Integrating Peer Support into the Primary Care Team: Public and Private Models of Integration

Manuela McDonough, National Council of La Raza
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INTEGRATING PEER SUPPORT INTO THE PRIMARY CARE TEAM

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INTEGRATING PEER SUPPORT INTO THE PRIMARY CARE TEAM
TALKING POINTS

› Evidence for Peer Support (PS)
› PCMH Key Features and PS Utilities
› Models of PCMH-PS Integration
› Lessons for Implementation
SOCIAL RELATIONSHIPS & HEALTH
SOCIAL RELATIONSHIPS & HEALTH

› Social support is a fundamental need for health and well-being

› A key factor in motivating behavior change and maintenance

› Support from “someone like me” is trusted and valued
WHO PROVIDES PS

- Community health workers
- Promotores de salud
- Peer health coaches
- Lay health advisors
- Sponsors
- Volunteers
- Friends
4 KEY FUNCTIONS

- Assistance in Daily Management
- Social/Emotional Support
- Linkage to Clinical and Community Resources
- Ongoing Support
PEER SUPPORT WORKS

Harnesses interpersonal relationships to activate intrapersonal change

› Feasible across settings and populations
› Reaches, engages, retains intended populations, including “hardly reached”
› Effective across clinical and QoL outcomes
› Especially effective among high-risk groups
PATIENTS LIKE IT

› Access: convenient, responsive, timely

› Ease of communication: non-directive, non-judgmental, culturally competent

› Security: reduce unknowns, emotional support, someone that’s there for them

› More than health: solving concrete problems in patient’s lives
PROVIDERS BENEFIT

› Encourages appropriate utilization of health care resources

› Improves patient-provider relationships

› “The doctor helps me decide what to do, the peer supporter helps me figure out how to do it.”

› Growing evidence of cost-effectiveness
# NCQA PCMH Standards

<table>
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<th>Category</th>
<th>Standards</th>
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<td>Team-Based Care</td>
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<td>Care Coordination and Care Transitions</td>
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<td>5C: Coordinate Care Transitions</td>
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<tr>
<td>Performance Measurement and Quality Improvement</td>
<td>6C: Measure Patient/Family Experience</td>
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PERSON-CENTEREDNESS

› Patient choice and empowerment
› Shared decision making
› Culturally sensitive
› Care personalized to the individual
PCMHC Key Features and PS Utilities

Patient
- Nurse
- Physician
- Social Worker
- Pharmacist
- Care Manager
- Peer Supporter
TIME ALLOCATION BY TASK

- Home Visits: 24.6%
- Phone Outreach & Follow Up: 16.4%
- Advocacy & Escort: 6.8%
- Writing Case Narratives: 11.6%
- Linking to Services: 9.6%
- Team Meetings: 7.9%
- Case Intake: 7.7%
- Professional development: 8.7%
- Accompany on med. visits: 6.8%

Findley et al. 2014
POINT OF CARE AND BEYOND

› Health care in the clinic and the community

› Support across the lifespan and chronic disease progression

› More touches, higher quality touches
PROACTIVE POPULATION MANAGEMENT

› Risk Stratification

› Tool to identify gaps, such as registry or EMR

› Extends support to the right people at the right time
PCMH Key Features and PS Utilities

Kaufman A, Alfero C, et al. University of New Mexico & HMS – Center for Health Innovation
MODEL OF INTEGRATION
MODEL OF INTEGRATION

• FQHC in Chicago, IL
• Serving 3,700 Latino adults with Type 2 diabetes
MI SALUD ES PRIMERO
MY HEALTH COMES FIRST

› 1 Program Manager
› 1 Program Coordinator / Training Supervisor
› 8 Compañeros en Salud / CHWs
› Primarily telephone contact
› Available onsite at the clinic
### 3,700 Patients with Diabetes

