



## SPECIAL COMMUNICATION

## Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field

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### Abstract

Peer support is a central tenet of the Disability Rights Movement and is based on the recognition that experiential knowledge and shared experiences provide opportunities for informational, emotional, and appraisal support among people with physical disabilities. “Peer support interventions” is an umbrella term used to describe a range of ancillary services provided by people with disabilities to people with disabilities, including peer mentoring, peer health education, and peer health navigation. A growing body of research documents the development, implementation, and outcomes of peer support interventions for people with physical disabilities in physical medicine and rehabilitation. The organization, structure, and objectives of peer support interventions vary tremendously, making it difficult to synthesize findings across studies and establish best practices to support their systematic implementation across the continuum of care. This article is a call to action for greater conceptual clarity in how peer support interventions are developed, implemented, and evaluated. We propose a 9-part evidence-informed framework delineating both theory-driven and contextual considerations to help strengthen the evidence base of peer support interventions for people with disabilities in physical medicine and rehabilitation.

Archives of Physical Medicine and Rehabilitation 2021; ■: ■■■■-■■■

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Peer support intervention (PSI) is an umbrella term to characterize a wide range of programs that capitalize on the strengths and experiential knowledge within the disability community to enhance health, participation, and quality of life outcomes for persons with a disability (PWD). The use of peer support among PWD is rooted in the disability rights and independent living movement. Examples of PSIs include a peer mentor intervention to educate persons with spinal cord injury (SCI) in self-management at an inpatient rehabilitation hospital,<sup>1,2</sup> a peer support program within an inpatient rehabilitation setting for men with violently acquired SCI,<sup>3</sup> a community-based peer mentor program to support return to school/work for persons with brain injury,<sup>4</sup> and a peer health navigator intervention to improve health care access for Medicare beneficiaries in the community.<sup>5</sup>

PSIs ease disability transitions and improve outcomes on psychosocial functioning, community reintegration/participation, and patient activation.<sup>1,3,4,6-21</sup> In 2015, the Society of Behavioral

Medicine published a call to action for the widespread adoption of PSIs to meet the “Triple Aim of improving patient experience, improving population health, and reducing costs and unnecessary utilization of resources” in *all* health care delivery settings and patient populations.<sup>22(p. 1)</sup> Accrediting agencies, such as CARF International, now require evidence of peer support services as part of spinal cord and brain injury rehabilitation services.

To date, there is no standard definition of what constitutes a peer supporter. Simoni et al suggest that the 4 essential elements that define a peer supporter are that they: (1) share key personal characteristics, circumstances, or experiences with the target population; (2) promote the benefits of PSIs largely from their status as peer; (3) lack professional training or status as a health care provider; and (4) function intentionally according to standard protocols. It is thus the peer supporters’ lived experience of disability coupled with intentional programming that form the core of PSIs.<sup>23</sup>

In physical medicine and rehabilitation (PM&R), there is tremendous heterogeneity in how PSIs are designed, implemented, and evaluated. This heterogeneity poses barriers to building the evidence base and establishing best practices to support widespread adoption and implementation of PSIs in PM&R. This article is a call to action for greater transparency and conceptual

Supported by the National Institute on Disability, Independent Living and Rehabilitation Research (grant no. 90RT5027).

Disclosures: none.

clarity in the development and implementation of PSIs in both research and as part of the clinical care continuum. We draw on an organizing framework originally conceptualized by DeGroff et al delineating key components of patient navigator programs for people with prostate cancer<sup>24</sup> to articulate both the theory-driven components of PSIs as well as the contextual factors that should be considered in intervention development.

Mounting evidence demonstrates that individual PSIs positively affect the people they serve, yet their effectiveness is difficult to synthesize into evidence-based practice guidelines because of the diversity in how programs are organized, who they target, and how outcomes are measured.<sup>1,3,4,6-21</sup> Specifically, we located 6 systematic and scoping reviews of PSIs targeting a distinct PM&R populations, including acquired brain injury,<sup>11,25</sup> SCI,<sup>13,26,27</sup> and veterans with postdeployment syndrome.<sup>10</sup> All of the review articles concluded that it was difficult to determine the effect of and best practices for PSIs because of difference in the key characteristics such as setting, intensity, health outcomes<sup>11</sup>; timing and focus, role of peers, and health outcomes<sup>26</sup>; and description of intervention.<sup>13,27</sup> These studies call for the systematic development and evaluation of PSIs.

