Organizational Readiness Assessment for Integration of Peer Staff

Getting Staff, Peer and Stakeholders Buy-In

- Current staff:
  - Do existing staff want peers added to the organization?
  - How will peers enhance or challenge the jobs of current staff?
- Peers:
  - Do peers want to be staff members?
  - How will their relationships with staff and clients be impacted when they become paid professionals rather than volunteer peers or clients?
- Key stakeholders in the community (i.e. Providers, donors, board members):
  - How will providers work with peers?
  - What are providers' concerns or challenges about working with peers? (Develop strategies to address concerns or challenges)
  - Can the Board promote and/or fundraise for peer programs?
  - How will current clients be informed about a formalized peer advocacy program? What feelings may current clients have about a peer program?

Organizational Values

- Is adding peer advocates consistent with the organization's Mission Statement?
- Value of Peers:
  - Are peers valued equally with other staff at the organization?
  - How is a peer's life experience valued?
  - Is there awareness about the importance of diversity (HIV status, life experience) within the organization?
- Challenges and benefits of incorporating peers:
  - What do you predict as the challenges of incorporating peers?
  - What do you predict as the benefits of incorporating peers?
  - Can the benefits outweigh the challenges?

Identifying funding sources and other financial issues

- Salaries for peers:
  - How can you set salaries for peers that are neither exploitative, nor cause tension with other professionals?
  - How will a salary impact the peers' benefits? (i.e. insurance, disability etc.)

Roles and responsibilities

- Does your organization have a framework to define roles and responsibilities for key staff and peers? (If not, can you create one?)
- Can your peers protect their needs as consumers while advocating in organizations where they also receive services? ("*If I complain about treatment my client got, will my own doctor/nurse/case manager be mad at me?*")

Developing Programs and Policies

- Is the leadership of the organization ready to accept a peer program?
- Will the peers have a role in decision making? What will their role be?
- Can the peers get input from clients/members regarding decision-making and program plans?
- Are mechanisms in place for clients to express concerns to peers and for peers to advocate for clients in a professional manner?
- Is the organization prepared to spend extra time on professional development for peers?
- Is staff familiar with ADA requirements?

Advocacy at the Local, State or National Level

- Is advocacy part of the organizational culture?
- Is management willing to advocate for peer inclusion in provider community?

PEER PROGRAM
ORGANIZATIONAL CAPACITY BUILDING BASELINE ASSESSMENT #1

I. Contact Information

Agency/Program Name:_____

Contact Name_____Title _____

Agency Address_____City _____ State ____ Zip_____

Phone_____E-mail _____ Fax _____

1. What HIV/AIDS programs/services does your agency provide? ***(Check all that apply)***
   - ☐ HIV Prevention Education
   - ☐ HIV Counseling & Testing
   - ☐ Support Services
   - ☐ HIV Treatment Education for patients/clients
   - ☐ Other:_____
   - ☐ HIV Medical care
   - ☐ Case Management
   - ☐ Peer Education and Advocacy

2. Approximately, what year did your agency begin offering HIV/AIDS services? _____

3. Approximately, how many unduplicated HIV/AIDS clients does your agency serve annually?_____

4. What is the approximate racial/ethnic breakdown, by percent, of HIV positive clients served by your agency in the past year?
   - _____% African American, Non-Hispanic
   - _____% Asian/Pacific Islander
   - _____% Alaskan Native
   - _____% Hispanic/Latino
   - _____% Native American/American Indian
   - _____% Native Hawaiian
   - _____% White, non-Hispanic
   - _____% Other

   100% Total

5. Does your agency currently have a volunteer program?
   - ☐ Yes ☐ No

   If yes, how many work in the capacity of a peer? _____

6. Does your agency currently have a peer program? **(If you answer No, please skip to question 10)**
   - ☐ Yes ☐ No

   If yes, how many peers are employed/volunteer in your peer program? _____

7. What services do peers provide to clients? ***(Check all that apply)***

- ☐ HIV Prevention Education
- ☐ HIV Counseling & Testing
- ☐ Support Services
- ☐ HIV Treatment Education for patients/clients
- ☐ Other:_____
- ☐ HIV Medical care
- ☐ Case Management
- ☐ Peer Education and Advocacy

8. Do peers provide individual or group level services

☐ Individual ☐ Group ☐ Both

9. What is your interest in expanding or enhancing your existing peer program? **(Circle all that apply)**

a. Improve training opportunities for peers
b. Improve peer performance
c. Improve staff/organizational acceptance of and/or buy into the peer program
d. Address existing problem areas
e. Expand their role
f. Expand the capacity of the program
g. Other_____

(If you responded to questions 7, 8, and 9, please skip to question #11)

10. What is your interest in implementing a peer program? **(Circle all that apply)**

a. I (or my organization) use peers for other patients/clients and want to expand to use them for HIV patients/ clients.
b. I (or my organization) have heard a lot about peer programs and want to explore it.
c. I am (or my organization) responding to consumer input.
d. I (or my organization) believe having peers will improve our services.
e. I (or my organization) believe having a peer program will increase the likelihood of receiving additional funding.
f. I (or my organization) believe that peers can provide services others can't.
g. Other _____

11. Please rate the following statements:

	Completely Agree	Partially Agree	Partially Disagree	Completely Disagree
	1	2	3	4
My organization's mission statement and philosophy support the employment of consumers				
Staff members at all levels of my organization would support the employment of consumers				
My organization has plans for how to use consumers as employees.				
Staff members who would work directly with consumer employees support the idea.				
My direct supervisor supports the employment of consumers.				
My supervisor's supervisor (or department director, or next higher up) supports the employment of consumers.				
My organization has policies and procedures that would support the employment of consumers.				
My organization's human resource department (or the person in charge of hiring) would support the employment of consumers.				
My organization would compensate consumers as employees with a salary or hourly wage.				
My organization would compensate consumers as employees with benefits.				
My organization would compensate consumers as employees with incentives such as transportation vouchers, meals, t-shirts/water bottles/backpacks etc.				
My organization has the space to employ consumers.				
My organization has the equipment (computer/phone/fax) to support consumers.				

12. What are the top three capacity-building assistance needs of your agency/organization? **(Write three letters from the list below)**

1._____ 2. _____ 3._____

a. Organization buy in
b. Staff buy in
c. Policy/Procedure development
d. Human Resource issues
e. Recruitment/Retention
f. Funding/Resource development
g. Peer Training
h. Staff Training
i. Supervision
j. Evaluation/Quality Management

i. Other _____

Is there anything you want to tell us that we didn't think to ask?

_____

_____

Thank you for your participation in this survey.

PEER PROGRAM
ORGANIZATIONAL CAPACITY BUILDING INDEPTH ASSESSMENT

Some of these questions depend upon whether the potential partner has an existing program or is developing one. Feel free to respond with N/A where appropriate.

Organizational Buy-in/Values

1) **What is your interest in implementing a peer program or enhancing your existing peer program? (What do you see as the objective of having a peer program – integrating peers into your organization? This is an alternate way to ask a similar question)**

2) **In what way is integrating peers into your program consistent with your organization's mission?**

3) **What are some of the benefits and challenges of having peers integrated into your organization? (How might having peers enhance or challenge the jobs of current staff? A further explanation of the question/alternate way of asking question)**

4) **How are peers valued in comparison to other staff at the organization (e.g. their life experiences). This question is only for organizations that have a peer program.**

5) **How does existing staff feel about having peers as part of the organization?**

6) **What will be the impact on the organization/staff if or when peers become paid professionals vs. volunteers (particularly if they were/are clients)?**

7) **How will providers outside your organization work with peers? (This question relates to possible referrals that peers may make to other providers on behalf of the client or how peers might engage in a conversation about a client with another healthcare provider).**

8) **What are some of the challenges that might emerge in the provider-peer relationship?**

9) **What is the Board's role in working with peers (peers may be Board members; the Board could fundraise for sustainability of peer program)?**

10) **What information will/do current clients receive about your peer program?**

11) **How is diversity viewed at your organization? (HIV status, life experiences, cultural competency – welcoming environment)**

12) **Who else at your organization needs to have buy-in to support the development/further enhancement of your peer program?**

Programmatic

13) Please define what roles and responsibilities your peers have or will have in your organization.