<table>
<thead>
<tr>
<th>High Need Group</th>
<th>Regular Care Group</th>
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<tbody>
<tr>
<td>• HbA1c &gt; 8%, Psychosocial Distress, Physician’s Referral</td>
<td>• Quarterly contacts, encourage clinical care and use of resources (e.g., group classes) and self-management</td>
</tr>
<tr>
<td>• 471 of the 3,700</td>
<td>• Transition to High Need as needed</td>
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<tr>
<td>• Bi-weekly contacts for 12 weeks</td>
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<td>• Monthly contact for 6 months until no longer meet criteria for High Need or until progress has stabilized</td>
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<tr>
<td>• Quarterly thereafter</td>
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<tr>
<td>Diabetes Self-Management (DSM) Services at Alivio</td>
<td>Regular Care</td>
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</tbody>
</table>
| Overall DSM program/services at Alivio  
*Everybody receives same services and messages about diabetes*                                             | X            | X         |
| Compañeros en Salud Community Events  
*Increase diabetes awareness, promote screening, diagnosis, and referral*                                   | X            | X         |
| Primary care PCMH clinical health services  
*Quarterly visits, care plan*                                                                                 | X            | X         |
| CES as a resource  
*Encourage use of community resources (healthy food, physical activity, etc.)*                          | X            | X         |
| Open events / drop-in activities  
*Health fairs, weekly info table in clinic lobby*                                                               | X            | X         |
| Diabetes self-management education  
*Group or individual*                                                                                                | X            | X         |
| Support groups  
*Bi-weekly, monthly*                                                                                           | X            | X         |
| Individual, intensive support for DSM                                                                              |               | X         |
AN ORGANIZATIONAL HOME

› PCMH provides structure and support that enables compañeros to focus on their unique role

› Health care providers provide essential supervision and backup of compañeros

› Compañeros highly effective at community outreach and engaging new patients
ADDITIONAL READING


Lessons for integrating peer support and primary care
LESSONS LEARNED

› Cross-training for continuity
› Regular training to reinforce concepts
› Define measures of success early
› Consistent measurement for QI
LEADERSHIP AND ORGANIZATIONAL COMMITMENT

› Influential champion in the medical leadership

› Administrative commitment to the model

› Reinforce attitudes by demonstrating improved outcomes and lower costs
SECURING PROVIDER BUY-IN

› Involve providers in the program planning and training process

› Develop clear scope of work so staff understand roles

› Build team relationships to enhance mutual respect and understanding

Lessons for Implementation

www.peersforprogress.org
FINANCING

› Value-based payment models

› Shared savings, bundled payment, capitation – predicated on care coordination, efficiency, and quality

› Wellness trusts

› Affordable Care Act provisions
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¡Mi Salud es Primero!
Programa de Diabetes

Lizette Martinez
Alivio Medical Center
Compañeros en Salud
Community Health Worker
Diabetes Self Management Support (DSME)

- Engage low income minorities to improve self-mgmt (med adherence, PA, healthy diet, glucose monitoring) and other key outcomes in diabetes (A1c, BP, BMI, etc.)
- Assistance in daily management
- Social and emotional support
- Linkage to care
- Ongoing support, extended over time
The DSME Team

MY HEALTH COMES FIRST TEAM

- Manager, Coordinator and 8 Diabetes Health Educators
Health educators received ongoing training

- Diabetes Self-Management Education
- Risk Reduction and Prevention of Diabetes complications
- Motivational interviewing
- Problem Solving
- First aid in Mental Health
- Affordable Care Act.

Peers Support Focus

- Listening
- Encouraging
- Guidance
“in my 17 years of being a diabetic, I’ve never reached 100’s.....not even 95 fasting!”