As more PSIs are being developed, PM&R would benefit from guidance of key considerations for implementation and evaluation of PSIs to support ongoing quality improvement and establishment of evidence-based best practice guidelines. Similar questions have been raised in several health care fields over the last 15 years.<sup>28-33</sup> In the rest of this article, we adapt DeGroff's organizing framework<sup>24</sup> of 9 key considerations in designing patient navigation programs in cancer care to the field of peer support in PM&R. We explain each key consideration using examples from the PM&R literature. We add nuance by subdividing the framework into theory-driven intervention components (including program goals and theoretical framework, target population, services [active ingredients, mode of delivery, dosage], and outcomes) and contextual variables (such as peer supporter characteristics, peer training, supervision, and setting). Contextual variables can be adapted based on practical and logistical considerations to support implementation across practice and community-based settings. (See [fig 1](#) for a graphical representation of the PSI element and key considerations.)

## Theory-driven components of PSIs

### Theoretical framework and program goals

In 1999, Turner and Shepherd characterized PSI as "a method in search of a theory rather than the application of theory to practice."<sup>34(p. 235)</sup> In the ensuing 2 decades, PSIs in rehabilitation remained largely atheoretical with relatively few interventions explicitly articulating a theoretical foundation to support program activities and hypothesized outcomes. A Cochrane systematic review of randomized controlled trials of PSIs for people with mental health concerns identified the lack of a clear change model, ie, an understanding of how what peer workers do is associated

with outcomes, as a potential limitation in existing clinical trials.<sup>35</sup> United Kingdom Medical Research Council guidance on evaluating complex interventions recommends theoretically and empirically modeling how complex intervention processes are associated with change in outcomes. This is particularly important in psychosocial interventions, such as peer support, where interpersonal aspects of the intervention might mediate outcomes.<sup>36</sup>

At its most basic level, theory helps explain why an intervention works the way that it does.<sup>37</sup> Theoretical frameworks foster a systematic approach to intervention development and implementation that would allow the use of PSIs in PM&R to move beyond simplistic, outcomes-focused approaches to examining the central processes underlying intervention effects.<sup>38</sup> Theoretical specificity allows for (1) accurate conceptualization of the problem targeted by the intervention, (2) specification of the population responsive to the intervention, (3) specification of critical elements of the intervention, (4) delineation of contextual factors that influence implementation and outcomes of the intervention, and (5) understanding of the mechanisms that lead to the desired outcomes, including the identification of specific mediators of change that influence an intervention's success. The intentional use of theory to align with programmatic goals defines and shapes the critical elements of PSIs, including decisions about creation and implementation, the target population, and expected outcomes.

Despite known strengths of theory-based intervention research, explicit use of theory in PSI research has been limited. Simoni et al proposed a 2-step process to conceptualize PSIs to promote health outcomes.<sup>39</sup> Step 1 emphasizes the identification of a sound theoretical basis for health behavior change and desired outcomes in a target population. Step 2 focuses on the justification of the inclusion of peers to achieve the theory-driven outcomes. [Table 1](#) provides examples of how the 5 primary types of PSIs<sup>39</sup> and their underlying theoretical frameworks drive intervention elements in PM&R.