14) What services do peers currently provide to clients (please list all with some detailed examples).

15) You expressed an interest in expanding your program. Please share in detail what this expansion of your current program might look like.

16) In what way can an integrated peer in your organization protect their own needs as consumers when they are receiving services from your organization? (e.g. 'if I raise a concern/complaint about treatment my client is receiving, will my own healthcare provider (doctor, nurse, case manager, social worker) be mad at me and treat me differently?' How do you ensure a peer has their needs protected as a consumer - an alternate way of asking the question)

Policies and Protocols

17) **In what way is the leadership at your organization prepared/ready to accept a peer program?**

18) **Will peers have a role in decision making and what will that role be?**

19) **In what way would peers gather input from clients regarding decision-making and program planning?**

20) **What mechanisms are in place for clients to express concerns to peers and for peers to advocate for clients in a professional manner?**

21) **How will your organization provide professional development for peers?**

22) **What role will your organization play in advocating for peer inclusion in the provider community?**

23) **What is the staff's understanding of ADA requirements?**

Capacity Building Needs

24) You checked off some capacity building needs in the assessment that was sent to you (question # 12 in baseline assessment). Please elaborate on those needs you checked off and share with me what success might look like if you were able to receive technical assistance in those areas?

Supervision

25) What supervision (administrative and clinical) systems do you currently have in place to support peers?

26) How are supervisors of peers supported in your organization?

Fiscal Support

27) Has your organization thought of ways to fiscally support a peer program (e.g. using Ryan White funding designated for core medical services) including salaries or stipends for peers?

28) If peers are salaried, how might this affect peers' benefits (insurance, disability etc.)?

Stakeholder Analysis

Name	Block	Neutral	Support	Champion

Please list your stakeholders under the name category; then determine whether you consider them to block, remain neutral, support or champion the process by placing an X in that cell; circle the Xs in the cells of those whom you believe don't need to shift; place a circle in the target cells of those stakeholders whom you believe should shift cells and then use the work planning tool to articulate your strategy in moving the X stakeholders to their respective circles.

PEER Center
Peer Education & Evaluation Resource Center

Visualization Statement:_____

Activity	Description of Action	Who	Time-frame	Desired Outcome	TA & Resources
Organizational buy-in					
Peer Job Description/ Responsibilities					
Recruitment Strategy/plan					
Hiring Process					
Compensation/benefits					

PEER Center
Peer Education & Evaluation Resource Center

Visualization Statement:_____

Peer Schedule					
Space/technology					
Administrative supervisory structure					
Clinical supervisory structure					
Orientation					
Retention/staff development					
Team integration					

Visualization Statement:_____

Documentation requirements					
Referral process					
Case load of Peer					
Evaluation measures					

Visualization Statement:_____

Technical assistance					

Peer Program Planning: Questions to Consider	
Organizational Buy-in	• How can a peer program strengthen your organization's mission? • Who are the decision-makers who would support this program? • Why do you want a peer program? • What results do you want to see from this peer program? • How can your staff benefit from a peer program?
Peer Job Description/ Responsibilities	• In what ways could peers support your clients? • What role would you like a peer to play in your organization? • What role would you NOT like a peer to play in your organization? • Full-time/ part-time/ volunteer
Recruitment Strategy/ plan	• Can you use the same recruitment strategy when hiring for other positions within your organization? • Do you already have someone in mind who you would like to be a peer? (i.e. current volunteer) • Are there support groups, other ASOs, etc. where you can advertise a peer program or recruit a peer?
Hiring Process	• Would the peer follow the same hiring process as staff? If so, what does that look like? • What kind of background would you like the peer to have?)i.e. work history, education, community experience/involvement) • Who makes the decision about the hire? (i.e. committee, one person?) • Are there any background circumstances that would keep you from hiring a peer?
Compensation/ Benefits	• Paid or unpaid position – Will number of paid hours affect SSI benefits? • Stipends? Gift cards? • Access to Employee Assistance Program, if relevant? • And other organizational benefits?
Peer schedule	• Full/part-time • Nights/ weekends • How many peers do you want working at any given time? • Ideal number of hours needed?
Space/ technology	• Shared office/ cubicle? • Separate phone line? • Computer? • Access to files?
Supervisory Structure	• Is the peer in an administrative role, clinical role, or supportive role? Based on the answer: what kind of supervision would that peer need? Who would they report to?

Orientation/ Team Integration	• How do you plan to introduce peer and peer role to staff? • How do you plan to introduce staff to peer? • What does peer and staff working together look like to you? • How will you handle "toe stepping" issues?
Retention/ staff development	• Ongoing trainings/ education? • In what ways do you plan to support your peer?
Documentation requirements	• What paperwork do you plan on having peer complete?
Referral process	• Who can give referrals? • Who is eligible for referrals? • Who coordinates the referrals and assigns them to peers?
Case load of peer	• How many clients vs. peer?
Evaluation measures	• What do you want to evaluate? • Qualitative/ quantitative? • Who can you partner with (if needed) to complete evaluation measures?
Technical Assistance	• What kind of support might your program need from People to People?

Other headings to consider or add might be "Confidentiality and Boundary protocol," protecting the client and the peer worker.

15 Steps to Starting an HIV Support Group
(Guide for a Peer Advocate)

1. Keep your meeting at the same place and at the same time during the beginning weeks. Have your meeting even if no outside guests show up. Sometimes it will take a few weeks for you to start getting participants on a regular basis.

2. Create flyer about your group and post at clinics, other agencies, churches, supermarket, etc.

3. Make phone calls to interested participants.

4. Search for volunteers to lead your support group.

5. Make a welcome kit for new participants: include a confidentiality agreement, contact sheet, fact sheet about HIV, and an outline of the general format of group meetings.

6. Make a sign-in sheet, and have participants sign it at every meeting.

7. Create group agreements on the first day of group and post the agreements at every session.

8. Have different topics available for each group meeting.

9. Provide incentives if possible.

10. Conduct a needs assessment every six months.

11. Providing food is very important; if you don't have money for food, then do a potluck style, or see if there are near-by restaurants willing to donate.

12. Choose a point person for the support group - someone who doesn't mind sharing their contact information or screening new participants.

13. Create a crisis plan in case your participants have serious issues going on in their lives.

14. Make a list of possible outside speakers for group meetings

15. Give everyone a contact sheet with names and phone numbers of participants who do not mind sharing their information with group.

Tips:
• Observe time limits. Start on time and end on time so that members feel you are reliable. If they should have babysitters, they will be able to work with them easier.
• Be up front if no child care is available, let members know ahead of time if children are welcome and if not, don't make exceptions.
• Be prepared to have you or your co-leaders do most of the speaking at the first few meetings until your members begin to feel comfortable with each other.
• Free space can sometimes be found at the local school, churches, non-profit and social agencies or at member's homes.
• Place chairs in a circle and close enough that all members can hear.

The Lotus Project
Women's HIV/AIDS Peer Education Training

KANSAS CITY FREE HEALTH CLINIC

PEER ADHERENCE PROGRAM

HIV EDUCATIONAL/SUPPORT GROUPS

2008

- Getting Older with HIV
- Mental Health and HIV
- Stigma
- Boosting the Immune System

2007

- Alcohol, Street Drugs and HIV
- Self-Assertiveness
- Adherence
- Diet, Exercise, and Nutrition on a Shoestring Budget

2006

- Communication Skills and Disclosure
- Stress and HIV
- Adherence
- Taking Charge of Your Health

TABLE OF CONTENTS:

I. GROUP BASICS

A. Purpose of Groups:

The purpose of the groups is to engage more patients diagnosed HIV positive into learning better ways of living with HIV and adhering to medication regimens.

Part of the responsibility of the Peer Educators and Peer Education Program is to offer these groups.

The Program is to include the following:

Group interventions focusing on education, skill building, and peer support addressing a wide array of adherence related issues. These groups will vary in length, subject matter, and group model but all will be co-facilitated by a Peer Educator. These groups will be internally marketed to all HIV positive patients at the Kansas City Free Health Clinic.

It is the Peer Education Program's goal to host 6 cycles consisting of 4 groups each per year. In addition, it is a goal to have 120 individuals attend the groups.