“I learn how to eat and I’m teaching my neighbor about what I’ve learned”

“If I would’ve known taking insulin would help me feel so much better I would’ve started sooner”
Successes

- Working as a Team within the DSME program
- Help pt obtain MD appts, eye referrals, glucometers and strips, medication assistance, community resources
- Providers received updates on their patients
- Support Group
- Diabetes Self Management Education classes
- One-to-one interactions
- Setting small goals
Challenges

- Gain trust from our patients, especially the most resistant patients
- Gain the trust of the providers and clinical staff
- Breaking Silos among Departments and staff
- Balancing the case load of patients
Lessons Learned

- Patient contacts should be flexible, nondirective but also focused on at least 1 of the 7 key DSM behaviors

- Support/supervision/training of CHWs/CES/peer supporters must ongoing and consistent

- Allow for CHWs/CES/peer supporters to learn from and support each other
Mi Salud es Primero
Programa de Diabetes
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Developing peer support on a behavioral health team in a PCMH

Justin M. Nash, PhD; Judy DePue, EdD; Daniel Evans, PhD; Marisa Sklar, MS

Brown University and Memorial Hospital of Rhode Island

PATIENT CENTERED PRIMARY CARE COLLABORATIVE
WASHINGTON DC
THURSDAY, NOVEMBER 20
Concentration of health care spending

5% of the population account for 50% of health care spending

Concentration of health care spending

20% of account for 80% of health care spending

Health conditions that account for cost

- Heart disease
- Cancer
- Mental disorders
- Trauma
- Pulmonary conditions

Health conditions related to cost

What else characterizes those in poor health

- Financially strapped.
- Live in substandard housing.
- Lack adequate transportation.
- Worn down by poor health.
- Angry, fearful, depressed.
- Ineffective communicators who can alienate others and feel abandoned by doctors.
- Lack trust in medical system.
- Stuck in bad habits and bad environments.

Objectives of behavioral health integration in primary care

- Improve health and patient experience while reducing costs
- Impact behavioral health, including serious mental illness
- Impact chronic disease through prevention and management
The Family Care Center

• NCQA Level 3 PCMH

• Hospital-based, academic teaching practice that provides training to Brown University medical students, family medicine residents, and psychology residents

• 13 faculty + 39 residents; 27 exam rooms

• Serves 12,500 active patients → 30,000 visits annually

• Diverse socioeconomic, ethnic, and racial patient population; 32% identify as Latino and 12% as Black
Ongoing challenges that are informing further behavioral health integration

- Patients who are not seeking service are not having needs addressed
- Brief visit with individual behavioral health clinician has limited impact given complexity of psychosocial and medical problems
- No mechanism to easily connect patients to needed community resources
- Medications do not address the social determinants affecting health
- Limits to population management: Behavioral health metrics like the PHQ-9 not routinely administered and recorded
Physicians, nurses, and medical staff manage and will continue to manage the bulk of behavioral health care

Focus is on impacting population of patients within and across the practice

Quality improvement process and use of Electronic Medical Record and other technology to guide approach

**A system of care is needed**

Care is *team*-based

Complex patients require connecting to resources in community including specialty behavioral health and other community agencies
Enhancing team-based and population-based care

- Team case conference at end of open access clinics to collaboratively develop plan for patients and connect with community resources

- Create a multidisciplinary team to provide virtual consultations to physicians in their management of patients

- Develop patient registry and quality improvement process to identify patients in need and track treatment progress

- Incorporate peers from the community to serve in a support role for patients in the practice
Project

The aim is to **create a model of peer support for behavioral health in diabetes patients** that targets the combination of depression (or other mental health issues) and diabetes in primary care.

Eight patients will be identified, trained, and serve on the behavioral health team as **peer supporters**.

**Patients** will be supported by peers in their management of both depression (or other mental health issue) and diabetes.
Selection of peers

Inclusion
- Live in community
- Type 1 or type 2 diabetes that was diagnosed at least 1 year prior
- Diagnosis of depression and/or anxiety is preferred, but not required
- History of successfully coping with diabetes
- Personal qualities that are well-suited for the role of peer supporter (i.e. personable, nonjudgmental, good listener and communicator)

Exclusion criteria
- Substance misuse (AUDIT≥8 and/or DUDIT>8 (for men) >6 (for women))
- Serious mental illness (i.e. Bipolar disorder, psychotic disorder, suicidal)
Selection of patients