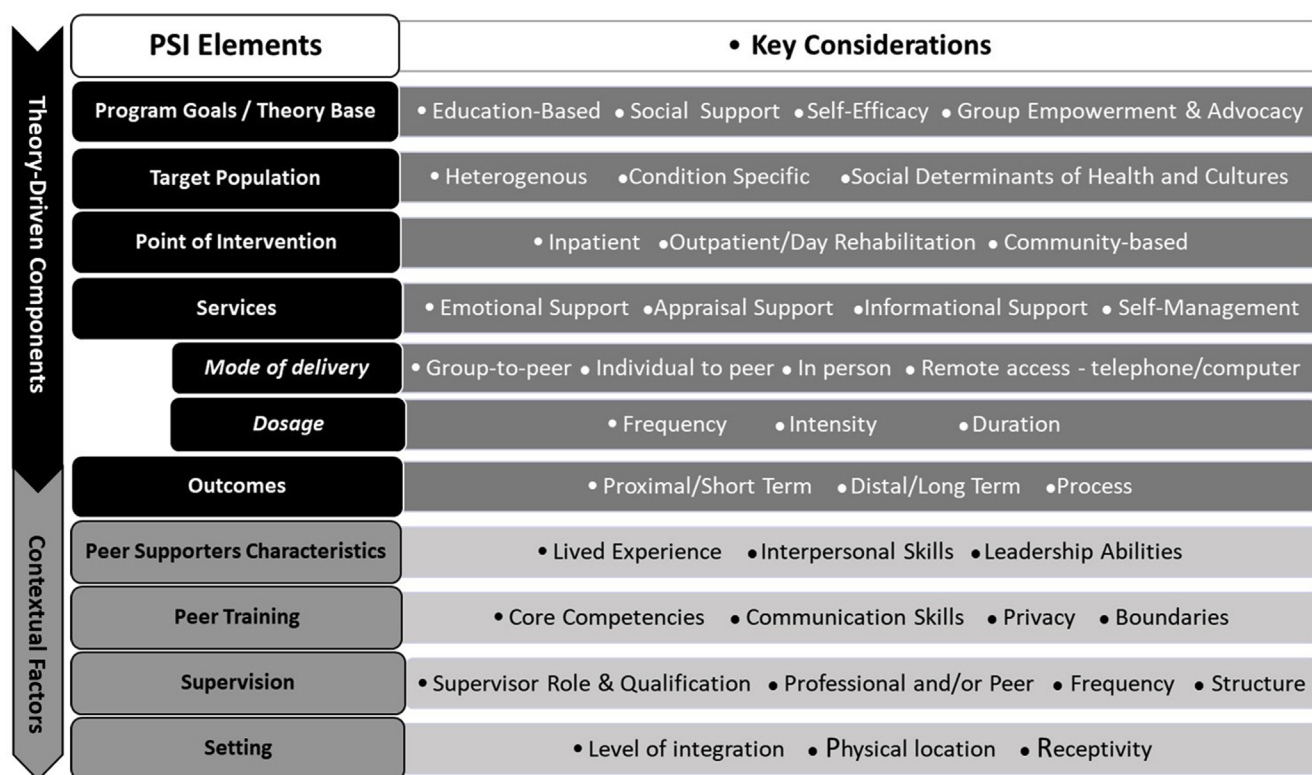
### Community characteristics: target population

To appropriately tailor PSIs to the target population, it is critical to have a deep understanding of that community's clinical and social needs and strengths. This requires going beyond medical diagnoses to understand the environmental circumstances that shape the lives of the people the intervention is designed to serve. Given that PSIs complement rather than replace medical and rehabilitation services, they are uniquely situated to address practical and logistical concerns that complicate the lives of PWD. Indeed, peer supporters' experiential knowledge of living with disability is where their unique value and potential lie.

Social determinants of health account for substantially more of the variation in health outcomes than medical care does.<sup>40</sup> By taking a broad view of health and a deep understanding of community characteristics, developers can tailor PSIs to the target community. Recognition of the unique community needs, resources, and cultures supports knowledge translation of evidence-informed PSIs to diverse community settings. For example, a peer support intervention developed and tested in an urban teaching hospital will require adapting to meet the needs of people from rural communities. Understanding the local community characteristics also provides opportunities to ensure that the PSI is culturally tailored to reflect the target population's racial and ethnic composition, culture, and values. Integration of person-centered goal setting helps ensure that the PSI is responsive to an individual's unique situation. Ensuring that peer supporters have the knowledge, skills, and abilities to practice with cultural

#### *List of abbreviations:*

<b>PM&amp;R</b>	<b>physical medicine and rehabilitation</b>
<b>PSI</b>	<b>peer support intervention</b>
<b>PWD</b>	<b>persons with a disability</b>
<b>SCI</b>	<b>spinal cord injury</b>



**Fig 1** Key considerations in designing and implementing peer support interventions for physical medicine and rehabilitation, including theory-driven and contextual factors. Adapted with permission from DeGroff et al.<sup>17</sup>

humility and responsiveness should be reflected in the peer selection and training processes.