A key piece of these groups is engaging people in care. It is important to spend a few minutes at the beginning of each group to discuss with participants the purpose of the peer program to open up access for potential clients.

Please see the article included in the Additional Information section of this manual to read about the importance of groups for persons living with HIV/AIDS.

B. Description of Groups

- Peer to Peer Group Development

- *Groups: 2006*

- *Introductory Group*

Purpose: This group will include an HIV/AIDS 101 educational focus and will introduce the plan for the group schedule and what is expected of group members. A pre-test may be administered to gain a better picture of the level of understanding of HIV of the participants.

- *Communication Skills*

Purpose: To present the skills necessary for patients to become more empowered patients in their medical care and in their personal life. For example, participants will learn effective communication skills for communicating with their Care providers and further developing techniques for disclosing one's HIV status to loved ones.

- *Stress and HIV*

Purpose: To present participants information based on scientific research that demonstrates the impact of stressors on a person's body and immune system who is living with HIV. Further, techniques to learn better ways of coping and dealing with stress will be presented.

- *Adherence*

Purpose: To present participants with information that demonstrates the importance of maintaining adherence to medications at or above 95% to prevent resistance. Further, participants will be provided with ways to deal with barriers to adherence. Not all participants will be required to be on medications to attend. This group will also focus on being adherent to medical and self care, rather than just medication adherence.

- *Taking Charge of Your Health*

Purpose: To present a holistic view of quality of life care in order for participants to engage in taking care of themselves and their medical care. Techniques and skills to be taught will focus on empowerment and advocacy for self within the medical care system.

A post-test may be administered during the last group to obtain feedback on the group content, format, delivery, and knowledge gained.

B. Description of Groups

Peer to Peer Group Development

Groups: 2007

Introductory Group

Purpose: This group will include an HIV/AIDS 101 educational focus and will introduce the plan for the group schedule and what is expected of group members. A pre-test may be administered to gain a better picture of the level of understanding of HIV of the participants.

Alcohol, Street Drugs and HIV

Purpose: To present the information on how alcohol and drug use affect adherence to medications and CD4 count, how substance abuse may cause a decrease in immune function and an increased risk of opportunistic infections, and how interactions between recreational drugs and antiretrovirals can be deadly.

Self Assertiveness

Purpose: To define what self-assertiveness "is" and "is not". Further, explain how being self-assertive promotes the strength and quality of Natural Killer (NK) cells in the immune system and how the body's immune system is directly influenced by our emotional well-being.

Adherence

Purpose: To present participants with information that demonstrates the importance of maintaining adherence to medications at or above 95% to prevent resistance. Further, participants will be provided with ways to deal with barriers to adherence. Not all participants will be required to be on medications to attend. This group will also focus on being adherent to medical and self care, rather than just medication adherence.

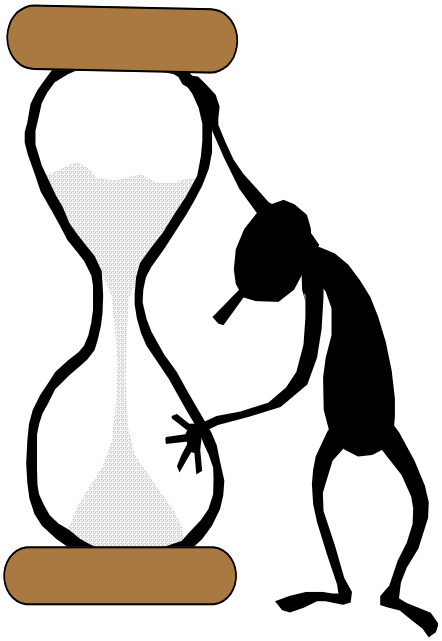
Diet Exercise and Nutrition on a Shoestring Budget

Purpose: To present a daily food guide, five easy things to boost nutrition, tips for good nutrition, food safety, and explain the benefits of exercise/activity for people living with HIV/AIDS, specifically resistance training.

A post-test may be administered during the last group to obtain feedback on the group content, format, delivery, and knowledge gained.

C. Flow of Groups → Logistics:

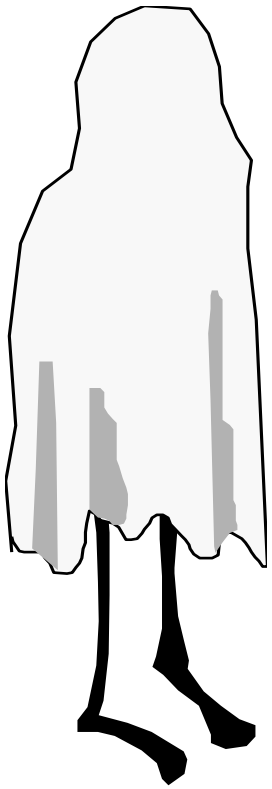
1. Please be prepared for your group before coming to the group to present
2. Please be at the clinic at least 15 minutes before groups start (Please let the Adhering to Wellness Coordinator or Supervisor know if you will be running late)
3. Material Responsibilities of Group Facilitator:
    a. Consent Forms
    b. Any materials to hand out to participants
    c. Food and drink preparation
4. Group Presentation (Educational Portion) → 30 – 45 minutes
5. Time for discussion or demonstration of tools → 15 – 30 minutes
6. Closure of group → ~ 10 minutes
7. Clean-up!! 10 minutes



D. Absent?

If you will not be able to facilitate your group, it is recommended that you give notice of this possibility ***as soon as you know***. If given enough notice, then you may switch nights with another peer. Otherwise, IT IS YOUR RESPONSIBILITY to find a replacement facilitator.

It is understandable that uncontrollable situations present themselves (i.e., illness, bad weather) but please remember that participants will be coming from many different places to attend group. Therefore, IT IS YOUR RESPONSIBILITY to be in touch with the Peer Treatment Adherence Specialist AND Adhering to Wellness Coordinator as soon as you know you will not be able to facilitate your group.



E. Ground Rules:

1. RESPECT between group members
2. TIMELINESS - Please be on time and stay the full time
3. CONFIDENTIALITY and PRIVACY are of utmost importance
4. These groups are developed for YOU – Please turn off cell phones and pagers when entering group to avoid distractions
5. Do not be afraid to ask questions, chances are someone else is wondering the same thing!
6. The groups are meant to be interactive, so please feel free to offer suggestions or advice related to the topics of groups based on your own experiences.
7. Please give us feedback if you feel there are topics you would like to learn more about
8. RELAX AND ENJOY!

