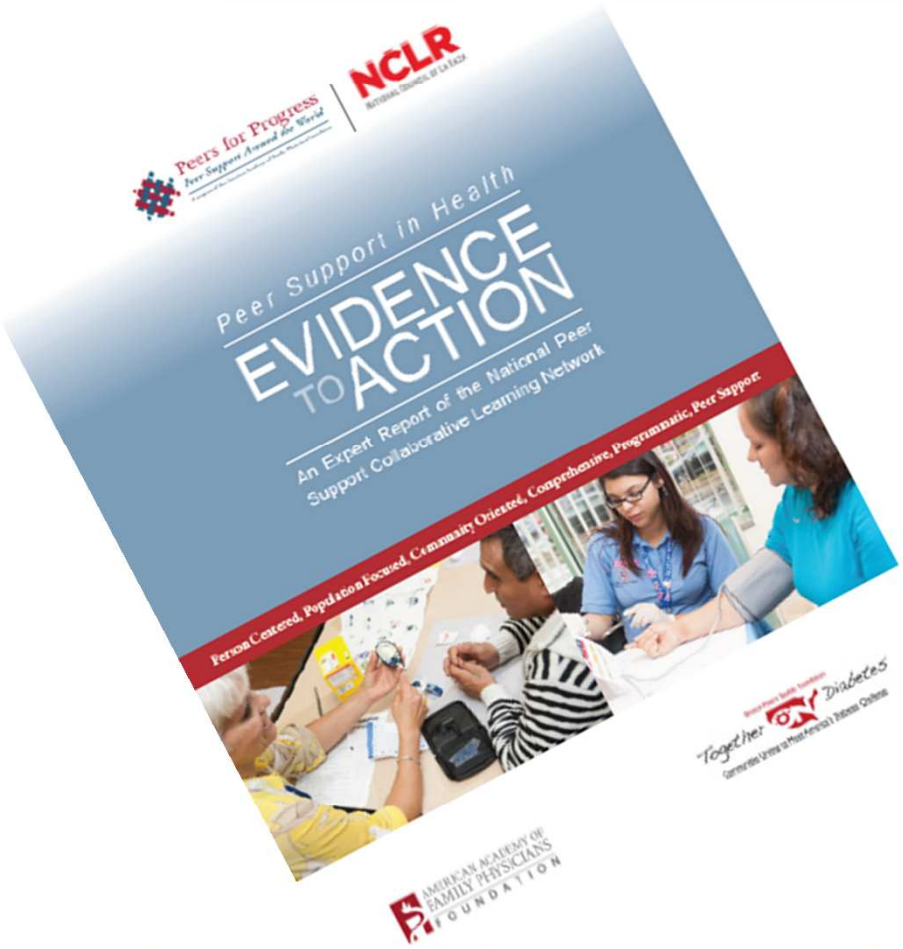
NCLR
NATIONAL COUNCIL OF LA RAZA



Comprehensive

Programmatic

peer-support that

Reaches Populations

while remaining

Patient Centered

Community Oriented

www.peersforprogress.org

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Reaching Entire Population of Adults with Diabetes