### Point of intervention

A critical decision in the development of PSIs is where in the continuum of care to implement them. Factors such as program goals, theoretical framework, and considerations including participants' readiness for change and acceptance of the disabling condition come into play when making these determinations.

Existing PSIs for PWD target a wide range of intervention time points, including inpatient rehabilitation, the transition to community living, and long-term independent living. All time points offer advantages and challenges; it is important to determine the best strategic alignment between program goals, access to the target population, and point of intervention. Determining where in the continuum of care the PSIs will occur can also help determine the most appropriate setting (eg, clinical, home, center for independent living) for the intervention to take place. For instance, during inpatient rehabilitation, having face-to-face programs in-house may be most appropriate for both practical and logistical reasons and to create of a supportive infrastructure (ie, opportunities for oversight and cofacilitation with health care professionals, especially related to health education). In contrast, people living with long-term disabilities in community-based settings may benefit from interventions that take place in their homes and local communities. Community-based PSIs allow for more peer autonomy and an emphasis on building self-efficacy in community and health systems navigation.

### Services

The specific services provided as part of PSIs should be determined by the program goals and desired outcomes.<sup>24,39</sup> Levy et al categorized the services provided as informational, emotional, and appraisal support.<sup>25</sup> The emphasis and provision of these types of support vary within and across programs. Emerging evidence suggests that PSIs that integrate informal, social, and emotional support and appraisal/role modeling are more effective at promoting community integration and quality of life. Program developers should clearly explain the nature of services within these broad categories to demystify PSIs.

Informational support is the provision of advice, suggestions, and information. Within PSIs, informational support can be grouped into 3 broad categories: educational programming, resource sharing and referrals, and informal information sharing. Almost all PSIs include informal brainstorming and idea sharing informed by the peer supporters' lived experiences and accumulated knowledge.

Emotional support includes expressions of empathy and understanding, displaying responsive and caring behaviors, and recognizing a peer's individual needs. Appraisal support is closely tied to role modeling that enables PWD to see alternative ways of seeing and being in the world. Appraisal support helps counteract some of the negative social constructions and structural ableism embedded in cultural framings of disability. By acting as role models and intentionally fostering trust and respect, peer supporters help mentees change their perspectives and reframe problems. Integration of disability rights and independent living philosophies into PSIs can help people reconceptualize their view

**Table 1** Theory-driven components of peer support interventions

Program Goals	Theory Base	Target Population	Program Activities	Outcomes
Improve symptom or disease knowledge	Dynamic social impact theory, social learning theory	Patients with <ul style="list-style-type: none"> <li>• Knowledge deficits</li> <li>• Difficulty managing symptoms</li> <li>• Risk of developing new-onset conditions</li> </ul>	Group or individual education sessions	<ul style="list-style-type: none"> <li>↑ Symptom management</li> <li>↑ Symptom knowledge</li> <li>↓ Complications</li> <li>↓ High cost utilization</li> </ul>
Improve adjustment and increase the recognition that you are not alone in dealing with disability issues	Stress and coping theory	Patients with <ul style="list-style-type: none"> <li>• New-onset disabilities who are having trouble adjusting to a new way of living</li> </ul>	Emotional support Informational support Aspirational support Friendly visits	<ul style="list-style-type: none"> <li>↑ Life satisfaction</li> <li>↑ Acceptance</li> <li>↓ Depression</li> <li>↓ Anxiety</li> <li>↓ Fear of the unknown</li> </ul>
Improve ability to manage aspects of one's disability, activities, or participation	Social cognitive theory and self-efficacy theory	Patients with <ul style="list-style-type: none"> <li>• Low self-efficacy</li> <li>• Low confidence</li> <li>• Self-management deficits</li> </ul>	Skills-based interventions that emphasize acquisition of new skills	<ul style="list-style-type: none"> <li>↑ Self-efficacy</li> <li>↑ Patient activation (depending on nature of the skills emphasized.)</li> </ul>
Improve/increase collective action against societal barriers and systems	Empowerment theory	Patients who are <ul style="list-style-type: none"> <li>• Socially marginalized</li> <li>• Stigmatized</li> </ul>	Advocacy training Assertiveness training Disability rights training Collective action	<ul style="list-style-type: none"> <li>Social change</li> <li>Critical consciousness</li> <li>↑ Assertiveness</li> </ul>
Change health behaviors, either adopting new practices or abandoning old ones	Group-mediated social control theory, diffusion of innovation theory, social network theory	Patients who need to <ul style="list-style-type: none"> <li>• Adopt new health behaviors or practices</li> </ul>	Peers as influencers to model behavior change and benefits	<ul style="list-style-type: none"> <li>↑ Adoption of targeted health behavior</li> </ul>

