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How Do Peer Coaches Improve Diabetes Care for Low-Income Patients?

A Qualitative Analysis

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Purpose

The purpose of the study was to explore the perspectives and roles of peer coaches, who are patients with diabetes trained to provide diabetes self-management support (DSMS) to other patients.

Methods

A focus group and 17 qualitative semi-structured interviews were conducted with community-based peer coaches in San Francisco in order to better understand the process by which these coaches engaged with their patients. Transcripts were coded and analyzed using methods based on grounded theory to develop a theoretical model of peer coach roles.

Results

Peer coaches play 3 principal roles in providing DSMS: advisor, supporter, and role model. While working with patients, peer coaches had different approaches to setting emotional boundaries and to allocating responsibility for implementing health behavior changes. Peer coaches were more consistent in how they sought resources from providers. Peer coaches also became empowered to better manage their own diabetes.

Conclusion

Peer coaches are a highly motivated potential workforce uniquely positioned to teach and empower patients by building trust through shared experiences. The variability in coaching styles suggests an inherent diversity among peer coaches that must be accounted for in future strategies for design, recruitment, training, and oversight of peer coaching programs.

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Diabetes self-management support (DSMS) improves health outcomes.¹ The National Standards for Diabetes Self-Management Education and Support now identify access to DSMS and ongoing support as 2 key features of successful long-term management of diabetes.² DSMS may be offered by trained health care personnel such as registered nurses, pharmacists, medical assistants, or other nonclinicians.³ However, these groupings are rarely present in sufficient quantity in primary care,⁴ and DSMS is not consistently provided by primary care practitioners due to insufficient time.^{5,6} One solution to expanding access to ongoing DSMS is the use of peer coaches, who are patients with diabetes trained to provide DSMS to other patients.^{7,8}

Peer coaching has gained acceptance as a solution for improving diabetes self-management.⁹ The World Health Organization (WHO) recently endorsed further development of diabetes peer coaching programs as part of a global initiative called Peers for Progress.^{10,11} Patients with diabetes are motivated to interact with other diabetes patients because they can learn from one another, which creates a unique role for peers in DSMS.⁸ Peer coaches, also known as peer advisors, counselors, or mentors, can meet with fellow patients in the community or in the clinic to discuss shared experiences of living with diabetes. They are trained to give advice about DSMS topics including diet, exercise, stress reduction, and medication adherence. However, a fundamental question about peer DSMS remains unanswered in the current literature: *How do peer coaches improve diabetes care for low-income patients?*

This qualitative study explores the reasons for success of peer coaches who participated in a randomized controlled trial (RCT) demonstrating that low-income patients

who received assistance from peer coaches in a primary care setting reduced their glycosylated hemoglobin (A1C) levels significantly greater than a control group.¹²

Although the experiences of peer coaches have been described in diseases other than diabetes,^{13,14} qualitative studies of peer-based DSMS have primarily focused on the perspectives of patients rather than peer coaches themselves.¹⁵⁻¹⁷ Due to the lack of qualitative research on diabetes peer coaches, their roles have been described from the perspectives of researchers. A literature review of peer DSMS by Brownson and Heisler proposed 6 essential peer coach roles: access to regular, high-quality clinical care; an individualized approach to assessment and treatment; collaborative goal setting; education and skills training; ongoing follow-up and support; and linkages to community resources.¹⁸ Dennis' analysis of peer DSMS in health care settings recognizes 3 main types of support: informational, emotional, and appraisal.¹⁹ These roles are prescribed duties assigned by researchers rather than the peer coaches' own descriptions of their activities.

This study proposes a qualitative model that gives insight into the perspectives of peer coaches who successfully helped patients improve their A1C.

Research Design and Methods

Research Design

The authors conducted a preliminary focus group followed by in-depth semi-structured interviews with community-based diabetes peer coaches. The open-ended focus group was used to reveal general attitudes among participants and to inform the development of the interview guide. Semi-structured interviewing in grounded theory is a qualitative technique that elicits the participant's beliefs about themes prompted by an interview guide, which is generated in an iterative process based on participant responses.²⁰ This approach provided detailed information about the coaches' understanding of their roles as peer providers of DSMS.