Inclusion
- Live in community
- Type 2 diabetes (HbA1c $\geq 8$ in the past year)
- Evidence of psychosocial distress, defined as
  - Elevated diabetes-related distress (mean DDS$>3$) and one or both of:
    - Diagnosis in the medical record of depression (PHQ-9$\geq 10$)
    - Diagnosis in the medical record of anxiety (GAD-7$\geq 10$)

Exclusion:
- Substance misuse (AUDIT$\geq 16$ and/or DUDIT$>8$ (for men) $>6$ (for women))
- Serious mental illness (i.e. Bipolar disorder, psychotic disorder, suicidal, inpatient past 6 months)
Peer/patient meetings and scope of peer role

Monthly in person meetings in the primary care clinic and weekly phone contact

Scope of role includes
- Provide support through active listening, discussing concerns
- Serve as coping models for patients in self-management
- Connect the patient to community resources

Scope of role does not include
- Role as treatment providers, extenders of clinicians, or agents of the clinic
- Answering medical questions or providing medical advice
- Advising patients on depression or other behavioral health issue
- Helping with urgent behavioral health or medical issues
Training and supervision of peers

Training focuses on support skills
- Understanding the peer supporter role and the primary care setting
- Understanding depression, diabetes, and self-management
- Communication skills including reflective listening
- Healthy coping skills with diabetes
- Understanding social support

Supervision in groups
- Twice monthly team meetings with behavioral health and medical provider
- Individual phone and in person meetings as needed
Indicators of program sustainability

Practice support of incorporating patients as peers

Ability to recruit and retain peers and patients

Ability to train peers sufficiently in role

Frequency and quality of contact
  ◦ Patients with peers
  ◦ Peers with supervisors
  ◦ Patients and peers with primary care professionals
Indicators of program sustainability

Satisfaction, helpfulness, and impact of the program
- For patients, peers, and primary care professionals

Impact on peers and patients
- Connection of patients and peers to community resources
- Self-management of diabetes (peers and patients)
- Self-management of depression or other behavioral health issue
- Symptom measures (PHQ-9, Diabetes Distress Inventory)
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COMMUNITY HEALTH WORKERS WITHIN THE HEALTHCARE SETTING

GINA PISTULKA, PHD, MPH, RN, APHN-BC
CHIEF NURSING OFFICER
PCPCC CONFERENCE, NOVEMBER 13, 2014
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Goals & Objectives

Funded by the Center for Medicare and Medicaid Services Innovation to Create an Integrated Care Coordination and Care Delivery System

• Improve access and coordination of care within the healthcare system within the District of Columbia. (key linkages, partnerships, technology)

• Improve the health of the CCIN participant population (HEDIS Measures)

• Reduce healthcare costs incurred by CCIN participants over 3 years
Our Partners and Subscribers

CURRENT PARTNERS

• Bread for the City
• La Clinica del Pueblo
• Mary’s Center
• So Others Might Eat
• Providence Hospital
• Children’s National Medical Center
• Unity Health Care
• Community of Hope
• AmeriHealth DC
• Trusted
• DC Primary Care Association
• DC Healthcare Finance
• Medical Mall
• Core Service Agencies (Green Door, Life Stride, Mary’s Center)
Who We Serve

Target Population
- Medicaid and Medicare recipients in the DC area (including parts of Maryland) selected based on Cost of Care, Health Behavior leading to Utilization of key cost drivers and a wide array of complex Health Conditions
  - Covering all 8 Wards
  - Four languages: English, Spanish, Amharic, French

Population Characteristics
- Approximately 2500 enrolled to date
- 39% of participants have hypertension
- 17% of participants have diabetes
- 25% of participants have asthma
- 25% of participants report more than 2 ER visits in past year, prior to enrollment
- 22% of participants are poorly compliant with medications at enrollment
CCIN Core Model

90-day behavior change intervention focusing on community-based care coordination and chronic illness management for residents in the District of Columbia.

- **Community Health Worker:**
  - Functions as the health system educator, navigator and care connector for enrolled participants.
  - Coaches to support behavior change related to improved health. Teach participants to advocate for themselves and how to better communicate with care providers.