of disability as a personal problem to recognize the effect of systemic barriers.

A growing number of PSIs extend beyond providing support to promote the development of self-management skills and align with self-efficacy theories. Self-management—focused PSIs, such as the wheelchair skills group of Best et al,<sup>41-43</sup> emphasize new skill acquisition and graded practice. Magasi<sup>5</sup> and Houlihan<sup>16</sup> and colleagues engaged participants in structured processes of person-centered goal setting and action planning to help participants build a repertoire of success that they could generalize to other life situations.

Defining boundaries around the types of PSI services and supports keep workloads manageable and ensure that the peers are prepared to effectively intervene within their scope of practice or training.<sup>44</sup> Maintaining a clear understanding of the peer supporters' roles ensures that those roles do not become diluted. Peer supporters must recognize where their expertise lies and when to provide appropriate referrals to other professional support providers who are trained to deal with physical and mental health concerns.<sup>45</sup> Setting boundaries supports peer supporters and prevents burnout.

### Services: mode of delivery

The method of communication between peer supporters and peers is influenced by peer and supporter preferences, program goals, and resources.<sup>24</sup> Hoey et al identified 5 primary means of delivering peer support interventions: 1-on-1 face-to-face, 1-on-1 telephone, group face-to-face, group telephone (may include video component), and group internet.<sup>46</sup> With advances in communications technologies, the range of ways to connect is expanding to include social media and web conferencing platforms, such as Facebook

Live and Zoom. Some interventions have specific communication requirements for the frequency of contact, such as minimum of 3 contact hours per month in person, telephone, or email.<sup>4</sup> In our 12-month peer health navigator intervention, in-person meetings occurred at pivotal milestones (intake, midpoint, 11- and 12-month transition planning) with monthly telephone contacts in between.<sup>5</sup> Participants were afforded the opportunity to meet more frequently as dictated by their individual needs and goals.

The variability of methods of communication between supporters and peers represents the diversity of goals and foci of interventions. It is important to know and understand the preferences of the people served to determine the method of communication that best serves them. Developers must be cognizant of the financial needs of peers, which may affect cell phone and internet use and inadvertently limit their ability to participate.

### Services: dosage

Understanding the optimal dosage of therapeutic interventions is critical to developing evidence-based rehabilitation practice.<sup>47</sup> There is significant variation in the dosage of PSIs from a single session to sustained contact over a period of months to years. PSI developers and implementers should carefully consider and document the frequency (how often do the peer supporter and participant meet, eg, weekly, monthly), duration (how long is the total intervention period, this ranges from a single encounter to sustained interaction of periods of weeks to months), and intensity of the intervention (how long are individual sessions [typically range from brief encounters to several hours]). Greater understanding of optimal dosage can help ensure that PSIs are implemented efficiently.

## Evaluation: outcomes and processes

The adequacy of how researchers operationalize successful outcomes of PSIs through their choice of measurement instruments influences a research study's contribution to building the evidence base.<sup>48</sup> The selection of outcomes should be informed by theoretical or conceptual frameworks that identify the PSI's goals and needed outcomes to achieve them.