Sample

Peer coaches participated in a program developed at the Center for Excellence in Primary Care in the Department of Family and Community Medicine at the University of California, San Francisco (UCSF), in conjunction with the Peers for Progress WHO global initiative.¹¹ The study protocol of this RCT, comparing peer

Table 1

Examples of Questions from the Final Iteration of the Semi-structured Interview Guide

Topic	Question
General	How would you explain what a peer coach is (if a friend were to ask you)? Walk me through a typical meeting with a patient whom you coach.
Efficacy	What influence, if any, do you think you have had on your patients? How do you know? What are the greatest challenges faced by peer coaches?
Role	What do you think are the limitations to what a peer coach can do for a patient? How would you define your role in relation to the patients you coach?
Training	In your experience, what have been the best ways for you to build trust with the patients? How could training of peer coaches be improved?
Self-Efficacy	Why did you decide to become a peer coach? How has being a peer coach influenced your own experience with diabetes, if at all?

coaching with usual care for patients with diabetes, is described elsewhere.²¹ Peer coaches were low-income English- and Spanish-speaking patients who received primary care at 1 of 5 San Francisco Department of Public Health clinics. Candidates to be trained as peer coaches needed to have an A1C less than or equal to 8.5%, considered the cutoff for good glycemic control for the purposes of this study. They were referred to the study by their physicians or the clinic diabetes team. Candidate peer coaches underwent a 36-hour-long training session about DSMS techniques followed by a written exam and observation of their coaching skills. Those passing the course were considered to be peer coaches. Peer coaches met monthly with the program director (second author) to discuss problems and receive refresher training. Most patients randomized into the peer coaching group chose their peer coach from a photo book. Peer coaches were expected to meet with patients once every 2 months during the 6-month intervention, to make phone contact every other week, and to attend at least 1 physician visit with each patient. Peer coaches were compensated \$150 for completing the training and \$25 per month for each patient they were actively coaching. Eligible participants in the qualitative study were the 21 peer coaches who had passed the training and were assigned patients prior to the interviews. The 4 most experienced English-speaking coaches were purposively recruited for the focus group. Four of the 21 coaches dropped out of the study prior to being interviewed. All the remaining 17 peer coaches, which included 3 of the 4 coaches from the focus group,

participated in the qualitative interviews. Approval to conduct this study was granted by the Committee on Human Research (Institutional Review Board) at UCSF.

Data Collection

A single open-ended focus group of 4 peer coaches was initially held. Seventeen individual semi-structured interviews, between 35 and 75 minutes in length, were then conducted with coaches in English or Spanish. After each interview, the interview guide was revised in an iterative process. The interview guide included questions about how peer coaches define DSMS; the coaches' roles with regard to patients and the clinical team; and how participation in the program affected their own diabetes management. Examples of questions from the final guide are presented in Table 1. There was sufficient commonality in the data to indicate that thematic saturation had occurred (ie, no new themes were identified). Peer coaches were compensated \$20 for their participation in the qualitative study. Sociodemographic data were collected with a quantitative survey as part of the RCT.²¹ To reduce social desirability bias, the interviewer (first author) was not involved in the RCT study, and coaches were assured that their responses would remain anonymous.

Data Analysis

The focus group and interviews were audio recorded by the first author and professionally transcribed by an outside agency within 1 to 2 weeks. Spanish interviews were

Table 2

Peer Coach Demographics

	No. of Peer Coaches	%
Gender (n = 17)		
Male	5	29.4
Female	12	71.6
Self-reported race/ethnicity (n = 17)		
White/Caucasian, non-Hispanic	3	17.6
Latin/Hispanic	6	35.3
Black/African American	5	29.4
Asian/Pacific Islander	1	6.9
Native American	1	6.9
Multiracial	1	6.9
Education level (n = 17)		
Did not graduate from high school	2	11.8
High school graduate or GED	4	23.5
Some college	4	23.5
College graduate	7	41.2
Employment status (n = 17)		
Full-time paid (> 30 h/wk)	3	17.6
Part-time paid (< 30 h/wk)	3	17.6
Retired	6	35.3
Unemployed	3	17.6
Disabled	2	11.8
Annual income (n = 16)		
Less than \$5000	5	31.3
\$5000-\$10 000	2	12.5
\$10 000-\$20 000	7	43.8
More than \$20 000	2	12.5