- **RN Care Coordinator:**
  - Provides clinical oversight for case management, CHW guidance and supervision, as well as training.
  - RNs utilize their knowledge of pharmacology, pathophysiology, patient care and a deep understanding of the health care system to lead teams of CHWs and help ensure a quality intervention for each enrolled participant.
  - Provide participants with advanced health education, medication adherence support and education, and triage via telehealth and in-person consults.

- **Technology:**
  - Electronic Care Coordination system tailored for CCIN
  - CHWs equipped with mobile devices (laptops, mobile phones, jetpacks, antennas)
  - Rolling out telehealth component
  - Leading the development and launch of the Capital Partners in Care Health Information Exchange
CCIN uses a high-touch, high-tech behavior change intervention to address the TRIPLE AIM of healthcare reform:

**IMPROVE THE HEALTHCARE EXPERIENCE, IMPROVE HEALTHCARE OUTCOMES, AND REDUCE COST**

**Mentor/Coach**
- Supports development of tangible skills to promote health and illness management
- Uses common social work approaches: Motivational Interviewing, strength-based approach, and praise to empower participants

**Modeling Participant Engagement**
- Encourages and teaches participants how to prepare for clinical care team visits, be proactive and able to advocate for their needs and quality services
- Supports clarification of chronic illness management recommendations and practices
Impacting the Triple Aim

**Cultural and Language Brokering**
- Makes knowledge understandable to a participant, teaching the culture and inner-workings of the health care system
- Advocates for language or literacy needs
- Supports necessary communication between Primary Care Provider and Specialty Providers

**System Navigator and Care Connector**
- Connects participants to the appropriate level of care to match the level of need
- Assists with finding transportation services
- Finds mental health and substance abuse treatment resources
Hospital As Partner

• Emergency Department
  – Educates on appropriate use of ED
  – Connects to primary care
  – Supports the reduction of barriers to engaging in one’s health and with health home.

• Transitional Care
  – Provides community-based follow up for people who are recently discharged
  – Provides support in ensuring the post-discharge appointment is made and attended
  – Ensures prescriptions are filled
  – Works with the RNCC on complex cases
Community Health Centers/Ambulatory Care as Partners

- **Patient-Centered Medical Home**
  - Acts as a community extension of the care team
  - Supports clinical care plan
  - Assists in patient engagement/re-engagement

- **Private Practice**
  - Provides care coordination service arm in the community
  - Targets higher cost, more complex patients

- **TeleHealth**
  - Supports Primary Care
    - Post-ED visit: visual assessment and prescription management or assistance (CHW led)
    - Physical: using Otoscope, stethoscope (RN/LPN led)
  - Supports Mental Health
    - Regular appointments, attendance individual or group counseling
Outcomes to Date

• 100% of participants receive a care plan at their first visit, goals focus on Health Care Utilization and patient identified needs

• 98.3% of participants are visited within 2 weeks of enrollment, the majority in under 1 week

• 72.7% of participants complete the 90 days of the program

• 100% of participants report that CCIN has made a positive impact on their health

• 99% of participants would recommend CCIN to a friend or relative

• 92% of participants attend their scheduled PCP appointment
Estimated Cost Savings

Utilization Change and Cost Comparison:

CCIN Enrolled CY2012 vs. CY2013 (n=1871)
* Decrease in ED visits, in-patient hospitalization, ambulance usage
* Decrease utilization 3.4%
* Estimated $4.2 million reduction (20.6% reduction)

Non-CCIN Enrolled Medicaid CY2012 vs CY2013 (n=1871)
* Increase utilization 23.5%
* Spending increase of $6.5 million (14.7% increase)
Lessons Learned

• Demonstrate value
  – Quantitative data
  – Success stories
• Develop partnerships at every level in the organization
• Work within an entity’s workflow
• Consider models that work for the setting: centralized vs inbedding CHWs
• Engage providers to improve recruitment and outcomes
• Communication and collaborative decision-making are important (Board, Subscriber Committee, Technology Committee)
• Provide an opportunity for Participant feedback
Contact Information:

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