Proximal and short-term outcomes should directly map to the services or intervention elements provided. For example, peer education programs can reasonably affect health behaviors and knowledge around symptoms and symptom management; support-focused PSIs can increase emotional, instrumental, and appraisal support, whereas self-management interventions may increase self-efficacy and patient activation. Skills tests and patient-reported outcome measures can be well suited for the measurement of these short-term outcomes. Coster provides practical guidance for researchers to identify appropriate measurement instruments for intervention research.<sup>48</sup>

Distal outcomes may include measures of the long-term effect that PSIs have on people's physical, mental, and global health; high-cost utilization, such as rehospitalizations; and community reintegration, social participation, health-related quality of life, and return to work. Information regarding distal outcomes may be from patient self-report using well-targeted and validated measures, extracted from the electronic medical record or claims data, or other performance-based assessments.

Process evaluations help ensure treatment fidelity, identify areas for supplemental training and infrastructure support, and maintain quality improvement. Process evaluations of PSIs may be conducted using focus groups, exit interviews, debriefing interviews, field notes or observations, and key stakeholder interviews. Developers should also consider evaluating the peer supporter training and curriculum because this is another critical part of PSIs.

## Context-specific factors and considerations

Once the theory-driven components of the PSIs are determined, program developers must consider the logistical and pragmatic realities that are distinct to their individual contexts. These considerations include peer supporter background and qualifications, training, supervision, and setting.

### Peer supporter background and qualifications

Peer supporters differ from naturally occurring social networks in their reach, scope, and lack of anticipatory reciprocity. The establishment of clear boundaries is necessary to the successful and sustained operation of PSIs, and boundaries are frequently codified into interventions' policies and procedures. The selection criteria for peer supporters is not well documented in PM&R, and programs adopt a variety of ways to determine who can be a peer supporter. Some conduct interviews with candidates and ask them to speak about their mentoring or advocacy experiences, their familiarity with the community, and their willingness to talk about their disability experiences. Many programs conduct background checks to ensure participant safety. Others chose peer supporters based on peers' volunteer participation in a community organization.<sup>14,15</sup> Often, peer supporters are former patients selected for their fit with program goals and then trained to deliver the

intervention.<sup>1,2</sup> For example, in a PSI for men with violently acquired SCI, peer supporters were chosen based on "progress they had made in their rehab process and observation by hospital staff of their positive interactions with other patients."<sup>3(p. 5)</sup> Some studies create clear qualifications for selection, such as years post injury, evidence of "high levels of acceptance and successful integration to community,"<sup>4(p. 65)</sup> or "history of advocating, educating, and supporting PWD."<sup>5(p. 5)</sup>

Peer mentors' skills, behaviors, and approaches have been found to align with dimensions of transformational leadership theory,<sup>49-51</sup> including idealized influence, inspirational motivation, individualized consideration, and intellectual stimulation. Idealized influence occurs when leaders clearly express their values and morals, are charismatic, and display a sense of purpose. Inspirational motivation occurs when peer supporters instill confidence in their mentees by motivating them to reach ambitious goals.<sup>51</sup> Individualized consideration is demonstrated by providing customized support and understanding each individual mentee's unique physical and psychological needs. Intellectual stimulation occurs when peer supporters stimulate independent thinking by encouraging mentees to come up with their own solutions and to think of old problems in new ways. Identification and evaluation of transformational leadership skills could be used to select candidates for peer supporter positions.

### Peer supporter training

Once candidates for the peer supporter role are identified, they must learn to deliver the intervention as designed. Competence of peer supporters is critical for the effective and ethical implementation of PSIs. While there are currently no national standards for peer supporter training in PM&R,<sup>24</sup> consensus on core competencies is emerging across related fields and include communication skills (including motivational interviewing); understanding the target practice setting; clear delineation of roles and responsibilities; cultural humility; patient privacy, safety, and boundary setting, including Health Information Privacy and Protect Act guidelines; and research ethics (if the PSI is implemented as part of a research study).<sup>24,52-54</sup> Tailored content that aligns with the PSI, such as disability etiquette, advocacy skills, nuances of the setting, or specific clinical information that informs the interventions, should be integrated as necessary to achieve the aims and activities.