analyzed in Spanish and specific quotations were translated only for publication. Using methods based on grounded theory, transcripts were encoded with AtlasTI qualitative data analysis software. A preliminary round of descriptive coding was performed inductively to develop a basic vocabulary of the data and to identify major themes, as outlined by Miles and Huberman.²² Interrelations were then conceptually mapped to develop the theoretical model. The coding and modeling were primarily conducted by the first author, a graduate student, under the supervision of the third author, an experienced qualitative researcher and professor of qualitative methods. The codebook was workshopped during meetings with the other authors, who have worked extensively with the coach population. A concept map of themes from the initial analysis was presented to the peer coaches, and their impressions of its accuracy were incorporated into further development of

the codebook as a way of verifying the analysis. Quotations are presented without specific demographic characteristics in order to protect anonymity.

Results

Description of the Sample

The mean age of the peer coaches was 60 years (range 47-80, SD 8.5). Additional demographic data are presented in Table 2. Only 1 of 17 coaches had not yet met with any patients at the time of the interview. Among the other 16 coaches, the mean length of time from the first patient assigned to a coach to the time of the interview was 120 days (range 55-229, SD 50.8), and the mean number of patients that each coach had been assigned was 5 (range 1-9, SD 2.4).

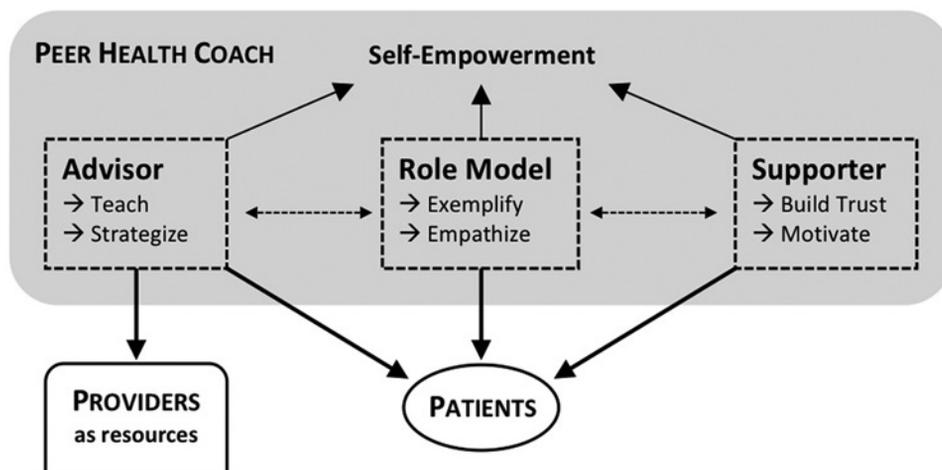


Figure 1. Qualitatively derived model for functions of peer coaches in practice. The main roles of peer coaches (in dashed boxes) include an advisor who teaches and strategizes, a supporter who builds trust and motivates, and a role model who incorporates personal experience in order to exemplify and empathize. Peer coaches sought resources from providers, primarily in their advisor role. They became self-empowered to better manage their own diabetes as a result of their work.

Qualitatively Derived Model

This model represents the roles and interactions of diabetes peer coaches working with patients in a community-based primary care setting (Figure 1). Analysis of the peer coaches' descriptions of their experiences identified 3 principal roles in their provision of DSMS: *advisor*, *supporter*, and *role model*. The advisor role focused on patients' health behaviors in order to implement diabetes self-management. The supporter role encompassed the emotional aspects of connecting to patients. As role models, the peer coaches incorporated their personal experiences into their interactions with patients. Peer coaches felt empowered by their work to better manage their own diabetes. Each of these roles is discussed below with illustrative quotations from peer coach interviews.