KANSAS CITY FREE HEALTH CLINIC
PEER ADHERENCE PROGRAM GROUP

CONFIDENTIALITY POLICY AND INFORMED CONSENT FOR PARTICIPATION

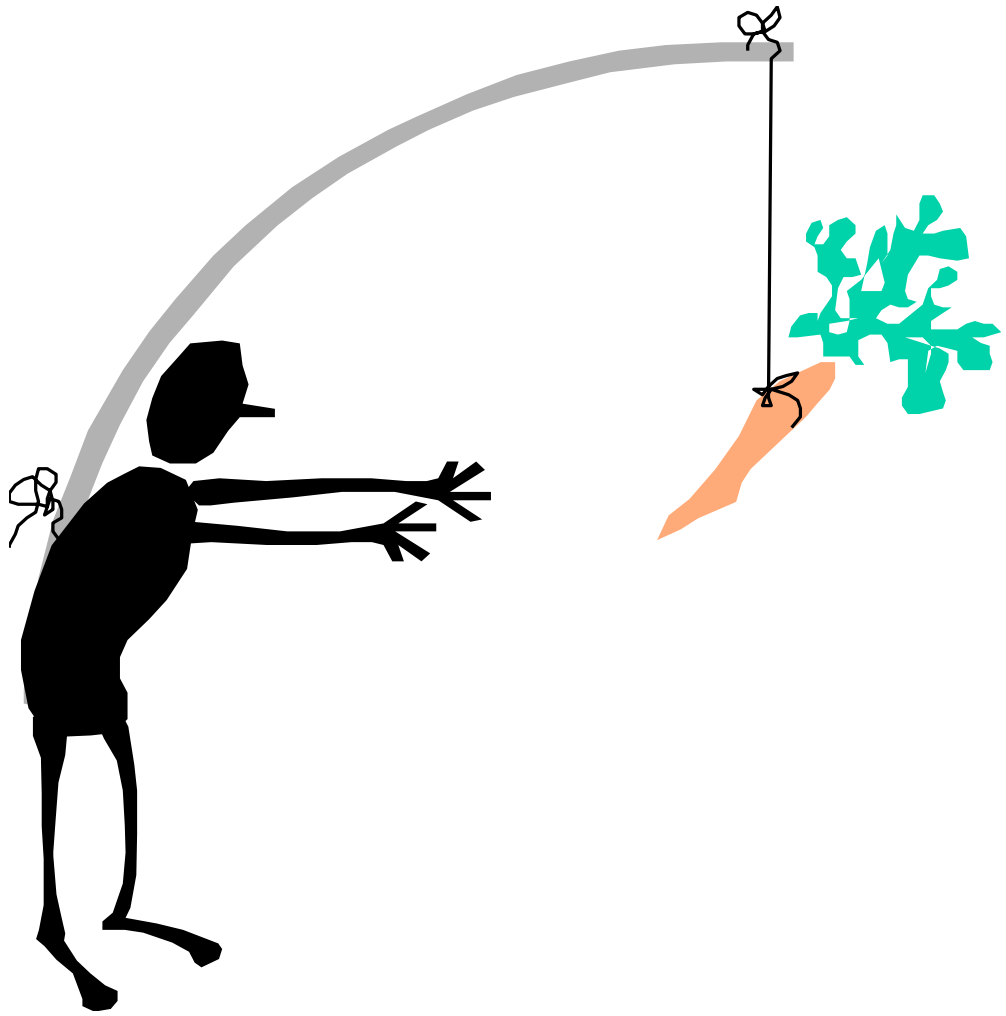
The Peer Adherence Program Groups will cover many issues related to HIV/AIDS. Information in this group is considered confidential. This means that the group facilitator(s), the members of the group, and you will not reveal information about you or other members of the group outside of the group. Further, as a member of this group, you will attend group with a clean and sober state of mind.

Your signature below means that a) you have read this document and have been given an opportunity to ask questions; and b) you understand and accept the conditions of this document.

_____ _____

Client/Participant Signature Date Counselor Signature Date

II.MARKETING STRATEGIES



METHODS OF MARKETING:

At least one month before groups are to start, one may complete the following

- Create Fliers
  - Send in mail to potential participants that can receive mail
  - Hang in patient rooms
  - Leave a stack at the front desk
  - Distribute to all case managers
  - Distribute at relevant community meetings
  - If allowed, post in drugstores/pharmacies

- Create a Letter
  - Send in mail to potential participants that can receive mail

- Phone Calls
  - Have peers call their clients to solicit groups
  - When making appointment reminder calls, peers could solicit groups to individuals who answer the phone if messages can be left

- Other ideas?

January 31, 2006

Dear Client,

We are writing to let you know about a group that we are developing for you. We want to expand the peer adherence program to include more opportunities for aiding you in achieving a better quality of life. We are going to offer a group that will consist of 5 different sessions covering topics that many of you told us you were interested in. Here are the topics we will be covering:

- Week 1: *(Optional)* Introduction → We will present an overview of HIV and the topics that will be presented. This group will also allow you to provide us with feedback on what you would like to see in the upcoming groups.

- Week 2: Communication Skills → This session will include techniques for learning how to communicate better with your care providers and also teach you ways of disclosing your status to loved ones.

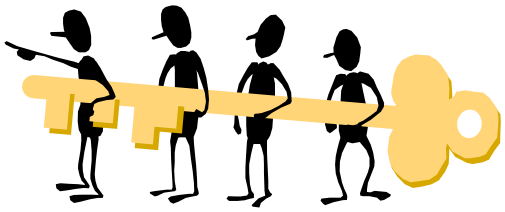
- Week 3: Stress and HIV → This session will provide you with information about how HIV impacts the immune system and provide you with the tools for dealing with stress. Watch how your t-cells/CD4 counts will rise just by learning how to relax!

- Week 4: Adherence → This session will provide you with information that demonstrates the importance of maintaining adherence to medications at or above 95% to prevent resistance. You will also be provided with "tools" for overcoming barriers to adherence. This session will also focus on being adherent to medical and self care, rather than just medication adherence.

- Week 5: Taking Charge of Your Health → This session will provide you with an understanding of how to create a better quality of life for yourself from a holistic viewpoint. Techniques and skills will be shared on how to become more empowered and how to advocate for yourself within the medical care system.

The groups will begin on Tuesday, February 14th (Valentines Day) and will be held from 10:30 a.m. → 12:00 at the Kansas City Free Health Clinic. Everything will be kept confidential in these groups.
We will have snacks and drinks for you! Please come take the next steps towards taking care of yourself and putting yourself first!
Please contact Megan at 777-2799 or the peers at 777-2723 for more information about the groups. We look forward to seeing you on Tuesday, February 14th at 10:00!

Sincerely,
Your Peer Adherence Team ☺



Do you know what it means to put YOURSELF FIRST?
Are YOU ready to change your life?
Do YOU want to live a healthier, stress free life?

We want to help YOU put YOURSELF FIRST!
Please join us (YOUR Peer Adherence Team) beginning **Tuesday, February 6th from 5:00-6:15** at the Kansas City Free Health Clinic we will hold weekly meetings for you and will cover the following topics: **2007**

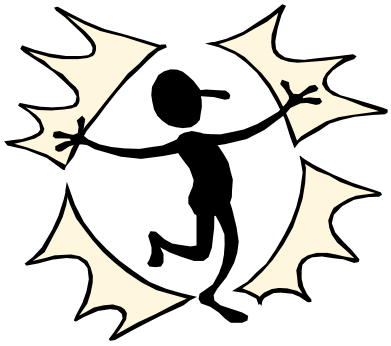
- Alcohol, Street Drugs and HIV
- Self-Assertiveness
- Adherence
- Diet, Exercise, and Nutrition on a Shoestring Budget

These groups are free and snacks and refreshments will be served!
All you need to do is be here on time to learn, discuss, and enjoy taking care of yourself!

We hope you will join us and we look forward to working with you!

Questions or Concerns?
Please contact LaTrischa at 777-2745 or the Peer Office at 777-2723.

Adhering to Wellness



Are you ready to put yourself FIRST? Are you interested in learning how to better your quality of life? The peer educators from the Kansas City Free Health Clinic will be presenting groups related to wellness for all individuals diagnosed HIV positive.

The groups will be confidential. Food and incentives will be provided for your participation.

Topics to be presented will include:

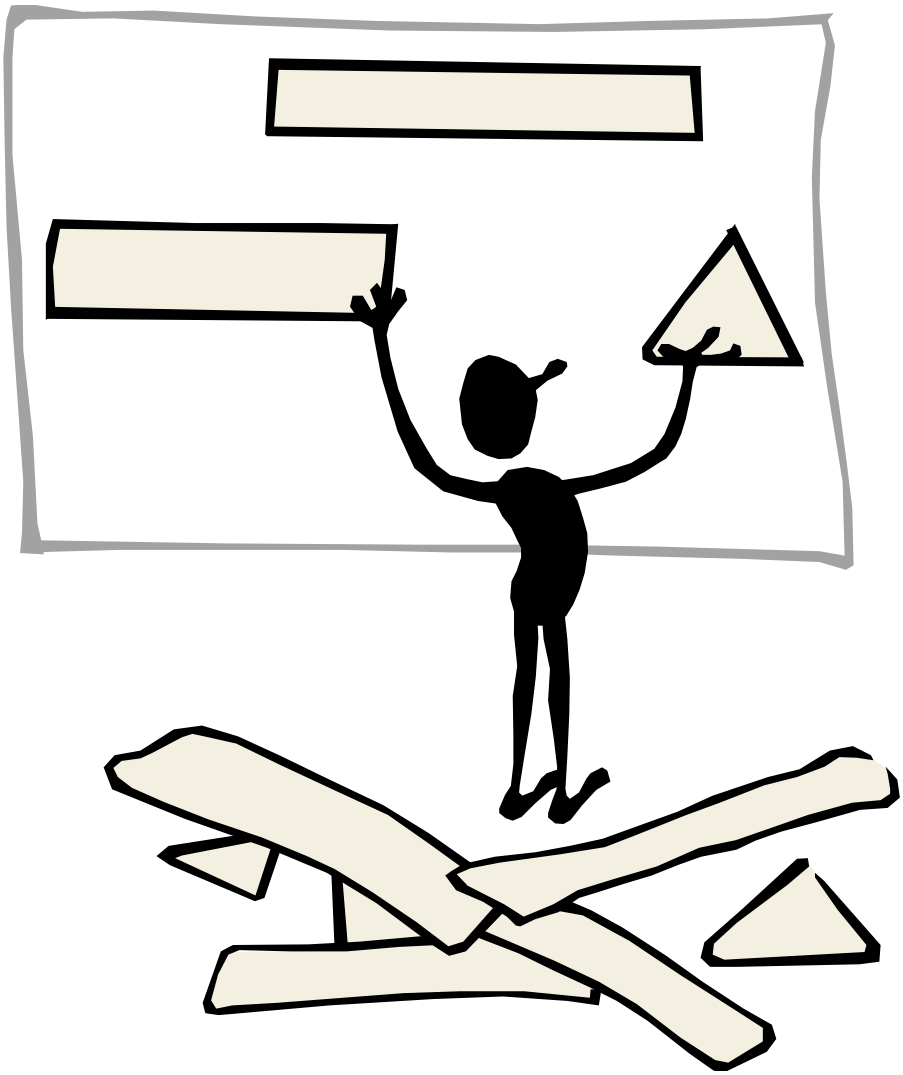
- Alcohol, Street Drugs and HIV
- Self-Assertiveness
- Adherence
- Diet, Exercise and Nutrition on a Shoestring Budget

Dates: Tuesday evenings from 5:00 – 6:15
February 6th , February 13th
February 20th , and February 27th

free health clinic KC
For a healthy community

Location: Kansas City Free Health Clinic
Need more information? Please call 777-2745 or 777-2723

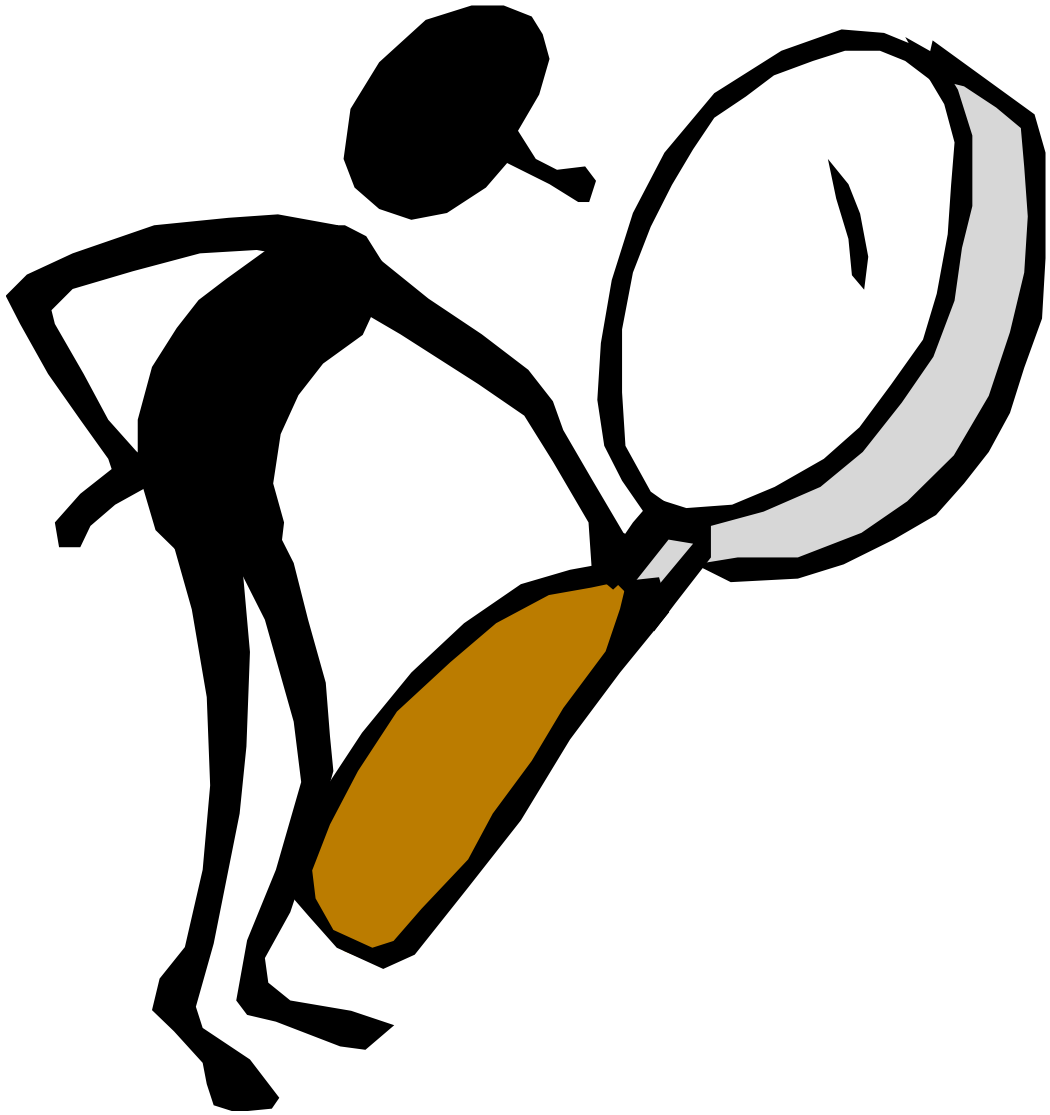
III. GROUP EDUCATIONAL MATERIALS



SAMPLE OUTLINE FOR

STRESS AND HIV (on PDF attachment)

IV.ADDITIONAL INFORMATION



A. INCENTIVES FOR PARTICIPATION:

Ideas:

1. Offer meals from Price Chopper (they will warm up meals – ex: lasagna, pizza, etc.)

2. Ask assistance from Pharmaceuticals to provide meals

3. Order Pizza

4. Provide snacks

Incentives for Participation Ideas:

1. Every group a raffle could be held for participants either at random or for those who answer questions correctly. They could win bus tickets, meals from local restaurants, movie passes, grocery store gift cards, etc.

2. If a participant attends all 4 groups, he or she will have their names entered into a drawing for a grand prize.

3. Participants completing evaluation will receive a gift certificate or gas card.

B. Article to Support the Need for Groups for Persons living with HIV

Hyde, J. Appleby, P.R., Weiss, G., Bailey, J., & Morgan, X. (2005). Group-level interventions
for persons living with HIV: A catalyst for individual change. *AIDS Education and Prevention, 17SA,* 53-65.

HEPATITIS C SUPPORT GROUP

Handbook

VERTEX

A note from Alan Franciscus, friend and advocate of people who have hepatitis C. He is also the Founder and Editor-in-Chief of the website, www.hcvadvocate.org:

For many people, living with hepatitis C is not easy. Every day, we are faced with making many important decisions that can affect almost every area of our lives. The best way to live well with hepatitis C is to learn as much about it as we can, so we can seek and receive the best possible medical care. An equally important part of staying healthy is to get support from healthcare providers, family, loved ones, friends, and peers. This means learning directly from others who have hepatitis C and who are willing to share their life experiences. One of the best places to find and receive peer support is in a support group.

I found out I had hepatitis C in 1996. At that time, there was very little information or support for people with hepatitis C. The information that was available then was hard to find, and much of it was just plain wrong. Shortly after I found out I had hepatitis C, I asked my healthcare provider to recommend a support group in San Francisco. To my surprise, he told me that there were no support groups in San Francisco for people with hepatitis C!