### Training approach

Evidence suggests that adult, transformative,<sup>55</sup> and social learning theories<sup>56</sup> are most appropriate for peer supporter trainings because they actively engage learners in peer sharing and listening, problem solving and problem posing, and leadership and experiential training.<sup>55</sup> Adult learning theory recognizes that learners' accumulated knowledge and personal experiences should be integrated within trainings. Peer interactions facilitate group problem solving and further support learning.<sup>57</sup> Experiential learning activities, such as case studies and practica, that simulate the elements of the PSI allow learners to build practical knowledge and confidence in delivering the intervention and provide trainers with opportunities to evaluate learners' development and compatibility with the PSI. Program-specific competency checklists, such as those adapted from the work of the Patient Navigation Research Network,<sup>52</sup> provide additional levels of quality assurance in ensuring that peer supporters are ready to deliver the PSI.

The details of the trainings are not well described in the peer-reviewed literature but may be available on funders' websites or by contacting investigators directly. Trainings range in duration. For example, a program for persons with violently acquired SCI required 20 hours of training before engaging with mentees.<sup>3</sup> The Wheelchair Skills Training Program included a 2-day training in SMART goal setting.<sup>41-43</sup> PSIs with an educational focus used half- or 1-day trainings.<sup>1,2,14,58</sup> The diversity of these trainings reflects the unique foci of the PSI and aligns with their goals and vision. In some cases, PSI developers are explicit with aligning their theoretical or conceptual frameworks to the peer supporter training.<sup>2,5,14,16</sup> For example, Magasi et al used an Independent Living advocacy model and social cognitive theory<sup>57,59</sup> within a community participatory framework to design and deliver a 40-hour training that included the history of disability rights and disability advocacy, advocacy skills, cultural humility, and motivational interviewing as well as intervention-specific skills, such as barrier identification, asset mapping, goal setting, and action planning.<sup>5</sup> Given the diversity within the community with disability and the culturally diverse communities that exist in the United States, it is particularly important to include content to ensure that peer supporters have the knowledge and skills to deliver interventions that are culturally tailored and practice with cultural humility. Demonstrating cultural humility is a challenging life-long process and should be revisited throughout the course of the intervention.<sup>60</sup>

As developers create trainings for peer supporters, we recommend considering 6 key domains in designing them: duration (how long the training is), location (face-to-face, online, hybrid), content (varies depending on focus of program/intervention), learning strategies (eg, adult, transformational learning), occupation of trainer, and ongoing training (ensuring peers retain and apply what they have learned).<sup>61</sup> Program developers and implementers should solicit peer supporters' feedback often and provide supplemental trainings to address emergent needs, such as mental health first aid or addressing social isolation during the coronavirus disease era.

## Setting

The goals of the PSIs should determine in large part where they will be housed. Lorthios-Guilledroit et al applied theoretical foundations from implementation science and complex systems theory to understand the dynamic interactional factors that influence the successful implementation of peer-led health promotion interventions.<sup>62</sup> They identified factors at the supporter, participant, programmatic, organizational, and external context. It is critically important to understanding the broader organizational factors and climate needed to successfully implement PSIs, including considerations such as trust, reach, fidelity, adaptation, and responsiveness. Skepticism by health care professionals can limit the effective use of PSIs in PM&R.<sup>63</sup> Intervention and program setting can have a significant effect on program reach, fidelity, adaptation, and responsiveness of the intervention as do readiness for change, receptivity to the proposed intervention, stakeholder buy-in, and champions.

The point of intervention helps determine the best physical setting for PSIs. For example, if the point of intervention is during the inpatient rehabilitation process, then having the intervention there makes sense but decisions still need to be made, eg, does the intervention occur in the patient's room, in the therapy gym, in a conference room, or in other space in the facility? These decisions are informed by consideration of what environments promote the

levels of trust, privacy, and social interaction needed to achieve the PSI goals. For patients who are transitioning to independent living, there are advantages to returning to the rehabilitation facility for groups or meeting at local advocacy organizations or in public spaces, such as at a public library. Interventions in the person's home affords advantages in terms of participants' comfort, reduced travel demands for participants, and the ability to see the individual in their natural environment. Potential downsides to home-based interventions include safety and accessibility concerns.