Advisor

Among many duties that peer coaches fulfilled, the advisor role encompassed the aspects of their work related to modifying health behaviors. *Teaching* activities were aimed at helping patients understand their A1C goals, implement behavior change, improve medication adherence, and engage in shared decision making. Coaches accomplished these goals by providing medical knowledge, answering questions, and referring patients to resources. Peer coaches also discussed *strategizing* how to actually implement DSMS techniques in their patients' lives.

All 17 of the peer coaches said that they spent time teaching. A majority of coaches shared information about medications with their patients, and many taught about diet and blood glucose—both self-monitoring of blood glucose and the meaning of A1C. Other topics included exercise and diabetes risk factors such as high cholesterol, high blood pressure, and stress. For example, one coach stated,

I'd be like a teacher, an instructor, teaching them the good things about the diabetes and the bad, and helping them also with their menus, their food choices. Tell them what is good and what is bad and how big the portions should be.

The other aspect of the advisor role was the time many peer coaches took to strategize about how to incorporate these lessons into their patients' lives, including making an action plan, using medication reconciliation, planning for future doctor visits, and checking in with patients to track progress. This coach described some of the main strategies taught during the training:

A peer coach is someone who assists you with working out your challenges with your diabetes. So—getting you an action plan and helping you learn your medications, your exercise, and your diet.

The informational and practical aspects of providing DSMS were the focus of the training curriculum, and

Table 3

Quotations Demonstrating the Peer Coaches' Variability as Advisors in How They Engaged Patients in the Process of Achieving Behavior Change Goals

	<p>"Sometimes they need a little pushing one way and pulling this way, but nicely, of course."</p> <p>"You can't make them do something they don't want to do. But you can work on changing their mind."</p> <p>"Diabetes is primarily a self-help disease. The doctor can only tell you what you should do. He can't do it for you. I can only tell you what you should do. I can't do it for you. Ultimately it's all up to you. Either you do it or you don't."</p>
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there was a consensus among peer coaches that advisory functions were a core tenet of their work.

Within the advisor role, each peer coach independently determined the dynamics of his or her interactions with patients. There was a wide range in how the coaches allocated responsibility to their patients, with some playing a more active role in the behavior change process and others leaving it more to the patients to follow through independently (Table 3). Some coaches tried actively to convince patients to adhere to their plans, whereas others maintained that success depended upon the patient's level of devotion.

In contrast to the variety in the allocation of responsibility to patients, there was a clear consensus about seeking help from providers. Providers include the patient's or the peer coach's physician and clinical care team, as well as the Peers for Progress program staff. Many coaches expressed caution about sharing information, stating that when they did not know how to answer a question or how to approach a situation, they would ask for help or refer patients to their providers. For example,

I shouldn't be able to do more than what they trained me to do. . . . So certain things I just refer them to the clinic, or to the advice nurse, or check on it for you and get back with you. I don't go farther than what I know.

Supporter

Whereas the advisor role focused on health behavior change, the supporter role encompassed the emotional aspects of peer coaches' interactions with patients. To

make patients feel comfortable enough to discuss their diabetes, many coaches felt it was necessary to *build trust* with patients by cultivating rapport and fostering friendship. Peer coaches also tried to *motivate* patients by giving reassurance and empowering them to use self-management techniques independently.

Almost all of the peer coaches said that they began most interactions by discussing their patients' personal lives. One coach said that this approach was an important way of building trust:

The first thing you have to do is try to earn their friendship, their trust . . . so that they feel confident in you. They can reveal everything, because when they don't have trust, they don't see the coach as a friend, and they're not going to come out with everything.

The peer coaches said that they were able to establish rapport with patients by listening carefully, being honest, staying positive, and showing compassion. Many coaches also said that their availability was important in building trust, especially because most doctors cannot be so openly accessible. For example,

We can develop a relationship with and sit with them, where when something happens that may be hurting them, with that problem, they can call us where they wouldn't call the doctor. . . . So that's a thing we can do that makes us—as far as I'm concerned—invaluable. Because if I had a peer coach 13 years ago, I'd probably be cured.