Alivio Medical Center, Chicago

Approximately 3800 with diabetes

High Priority – HbA1c > 8%, Psychosocial Distress, Physician's Referral

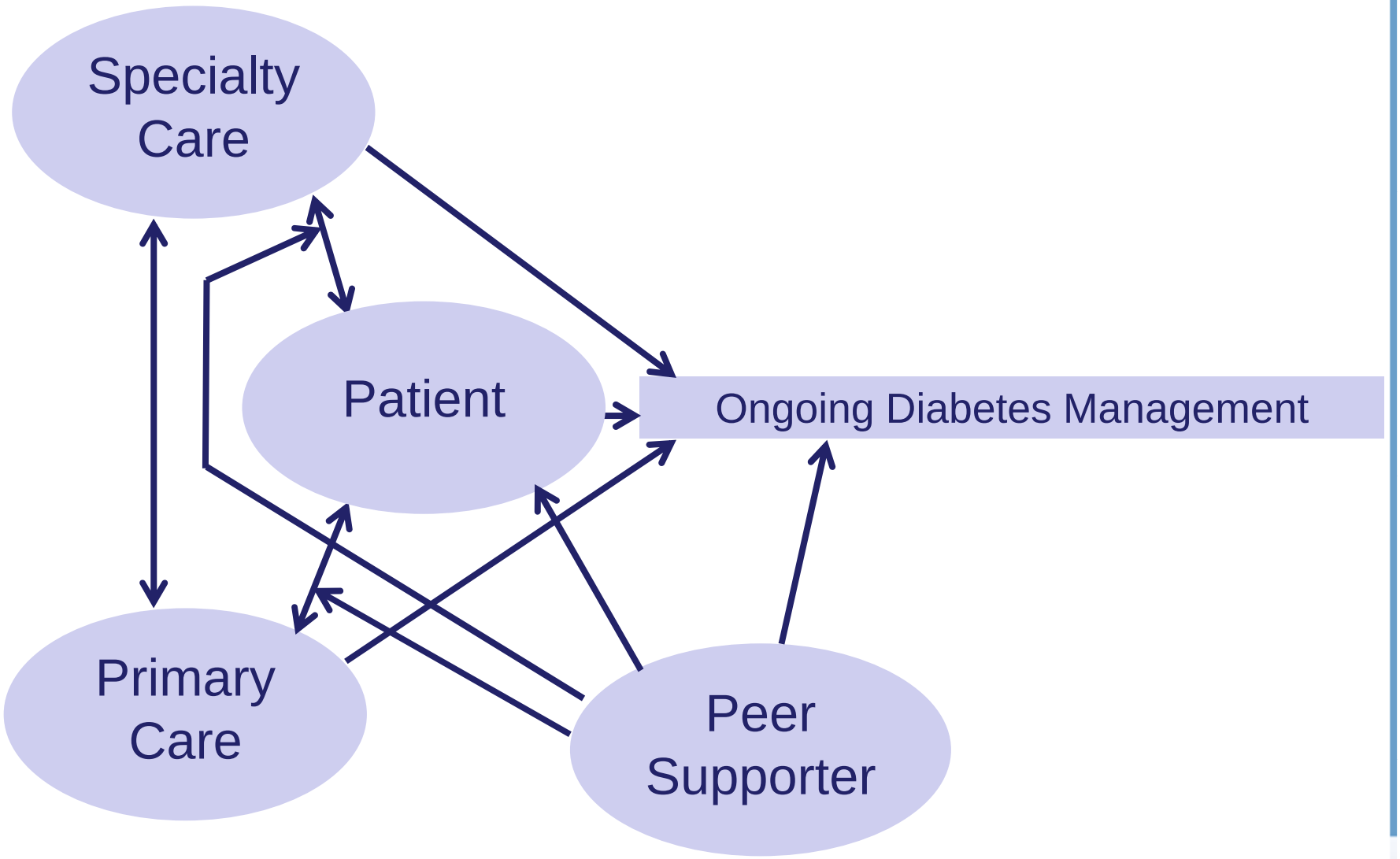
- 472 of the 3,800
- Individual contact biweekly, then monthly
- Focus on regular care, diet, exercise, emotional support, assistance with other problems

Normal Priority – Education classes, Support groups, activities, contacts at clinic visits

Progress to Date — August, 2012 – April, 2014:

409 / 472 (86.6%) of High Priority have been reached

2476 / 3328 (74.4%) of Normal Prioirity have been reached


Specialty Care
Patient
Ongoing Diabetes Management
Primary Care
Peer Supporter

Shared Care Plan:

Critical in Linking Patients, Clinical Team, Peer Supporte
Complementarity of Roles

Goals
(e.g. Live to 80)

Objectives
(e.g., lose 10 lb)

Specific Behaviors
(e.g. walk after dinner)

←←←←←←←←←Person with Diabetes→→→→→→→→

Physician →→→→→

Clinical Team→→→→→

Peer Supporter→→→→→→→→→→

Benefits for Health Care Providers

1. Strategy for culturally sensitive outreach and follow-up
2. Coaching patients to assume more active roles in health care
3. Enhanced ***linkage between patients and provider teams***
4. Strategy for ***diabetes self management support*** (chronic disease self management support)
5. Emerging evidence of ***reduced costs*** (e.g., hospitalization in Hong Kong)
6. Strategy for recognizing and promoting appropriate care for ***psychosocial problems***
7. Part of ***alternative to PCP serving as social worker, dietitian, and psychologist***
8. "With all of this, I get to practice medicine"

Peers for Progress in China, Taiwan, Western Pacific

Collaborative Model:

- **In-country leadership and ownership**
- **Peers for Progress: General expertise in peer support, global networking**

Taiwan Association of Diabetes Educators (TADE)

- **Three workshops, over 120 representatives of 36 hospitals/clinics**
- **Workshops starting tomorrow in Taitung**

Suzhou, August, 2013: Workshop for 200 program managers

Chinese Diabetes Society's Study Group of Diabetes Care and Education

- **Two workshops and follow-up 60 program managers, representing over 28 hospitals and community health centers**

Beijing – *8760 Program* of Beijing Diabetes Prevention & Treatment Association

- **500 Peer Leaders through 50 hospitals/Community Health Centers to reach 50,000**

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Peer Support in Health and Health Care

A Guide to Program Development and Management

http://www.peersforprogress.org / Implement / Start a Program

Peer Support Modes

- Peer Supporters as part of community based organization, linked with clinical providers
- Individual, trained peer supporters offer assistance, coaching, “being there”
- Group classes and support sessions
  - Group Medical Visits
- Mutual-help groups
  - May be self governing
  - Experienced leaders are important
- Outreach, patient engagement, and self management/education from primary care, e.g., “Patient-Centered Medical Home”
- Peer Supporter as part of clinical team
- Peer Supporters working as “extenders” and under supervision of Care Managers
- Peer Supporters based in and extenders of Group Medical Visits

Recruiting Peer Supporters

- Time available – availability to those served is key
- Like to talk to others, happy to find out about others' children, interests, etc.
- Able to learn and teach basic disease management or health promotion behaviors
- Motives may be mixed – both interest in being useful and engaged as well as desire to help the community

Key Personal Characteristics:

- Broad minded, do not see diabetes or people's problems as simple, no easy answers
- Will embrace team, will use back up support from professionals

Training Peer Supporters

- Goal is to be able to help others implement their management plan
- Don’t need skills of nurse or dietitian
- So, ***training is to knowledge of a patient who understands their diabetes well***
- Teach skills for
  - Simple counseling (active listening, motivational interviewing)
  - Promoting behavior change

Management of Peer Support Program

- Clearly identified manager of program with time allocated for this responsibility
- Back up plan
  - Questions, issues peer supporter cannot answer/handle
  - Refer to nurse, primary care, specialist
  - **Prompt response** to patient's question
- Ongoing support for supporters
  - Weekly meeting
  - Share questions, problems, develop program improvements
  - Emotional support for difficulties encountered
- Monitoring and supervision as reflecting the importance of the work, not mistrust; tone of improving, not surveillance

Success Factors

- Keep it simple – Remember that peer support is meant to be from “people like me”
- Avoid too many details of training – Remember, key is knowing, listening, and ***being available***
- Key: ongoing support and information for peer supporters
- Back up system in place is critical

Human beings are happier **and more effective** when they have someone they can talk to about personal matters, who cares about them, and who is reliably available

So…

Peer supporters can make real contributions without fixing things or being experts, but just by listening, knowing those they want to help, and being available

Frequently Asked Questions: Quality Control, Misinformation??

- ***Key:*** Consider situation of peer supporter – basically a good person wanting to do no harm but wanting to help people who often face serious obstacles
  - If provide readily accessible resources, peer supporter will use them
  - If make resources hard to access, peer supporter will try to help with whatever resources they have available
- Recognize that information is not controllable
  - Promoting good information creates channel of influence
  - Trying to control or police information (impossible task) shuts off a channel
- Solid training and careful selection for those willing to be part of team as opposed to wanting to be heroes or the source of all knowledge and help
- Clarify: key role is support and assistance, not clinical expertise
- Key is back up, support, monitoring ***of the peer supporter***
  - Regular supervision, opportunity for peer supporters to discuss problems
  - 24/7 contact for peer supporters (titrate according to, e.g., routine, need within 24h, emergency)
  - Becomes major value added – peer supporter can get authoritative answer to questions from nurse, primary care provider, specialist prn

Peers for Progress
Peer Support Around the World
A program of the American Academy of Family Physicians Foundation

NCLR
National Council of La Raza

National Peer Support Collaborative Learning Network

Advisory Committees:

- Quality Assurance (incl. definition, certification, supervision)
- Financial Models
- Special Audiences and Populations
- Advocacy
- Communications & Networking
- Organizational Factors and Integration

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Take Action
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