About 4 months after I found out I had hepatitis C, I began treatment with interferon monotherapy. I soon realized that I was not prepared to deal with the many physical and mental side effects of interferon. The physical side effects included terrible headaches, as well as muscle and joint pain. I also became anxious and depressed. Worst of all, I did not recognize the signs of the depression and anxiety that I was having. After a couple of months (and at a friend's urging), I talked with my healthcare provider and received advice about the mental and emotional side effects of anxiety and depression, as well as the medicine I could take for these issues. It was at this point that I fully realized how important peer support is for someone going through hepatitis C treatment. I also realized that I didn't want anyone else with hepatitis C to go through the same issues without getting the support that I needed to stay on therapy and help make the journey easier. So, I made a pledge to myself that once I finished treatment, I would start a hepatitis C support group.

True to my word, I worked with a friend of mine to open the first hepatitis C support group in San Francisco in 1997. I'm happy to report that after all these years, that support group is still running and thriving.

It wasn't really difficult to set up and maintain a support group, but a lot of what I needed to know I gained from taking a workshop and by "hit or miss." It would have been much easier for me if I had had some sort of material and advice that was geared towards starting and running a hepatitis C support group.

The need for this type of information became clear when people from all over the country started contacting me for advice about starting a support group in their community. I began to gather information pulled from my own experience, along with advice from others that I had collected, into a document. The result of my years of trial and error and, more importantly, the advice from others, is what is included in this handbook.

I hope that the handbook will give you the necessary tools for starting a support group. Support group leaders don't necessarily need a lot of knowledge or skills to run a group. The most important qualities of a support group leader are dedication, putting the members' needs first, and being a person who cares about others. I am continuously amazed by the people who run support groups. They are a special kind of person who touches the lives of so many others affected by hepatitis C. I am assuming that since you are reading this handbook, you are taking the challenge to be that very special person for your community. I hope so, because we really need you!

Alan Franciscus

Table of Contents

The information in this handbook is designed to help you understand hepatitis C. It is not intended as medical advice. If you have hepatitis C, you should consult a healthcare provider.

Introduction

Every day, men and women learn that they have hepatitis C. They may think they are the only ones struggling to cope with the disease. Good thing there are caring people like you who prove them wrong by bringing together people with hepatitis C.

When people first learn they have hepatitis C, they often feel alone. But the truth is, there are millions of people with hepatitis C. Studies show that people born from 1945 through 1965 have been hit the hardest by the hepatitis C virus.

While this news may be a bit overwhelming, it should also bring a little comfort to everyone living with hepatitis C. They should know that getting help, support, and understanding isn't limited to caregivers. There are also a lot of people who have—or are going through—the same thing, so they can relate firsthand.

This handbook is designed to help you take this "people power" and turn it into a support group for those affected with hepatitis C in your community. We've put into this handbook everything we think is needed to start and run a successful group.

The only thing missing is you.

This handbook is designed to:

- *Help you start and lead a support group*
- *Give you tools to help your existing support group*

Throughout this handbook, we refer to the person who organizes or leads the support group—you—as the *leader*.

Who needs a hepatitis C support group?

- *People who have just been told they have hepatitis C*
- *People who are being monitored, but not treated, for hepatitis C (some people have symptoms and some do not)*
- *People thinking about treatment or are currently in treatment for hepatitis C*
- *Family members and close friends of someone who has hepatitis C*

No two support groups are alike.

Just as every person is different, so is every support group. Not everything in this handbook may be ideal for every support group to use. As the leader, you may feel you need to make changes to better fit your group.

The accompanying ***Hepatitis C Support Group Lessons*** has 12 lessons to help you get your group up and running. Each lesson has 1 to 4 pages of text, plus a 1- to 2-page handout. We hope you find them interesting and helpful.

1: Why Do People Need Support Groups?

Support groups may help people make better decisions.

People with hepatitis C need support groups to help work through different issues. At a group, members can:

- *Give each other help and advice*
- *Give each other emotional support*
- *Help each other make better choices in their lives*
- *Help each other feel safe and secure*
- *Help each other feel better and understand themselves better*
- *Learn how to teach others about the basics of hepatitis C, such as:*
    - *o How the virus spreads*
    - *o What is safe to do (kissing, hugging, and playing with their children, etc)*
    - *o What is not safe to do (sharing toothbrushes, razors, etc)*

Support groups are very helpful for people who live alone or who need a bit of extra support close by. They also help people learn how to talk about hepatitis C with friends, family, and coworkers. And healthcare providers are often happy when their patients have the aid of a support group.

Support groups may help people make good choices.

People with hepatitis C are often confused and stressed out. Support groups can help them feel both more calm and more hopeful. Below are some of the things people may want to discuss at their support groups.

Did you just learn you have hepatitis C?

Learning you have hepatitis C can be upsetting, and you may find yourself with a lot of questions, such as:

- ***What is hepatitis C?***
    - *o How do I deal with such a serious disease?*
    - *o Can I get rid of this virus?*

- ***How do I tell others I have hepatitis C?***
    - *My wife, husband, girlfriend, or boyfriend?*
    - *My friends and family?*
    - *Should I tell my coworkers?*
- ***How do I protect others from getting hepatitis C?***
- ***How can I talk about treatment choices with my healthcare provider?***
    - *Should I start treatment now?*
    - *What about herbs and other supplements?*
    - *Should I avoid alcohol, smoking, and street or illegal drugs?*

What is a social stigma, and how do you deal with it?

Social stigma is when someone disapproves of someone else's association with a group that some people may look down upon. They might look different, be of another race, follow another religion, or even have a disease.

Some people may judge you because you have hepatitis C. They may:

- *Judge you for what you did in your past*
- *Think that they should stay away from you so they won't get sick too*

When people feel negatively about others based on what they think is a fact, they are *generalizing*, or having a *bias*. Unfortunately, these attitudes are common in every society, and they are simply caused by ignorance. Some people just don't like what they don't understand.

How you handle the stigma that often comes with hepatitis C is important. How other people act because you have the virus can affect almost every area of your life.

Social stigma affects everyone differently. Some people may respond by going into *denial* (not admitting the truth to themselves or others). This could lead to:

- *Spreading the virus because the person is too embarrassed to tell their family or friends about the risks*
- *Not seeking medical care because the person is afraid that people they know may find out*

How does your life change with hepatitis C?

Once your healthcare provider tells you that you have hepatitis C, you have to make some very important decisions about many things, including:

- *Stopping all alcohol, smoking, and drug use*
- *Living a healthier lifestyle by eating better and exercising*
- *Learning how not to spread the virus to others*

Do you know what your treatment choices are?

Many people join hepatitis C support groups to learn about getting treated for the virus. They come to hear what others have gone through during treatment, and to learn ways to handle the side effects of the medicines.

Peer support (getting and giving help to others like you) is very helpful for people taking medicines for hepatitis C. This therapy can cause many side effects. People who have been through the treatment before can give you tips and advice on how to cope.

What do I need during treatment?

Talk with your healthcare provider before starting treatment. You need to ask what you may expect, because everyone reacts differently to medicine. Your healthcare provider can help you understand:

- *Treatment results from clinical studies*
- *What are common side effects and how they would be managed*
- *How long your treatment may take*
- *What you may need to do to prepare for treatment*

What happens after treatment?

The end of treatment can be a tough time too:

- *It's common to have side effects, even after the regimen is over. It can take months to feel back to normal*
- *It can be very hard waiting to hear if you are cured or not.*
    - *o* Cure *means that the virus is no longer in your blood 6 months after you finish all treatment. Another name for this is* Sustained Virologic Response (SVR)
- *Unfortunately, not everyone is cured or clears the virus*

Learning that the virus has come back after you've finished your treatment, or that treatment does not work for you, can be heartbreaking. It may be difficult deciding what to do next and how to move forward after the shock wears off.

Support groups can welcome friends and family.

Sometimes, friends and family members need as much information and emotional support as the person living with hepatitis C. They may feel powerless when someone they love is ill.

These caregivers might find support groups very helpful for themselves, too.

2: Do You Have What It Takes to Lead a Support Group?

The purpose of a hepatitis C support group is to give its members the power to help each other.

Many people who start or lead a hepatitis C group have never done it before. A lot of support group leaders aren't medical experts. Many do not have a medical background. But you don't need to be a person living with hepatitis C to run a support group. You simply need a kind heart, a little patience, and a strong desire to help others. Then, you need to commit to lead and be there for others.