Table 4

Quotations Demonstrating That as Supporters, Peer Coaches Ranged from Being Open about Emotional Issues to Avoiding These Topics

 <p>More open</p> <p>Less open</p>	<p>"It's clear that sometimes we have to be careful about intimacies because their points aren't ours. But there are moments . . . when frustration makes them reveal their personal issues and we have to understand them and, above all, be friendly."</p> <p>"And tell them a little bit about yourself, so that they can get a feel that—you build up a friendship with this person. But you have to know where the line is . . . where it's not too personal, but personal enough. That's the key thing."</p> <p>"I'm not used to being around anybody who's depressed. . . . What are you going to do? Because that's something above and beyond what we get any kind of training."</p>
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While trying to motivate patients, many peer coaches said that it was important to encourage patients to follow through on their strategies for diabetes self-management, which was highlighted in their training. This coach motivated patients to stay optimistic and persistent by emphasizing that it is possible to live with diabetes for a long time:

To make them aware that it's a disease that can be taken care of, I tell my patients, "Look, you have to learn one thing: that those who are diabetics can last a long time if we are obedient about our medications and diet."

In addition, some peer coaches stressed that the knowledge that patients gained from coaching was itself a form of empowerment, as demonstrated here:

Lack of knowledge makes a man ignorant. So if he knows how to do a certain thing and doesn't do it, that's on him. But after he learns how to do something, and he follows the directions and he sees the results, he can live like this for the rest of his life and never worry about that anymore.

Similar to the distinct boundaries set by each peer coach in the advisor role, peer coaches varied greatly in the supporter role in the degree to which they were willing to discuss emotional issues with their patients. A majority of peer coaches said that they were open to personal topics and became deeply invested in their patients' lives, whereas others said that they were not

sure how to deal with emotional issues that arose or they avoided them altogether (Table 4).

There were even a couple of cases in which the patient's personal issues went beyond the scope of the peer coach's training, and professional help was sought. For example,

One of my clients . . . was real depressed. . . . And I contacted [the social worker] at our clinic . . . and I said, "I don't know what to do. She is so depressed." And I had asked my client, "Do you need someone to talk to besides me?" And she told me, "Yes."

Each peer coach had his or her own style of coaching, as can be seen in their different approaches to setting boundaries with patients in their roles as advisors and supporters. Despite sharing an identical training curriculum, this lack of consensus suggests that personal factors play an important role in coaching dynamics. With that said, the peer coaches' consistent approach to contacting providers when encountering situations beyond their training suggests that they maintained a clear sense of the limits of their knowledge and abilities.

Role Model

Whereas many peer coaches described their activities in terms of lessons and techniques acquired during their training, they also brought personal experiences to their

work in these advisor and supporter roles. As role models, coaches *empathized* with patients by sharing their experiences and lessons learned. They also *exemplified* their own healthy behaviors by demonstrating self-management strategies that have worked for them.

A majority of peer coaches said that they empathized with patients by bonding over shared experiences and by understanding their patients' struggles. For example,

Sometimes I tell them about my disease—I tell them that I also have diabetes and that I also do the same things that I'm explaining to them . . . that I'm like them. Then they say, "Oh, good," and they say, "That's good because this way we can gain your experience."

Although many experiences were mutual, some coaches acknowledged that they did not necessarily have the same experiences as their patients. Nevertheless, a few coaches went so far as to exemplify healthy behaviors by exercising or sharing foods with patients. This coach conveyed the message that it is important to "practice what you preach":

Someone asked me, say, "Why are you walking so much?" I said, "Because I'm going to practice what I'm going to be preaching. I'm not going to tell some guy to walk 3 days a week if he can make it to that, and I can't walk 3." You see? I want to be able to do what I'm telling you to do.

Peer Coach Self-Empowerment

Many peer coaches said that their experiences initiated a process of becoming empowered to better manage their own diabetes (Table 5). They were motivated to join the program by multiple factors, including altruism and a desire to learn more about diabetes. Most of the peer coaches also said that being in the program led to an improvement in their diabetes self-management, whereas a couple of coaches said that their health declined due to personal circumstances.

Thanks to becoming empowered, many of the peer coaches continued to draw upon their training while giving advice to family and friends, serving as a community resource, and even coaching their patients beyond the completion of the study.