Finally, developers must consider the level of integration between the PSI team members and the clinical and medical teams. Autonomy of PSI enables a focus on person-centered goals without undue influence from payers or medical professionals and creates opportunities to address a broad range of health care needs, including those related to social determinants of health, such as transportation, housing, food security, social participation, and leisure. Closer integration with the health care systems confers advantages, such as clear processes for referral to appropriate health and supportive services for issues outside of the PSI scope of practice, opportunities for team-based problem solving, and legitimization of the peer supporters' distinct value and contributions.

## Supervision of peer supporters

Oversight of peer supporters is essential to ensure program goals are met and the work is of high quality. To supervise peer supporters, PSIs develop an infrastructure of support and supervision. Typically, supervisors are people with clinical or administrative background in fields such as psychology, social work, nursing, and occupational therapy who oversee day-to-day activities, ensure supporters complete necessary documentation, and process referrals as articulated in intervention manuals. Some programs bring peer supporters together for meetings with or without clinical supervisor facilitation to debrief, review cases, and support each other. Interactions among supervisors and peer supporters are not described in detail in the literature. We recommend that developers engage in oversight and supervision of peer supporters in ways that align with program goals, theoretical frameworks, and the specific needs of PSIs and peer supporters. Clinical supervision can help ensure intervention fidelity over time.

Providing peer support can be emotionally, cognitively, and logistically demanding and can easily lead to burnout. It is important to integrate ways to support the peer supporters. Developers can incorporate supportive strategies, including acknowledging the demands of the job, setting clear boundaries so that the navigators do not take on too much responsibility, providing opportunities for debriefing and sharing among the peer supporter team, offering stress management and self-care resources and opportunities, and recognizing that working closely with people in "crisis" can elicit peer supporters' own personal issues.<sup>64</sup>

## Discussion

Based on our experiences with developing a PSI, our 15-year involvement in the field of peer support in PM&R, and our reviews of the literature, we are impressed with the proliferation of PSIs as well as the emerging evidence to support the effectiveness of individual PSIs. The routine adoption of PSIs as part of the continuum of care is, however, stymied by the heterogeneity across programs.

There is a need for a more robust literature that documents the key considerations used to design peer support, including the

process and outcome measures used that correspond to underpinning theories and goals. To evaluate whether and how PSIs work, to determine whether they are successful in influencing the lives of those they serve, and to decide which intervention to use and in what circumstances, we need a systematic approach to PSI development, implementation, and evaluation.

Our call for greater clarity in describing components of PSIs is consistent with efforts, such as the Template for Intervention Description and Replication 12-item checklist standard reporting guidelines for clinical interventions.<sup>65</sup> Our approach builds on this approach and asks developers to clarify not only the intervention's elements but also its theoretical framework and targeted short- and long-term outcomes. Routine inclusion and reporting of these elements will support greater adoption and tailoring of PSIs with diverse populations across various settings while also helping to build the evidence base.

## Conclusions

In this article, we proposed an evidence-informed organizing structure to support the development, implementation, and evaluation of PSIs in PM&R. We outlined 9 theory-driven and context-specific considerations to ensure that PSIs are evidence informed and theory driven while simultaneously affording developers the flexibility to tailor their PSIs to their unique clinical and sociocultural contexts. Our framework aligns with and expands the Template for Intervention Description and Replication 12-item checklist standard reporting guidelines for clinical interventions<sup>65</sup> by advocating for the inclusion of the PSI's theoretical framework and targeted short- and long-term outcomes. There is no one-size-fits-all best practice approach to meet the diverse needs of the community with disabilities. It is, however, our hope that a clearer articulation and documentation of PSIs will contribute to the evidence base and support their widespread implementation.

## Keywords

Disabled persons; Psychosocial support; Rehabilitation

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## Acknowledgment

We thank Ricardo Ramirez, OTD, OTR/L, for his editorial and administrative support.

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