Of course, it doesn't hurt to have the help of experts when you have questions. It's vital to build good relationships with:

- *Healthcare providers (doctors, nurses, physician assistants, etc)*
- *People who have run support groups before*

What do you want to get out of leading a support group?

Ask yourself these questions:

- *Is it to help myself?*
- *Is it to help others?*
- *Is it to help both myself and others?*

There is nothing wrong with starting a support group for your own good. But it is equally important that you want to help other people too.

How open-minded are you?

Everyone has some biases or *prejudices* (disliking someone for no specific reason). Will the way you feel about other people get in the way of you helping all the members of the group the same way? Ask yourself:

- *Can I accept all members, regardless of their race, religion, or sexual preference?*
- *Will I feel differently about someone who got the virus from a blood transfusion than someone who got it from injecting drugs or having sex?*
- *Can I put my own issues aside for the sake of the entire group?*

- *Will I be comfortable talking to other people about their:*
    - *Sex lives?*
    - *Drug and alcohol use and abuse?*
    - *Family issues?*

How you answer these questions will help you decide if you are open-minded enough to lead a support group.

How organized and dedicated are you?

As the support group leader, you need to be determined to lead the people in your group on a regular basis. They count on you to be there to guide the meetings. Can you make a full commitment?

3: Gathering Information

Learning more about hepatitis C is helpful to you and the people in your group.

Identify experts.

The people in your group can usually get expert advice from their healthcare providers and you should suggest they go there first. So don't feel that you have to be an expert to lead your group. You just have to make sure that everyone gets a chance to share their story, and that everyone understands the ground rules of the group. Let the healthcare advice come from healthcare professionals.

The only difference between you and the other people in your group is that your focus and interest are in helping others as well.

Even though you don't have to be an expert, you should still try to learn as much as you can about hepatitis C. Free information is available from many sources:

- *The Internet (but get your information from credible sources)*
- *Various governmental agencies*
- *Nonprofit hepatitis C groups*
- *Companies that make hepatitis C medicines*

The information contained in this handbook will also give you some basic information about hepatitis C.

The most reputable websites will list the dates of their research, so you can be sure that you are getting the latest information. You'll find a list of useful sites at the end of this handbook.

Another way to educate yourself is by talking with local hepatitis C healthcare providers, who can also serve as guest speakers or advisors to the group.

Medical institutions and nonprofit organizations may offer sponsorships and free space for your meetings. They may also help you with advertising to invite potential members. It wouldn't hurt to give them a call to find out.

Do you need a co-leader?

Running a support group can be a big job. One way to make it easier for you is to share the responsibility. Once your group starts, you might want to choose someone who is willing to help you run the group. We will explore the benefits of having a co-leader later in this handbook.

Finding out more from other groups.

There are a lot of ways to learn how to run a successful group:

- *Sit in on other hepatitis C support groups in your area. This can help you:*
  - *Learn how others run their groups*
  - *Find out if the area you live in needs a group. You may choose to start a group for veterans, family members, substance abusers, or people of a certain age group*
  - *See if the best use of your time and energy is in helping an existing group, rather than starting a new one*
- *Visit other types of support groups:*
  - *Meetings for groups of people with other disorders or diseases can give you ideas on how to run your group*
  - *Be sure to tell the members of the group you visit that you are there to learn ways to help your own group. Honesty is very important in support groups*

Organizations that run support groups print leaflets and other materials that contain helpful hints on starting a group. Also, some local agencies may offer services or seminars on running a group.

4: Types of Support Groups

Support groups can be driven by information or experience. What do you want your group's focus to be?

There are basically 3 kinds of support groups:

- *Educational (often in a lecture format with guest speakers)*
- *Thoughtful (in which people with hepatitis C share experiences and advice with each other)*
- *A blend of educational and thoughtful (many groups are a little bit of each)*

You may want to divide the group meetings into 2 parts. The first part can be educational (perhaps featuring a guest speaker), followed by a short break. The second part of the meeting could then give members the chance to talk about their own experiences and feelings.

What's in a name?

Some people are uncomfortable coming to something called a "support group." They may feel more at ease attending an "informational meeting," a "discussion group," or a "get-together." It's something to think about when deciding what to call your group.

Drop-in groups.

Drop-in groups help people who need emotional or educational help at the spur of the moment. They may be in the middle of a crisis and need understanding and compassion.

Educational group meetings.

These can help people who want to learn more about hepatitis C in general, or about a certain related topic.

These meetings are a good way for people to learn about living with hepatitis C. These groups are more about listening than talking. This is the right group for people who aren't ready to talk about personal issues.

Even though the main focus is about learning, these groups can also give people emotional support. People can feel more comfortable being with others like them, who have the same interests, fears, and questions as them.

Sometimes, informational meetings end with group members discussing issues. And sometimes, these discussions get personal.

Thoughtful group meetings.

These are the right groups for people who want an emotional connection with others going through the same things as them. At these groups, members may share with each other their most private thoughts, fears, and struggles. They can give each other tips for dealing with side effects, staying healthy, and finding good, reliable information. They also sometimes lend each other a shoulder to cry on.

The important thing to remember is that you get to choose the kind of support group you want to lead. You are the one who will maintain the focus of the group, centering either on educational facts or on life experiences, and probably, including a little of both.

5: It's All in the Details

Plan all the details in advance. It will save you from needless worry, and it will make your group much more successful.

Before your first meeting, you have a few important decisions to make, such as:

- *Finding a location*
- *Choosing a format*
- *Picking experts*

Planning ahead can make things easier for you and help you create exactly the kind of group you want.

Do you want a closed or open group?

Some longtime group members like having newcomers join in. Newcomers can bring a different outlook. They can:

- *Renew the group's commitment*
- *Invigorate the discussion with new ideas*

But a newcomer's fresh perspective can also come with some concerns:

- *Longtime members may not be comfortable with newcomers*
- *New members may have different emotional needs*
- *Newcomers may not know what is already familiar to longtime members*
- *Newcomers may not be prepared to see the disease or the treatment's side effects on longtime members*

As the leader, you will need to be supportive of the longtime group attendees, as well as be sensitive to the needs of new members (if your group is open to them). It's important to strike a balance.

Getting to know your members.

To understand your members better, it helps to meet each of them in the days or weeks before the first meeting (if you can). As you talk with them, ask yourself, "Would this person be a good fit for the group?" Be honest during this process. This is not because you want to keep anyone out, but because not everyone will be a perfect fit with your other members.

Here are some questions you may want to ask at each interview:

- *"Our support group includes people who are currently being treated for hepatitis C. Can you handle discussions about that and deal with the emotions that may surface?"*
- *"In our group, we don't talk about how each of us got hepatitis C. We don't judge members because of things they may have done in the past. Do you think you can accept these conditions?"*
- *"Can you keep the things we talk about in meetings confidential?"*

Sometimes it is not practical to meet each group member. So before each meeting, go over the ground rules. You'll see some examples of ground rules later in this handbook.

How many members should your group have?

Support groups can be any size. Even 2 people at a meeting can be a very powerful support group. The size of the group will depend on what type of group you want. For example:

- *A thoughtful support group should be on the smaller side. Too many people can make the setting feel impersonal, making it hard for people to open up and share freely. As a rule, 6 to 15 people are best for this kind of group*
- *An educational meeting can have many people attend. The members are there to learn more about hepatitis C from a speaker, not from each other. They are basically an audience*

Keep in mind that the meeting room may limit how many people can attend.

How often should your group meet?

The kind of group you have helps dictate how often to meet:

- *For thoughtful support groups, members meet weekly or every other week. Because close bonds may develop at these meetings, the members will look forward to seeing each other and sharing with each other more often*
- *For educational groups, monthly meetings usually work best*

How long should each meeting last?

The length of the meeting also depends on the format of the group:

- *For a thoughtful support group, 90 minutes usually works best; some people may even prefer more time*
- *For an educational group, the time frame may be decided by the amount of time the speaker has to dedicate, or by how much information there is to discuss*

Once the group decides, make sure you always start and finish on time. People are busy, and if you start or end late, attendance can suffer. If you let certain members come late too often, it could hurt the group as a whole. Group members likely have enough uncertainty in their lives. Your meetings and meeting times should be one thing they can always count on.