Discussion

This qualitative study of diabetes peer coach roles is derived from the quantitative study, "Impact of peer

health coaching on glycemic control in low-income patients with diabetes," a RCT demonstrating that patients working with peer coaches had significantly lower A1C levels after 6 months than a control group.¹²

The advisor role focused on teaching and strategizing in a wide range of topics included in the coach training, and coaches varied in how closely they engaged patients in the process of achieving behavior change goals. As supporters, peer coaches motivated and built trust with patients, although they differed in how they set emotional boundaries. Peer coaches were well aware of their limitations in both roles and were careful to seek resources from providers whenever necessary. Finally, peer coaches acted as role models by drawing on their own experiences to empathize with patients and exemplify healthy behaviors. This work resulted in self-empowerment among the peer coaches themselves.

The various styles within this small group of diabetes peer coaches, all of whom received the same training, suggest that personal preferences among coaches may introduce both desirable diversity and complicated inconsistencies into peer coaching programs. Nevertheless, despite the differences among coaches, the group as a whole was successful at helping patients improve their diabetes management. Further mixed-methods analysis is required to determine which traits among peer coaches resulted in better patient outcomes.

The peer coaches' descriptions of becoming empowered were overwhelmingly positive. As with coaches providing self-management support for heart disease,¹³ these peer coaches were highly motivated by a spirit of altruism. They benefited from health education that they had never received as patients, resulting in their feeling more confident about managing their own diabetes. They then shared their lessons not only with the patients assigned by the study but also with their families and communities.

Physicians, nurses, and other paraprofessionals are often limited to an advisory role because of the time constraints in primary care.⁵ Figure 2 shows that although many people on the spectrum from layperson to provider can fill some of the peer coaches' main roles, only peer coaches satisfy all 3 at once. The extensive training in this program distinguishes these peer coaches from untrained coaches in other studies who primarily play a supporter role.²³ To reincorporate DSMS into chronic disease management in primary care, peer coaches can fill the current gap in the health care team.

Table 5

Quotations Demonstrating Peer Coach Self-Empowerment

Domain	Subdomain	Example
Motivation to participate	altruism	"I gave them tools they needed, and I've seen their enthusiasm. . . . It made me feel proud. . . . This is my passion, doing this! So it makes me very fulfilled."
	education	"And it helps me, too, to also know more correct information. Because even now I don't know everything about it. I learn things about myself even on it."
	helping providers	"The doctor handles the medical and handles all the things that the peer coach handles but doesn't have the time to, which are the non-medical things, which are the diet and the exercise, helping plan a diet, helping them to get it within their financial budget. . . . The type of things that within 15 minutes, which is basically what the doctor has to see the patient, he could not possibly do."
	improved health	"I have some pretty good clients. They help me, too, you know. I'm telling you, it works both ways. Whether they know it or not, they're peer coaching me, too." "It helped me do a lot of things that I haven't been doing for myself. Because I say, how can I be an example to my patients if I'm not doing it? . . . I want to set an example, being a peer coach, hey, look! I got mine under control! You can do it, too."
Becoming community leaders	family	"That's the first thing that is in my mind, if I will learn, then help myself and other people and the family, too. Because my mother was a diabetic, and my father, both of them died already. So maybe I can help the family."
	patients	"After this program was over . . . 5 months from now, I can still be this person's buddy and keep in contact with this person, not only for their sake, but for your own sake."

Limitations

Although all peer coaches active at the time of the study participated in the interviews, this study did not include a later cohort of 3 coaches as well as the 4 coaches who dropped out prior to the interviews and may have had negative experiences in the program. Social desirability bias may have been a factor in the coaches' responses. Finally, these findings are specific only to this group of diabetes peer coaches working in a low-income primary care setting and cannot be generalized to all peer coaching contexts.

Implications

By learning from the perspectives of peer coaches, this qualitatively derived model assists with development of future peer coaching programs in the following ways:

- *Recruitment:* Given that coaches had a wide range of personal coaching styles, entrance interviews may clarify which candidates are likely to work well with a diverse group of patients. Furthermore, recruitment should emphasize the potential benefits to peer coaches themselves, including improved management of their own diabetes and becoming a community resource.
- *Training:* As advisors, the coaches' various approaches to allocating responsibility to patients could potentially include either pressuring patients to adopt new health behaviors or remaining so hands-off as to render themselves ineffectual. Coaches also have the potential to become too emotionally involved as supporters. The peer coach training program should carefully define boundaries and clarify expectations.
- *Oversight:* Peer coaches consistently sought advice about health behaviors or emotional issues when they were confronted with situations that went beyond their knowledge and abilities. Future programs must ensure access to program staff, providers, and additional outside resources.

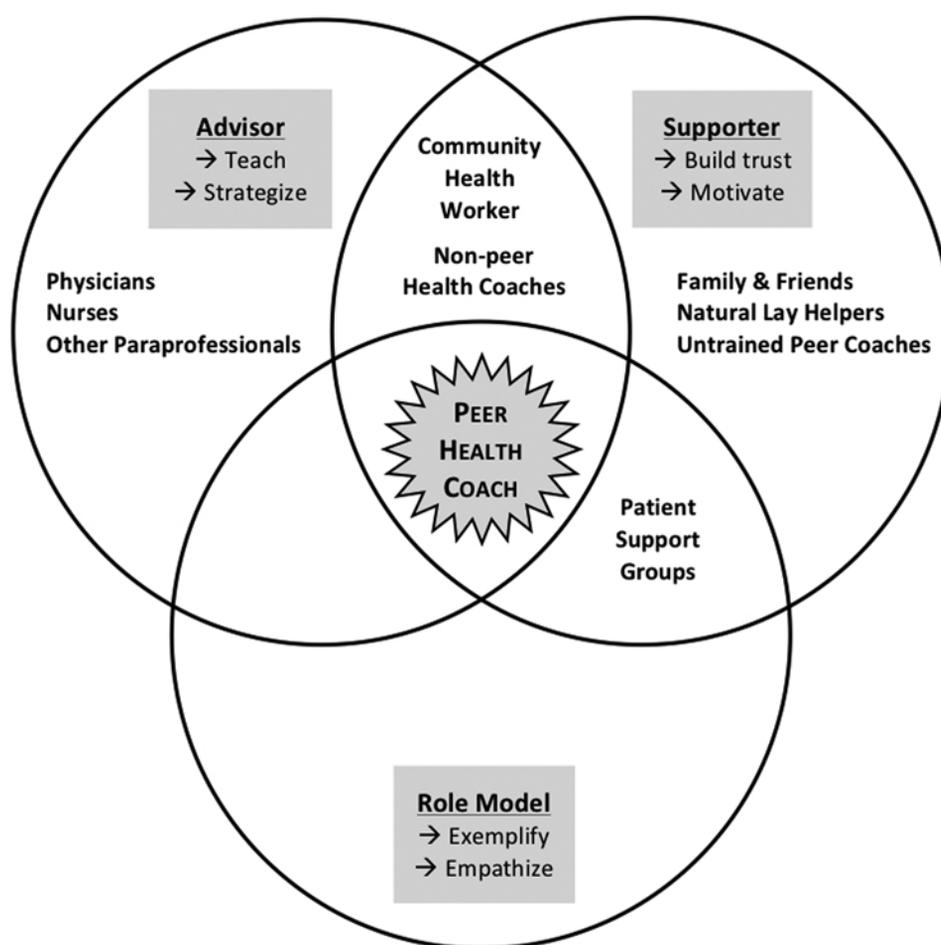


Figure 2. Spectrum from laypersons to providers fulfilling peer coach roles. Schematic representation (developed by the authors) showing how various providers of self-management support fulfill some of the principal peer coach roles of advisor, supporter, and role model, but only peer coaches satisfy all 3 at once.

DSMS is lacking in primary care,⁵ and primary care providers no longer have time to provide this essential component of chronic disease management.⁶ Peer coaches are an effective and highly motivated potential workforce for providing one-on-one DSMS, particularly when they receive training. This qualitative model shows that peer coaches are uniquely positioned to teach and empower their patients by building trust through shared experiences.

References

- Norris SL, Engelgau MM, Narayan KM. Effectiveness of self-management training in type 2 diabetes: a systematic review of randomized controlled trials. *Diabetes Care*. 2001;24(3):561-587.
- Haas L, Maryniuk M, Beck J, et al. National standards for diabetes self-management education and support. *Diabetes Care*. 2012;35(11):2393-2401.
- Margolius D, Bodenheimer T. Controlling hypertension requires a new primary care model. *Am J Manag Care*. 2010;16(9):648-650.
- Margolius D, Bodenheimer T. Transforming primary care: from past practice to the practice of the future. *Health Aff*. 2010;29(5):779-784.
- Peyrot M, Rubin RR, Funnell MM, Siminerio LM. Access to diabetes self-management education: results of national surveys of patients, educators, and physicians. *Diabetes Educ*. 2009;35(2):246-248, 252-246, 258-263.
- Ostbye T, Yamall KS, Krause KM, Pollak KI, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med*. 2005;3(3):209-214.
- Nettles A, Belton A. An overview of training curricula for diabetes peer educators. *Fam Pract*. 2010;27(suppl 1):i33-i39.
- Sullivan ED, Joseph DH. Struggling with behavior changes: a special case for clients with diabetes. *Diabetes Educ*. 1998;24(1):72-77.
- American Association of Diabetes. A sustainable model of diabetes self-management education/training involves a multi-level team that can include community health workers. <http://www>

- .diabeteseducator.org/DiabetesEducation/position/White_Papers.html. Accessed June 9, 2013.
10. World Health Organization. *Peer Support Programmes in Diabetes: Report of a WHO Consultation*. Geneva, Switzerland: WHO; November 2007.
 11. Boothroyd RI, Fisher EB. Peers for progress: promoting peer support for health around the world. *Fam Pract*. 2010;27(suppl 1):i62-i68.
 12. Thom DH, Ghorob A, Hessler D, De Vore D, Chen E, Bodenheimer TA. Impact of peer health coaching on glycemic control in low-income patients with diabetes: a randomized controlled trial. *Ann Fam Med*. 2013;11(2):137-144.
 13. Barg FK, Weiner MG, Joseph S, Pandit K, Turner BJ. Qualitative analysis of peer coaches' experiences with counseling African Americans about reducing heart disease risk. *J Gen Intern Med*. 2012;27(2):167-172.
 14. Nguyen TU, Tran JH, Kagawa-Singer M, Foo MA. A qualitative assessment of community-based breast health navigation services for Southeast Asian women in Southern California: recommendations for developing a navigator training curriculum. *Am J Public Health*. 2011;101(1):87-93.
 15. Joseph DH, Griffin M, Hall RF, Sullivan ED. Peer coaching: an intervention for individuals struggling with diabetes. *Diabetes Educ*. 2001;27(5):703-710.
 16. Davis KL, O'Toole ML, Brownson CA, Llanos P, Fisher EB. Teaching how, not what: the contributions of community health workers to diabetes self-management. *Diabetes Educ*. 2007;33(suppl 6):208S-215S.
 17. Heisler M, Piette JD. "I help you, and you help me": facilitated telephone peer support among patients with diabetes. *Diabetes Educ*. 2005;31(6):869-879.
 18. Brownson CA, Heisler M. The role of peer support in diabetes care and self-management. *Patient*. 2009;2(1):5-17.
 19. Dennis CL. Peer support within a health care context: a concept analysis. *Int J Nurs Stud*. 2003;40(3):321-332.
 20. Patton MQ. *Qualitative Evaluation and Research Methods*. 2nd ed. Newbury Park, CA: SAGE Publications; 1990.
 21. Ghorob A, Vivas MM, De Vore D, et al. The effectiveness of peer health coaching in improving glycemic control among low-income patients with diabetes: protocol for a randomized controlled trial. *BMC Public Health*. 2011;11(1):208.
 22. Miles MB, Huberman AM. *Qualitative Data Analysis: An Expanded Sourcebook*. 2nd ed. Thousand Oaks, CA: SAGE Publications; 1994.
 23. Lorig K, Ritter PL, Villa FJ, Armas J. Community-based peer-led diabetes self-management: a randomized trial. *Diabetes Educ*. 2009;35(4):641-651.

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