If the group meets for longer than an hour, it's a good idea to take a short break in the middle of the meeting. This gives everyone a chance to stretch and use the facilities. It also makes it easier to change the group format.

Should your group meet just for the short term or forever?

Some groups meet for as long as the members are interested in keeping the group going. This can mean months, years, or even decades.

Other groups are designed to meet for only a few weeks to several months. How long you want your group to meet is up to you.

If your group is designed to get together only for a certain number of meetings, be sure to tell the members the exact dates when the program will begin and end.

A group that ends on a specific date works well for people who may not want to commit for a long time.

Sometimes, group members form personal attachments with each other, so they may decide to continue meeting on their own. They may also decide to take over the group to keep it going. If this is the case, you may want to help teach them what you know about running a group.

Location.

Support groups need to meet where members feel safe and comfortable.

Preferably, the meeting location should:

- *Offer easy access to public transportation and free or affordable well-lit parking*
- *Let people travel safely there and back in the day or evening*
- *Be easy to find*

Look for space at hospitals, community centers, churches, or other public buildings. They will often provide free space for nonprofit groups.

A home is not a good idea for most types of support groups. It can be hard to separate the group from the host's personal space. Most people prefer a neutral location.

The meeting room.

The meeting room helps set the tone for a support group:

- *A drab and dreary room is depressing. It should be a cheerful, encouraging place that makes people feel comfortable and at home*
- *A group that doesn't have a lot of funds can also spruce up their space using posters, flowers, or other items that will lift the group members' spirits*

Check the meeting space for:

- *Privacy. It is important that people feel comfortable attending meetings without advertising that they have hepatitis C*
- *Size. The room needs to be large enough to fit everyone, even if you break into 2 smaller groups. But it shouldn't be so large that the group doesn't feel some degree of intimacy (feeling of closeness)*
- *Furniture. Comfortable chairs are important for people with hepatitis C, since many suffer from muscle and joint pain*
- *Lighting, air, and temperature control. Each one affects how people feel and how they relate to each other*
- *General atmosphere. Nothing in the room should offend anyone's cultural or religious beliefs*

Seating.

Think about how you want to set up the chairs. How you do it can affect how close people feel (physically and emotionally).

Here are some thoughts to consider for theater or classroom-style seating:

- *This works for educational meetings, but not as well for thoughtful groups:*
  - *The people in the front will have to twist around to see those speaking behind them*
  - *If they can't see each other, it can be harder for some people to speak openly*
- *If you have a thoughtful group but are stuck with classroom-style seating, come up with new ways for people to talk comfortably. For example, have people sit in a "U" shape. That way, people can speak to each other "face to face"*
- *It's good to have the door at the back of the room, so that if someone comes in or leaves, people will not be disturbed*

Here are some thoughts to consider for circle seating:

- *This is the best arrangement for a thoughtful support group:*
  - *Leave the middle of the circle empty so members can see each other. People talk with their voices, but being able to see facial expressions and body language creates trust*
  - *Remove all empty chairs from the circle to help everyone feel connected*
  - *Put a box of tissues in the center. This tells everyone that it is okay to express emotions—even if it means shedding tears*
- *The circle format may be difficult for larger groups. Consider splitting the group into 2 smaller circles. This can work well if you have a co-leader to head the other circle*

Should you have beverages and food?

Food brings people together; however, if you decide to have food at your meetings, request that members not eat during the actual session. (You may want to make an exception for people who need to eat for a medical reason.) You want them to be able to give each other their complete attention. Beverages are also nice to have on hand; water is especially good for people going through treatment. Of course, food and beverages can be difficult to supply if money is an issue.

Here are some ways to deal with money issues:

- *Ask for volunteers to bring in food and beverages on a rotating basis*
- *Request a donation at the beginning or end of each group*
- *Invite local businesses, nonprofit groups, and other organizations to donate money for snacks*

You may prefer not to allow food during meetings. If so, make this clear to members so you can manage their expectations.

Educational materials.

Giving people information about hepatitis C helps them make decisions about their health and take charge of their own care. Remember, when you give out information to the group, they may think that you endorse or recommend the information. That's why it is important that you always know who created the materials you share. You need to be sure that the information is from a reliable source. Some good places to find information are:

- *The Internet (a list of reliable sites is at the back of this booklet)*
- *Government agencies (such as the Centers for Disease Control and Prevention and the US Department of Veterans Affairs)*
- *Nonprofit hepatitis C groups*
- *Drug companies, which often have websites and brochures about specific diseases and treatments that they make. (If you decide to go this route, you should make sure to handle it delicately. It is important to keep the group's trust in you as a leader. You don't want to appear as though you are pushing a product.)*
- *Hospitals or healthcare provider offices*

See the information and handout material included in the accompanying ***Hepatitis C Support Group Lessons***. The manual also provides some basic information about hepatitis C and many topics for group discussions.

The cost of educational materials may prove to be an obstacle. Here are 3 ways to help with that cost:

- *Ask people to print out or make copies of educational materials that they can bring to the meetings. Have everyone in the group share the responsibility of doing this*
- *Order information from drug companies, advocacy groups, and nonprofit agencies, such as the Hepatitis C Support Project (see the Resources section). You need to read the information closely to make sure that it is accurate, true, and appropriate*
- *Ask for donations from the support group members*

6: Leading a Group

You've already shown initiative by taking the first step and picking up this handbook. This is an important trait of a leader.

What makes a good support group leader?

As the leader, you have many responsibilities, including:

- *Finding a place to meet*
- *Keeping the meeting on track*
- *Making sure your meetings have helpful information for members*

You may be a natural-born support group leader. Or, you may have to learn as you go. The point is, you already have what it takes, because your heart is in the right place.

How much time and energy you want to spend on being the support group leader is up to you.

Most people who start a group take on the role of the leader. But some people prefer to have someone else direct the group once everything is set up.

Some groups have more than 1 leader. Others have a rotating leadership policy among their members. One example is Narcotics Anonymous®* (NA). NA groups follow strict rules that never change, but the leadership role rotates from member to member.

What is the leader's role?

Since you have decided that you would like to lead a support group, you have a few important steps to follow before your first meeting:

- *Understand your role. Basically, a leader's job is to help guide and support the entire group*
- *Realize your talents. Honesty and the willingness to listen will help you to earn the trust and respect of your fellow group members*
- *Be patient with yourself. Some people take naturally to the role, while others may get there with practice*

What makes a good support leader?

A strong support leader has these 7 qualities:

1. *Focus: The ability to set clear goals and keep focused until the end. This person can put his or her ego and personal feelings aside*
2. *Communication skills: Listens well and has the ability to express him or herself clearly and effectively*
3. *Compassion: Cares deeply about people's feelings and well-being*
4. *Trust: Approachable, truthful, and keeps things private*
5. *Knowledge about hepatitis C: Not necessarily a medical expert but knows the facts enough to help correct misinformation*
6. *Unbiased and nonjudgmental: Accepts everyone equally, regardless of race, religion, sexual preference, or how they became infected*
7. *Optimistic: Looks for the positive in people and in life instead of the negative*

This may seem like a long list of qualities, but you may be surprised by how many you already have.

Will you need a co-leader?

If you have a large group, you may want to have a co-leader to:

- *Split the group into 2, where each of you runs one half of the group*
- *Jump in if the discussion seems stuck, or when there are unexpected issues*
- *Step in for you if you have to miss a meeting*

If you are looking for a co-leader, choose someone you're comfortable working with.

7: Getting the Word Out

It's important to make sure that anyone who is looking for a support group is able to find one. That's why publicizing your group is so important.

Be clear about the goals of the group.

When you're looking for people to join the group, remember that different people have different needs. Some may want an informational meeting on hepatitis C. Others may be seeking an emotional support group.

People need to feel safe to discuss very private feelings. This is important to keep in mind as new members get to know each other. Some people simply can't ever have this kind of trust. For them, an informational meeting may be better. As you develop your strategy as the group leader, it's important to remember that you can't please all of the people all of the time.

What are some ways to invite members?

First, you need to get the word out that you are starting a hepatitis C support group. Here are some suggested strategies:

- ***Develop a flyer that encourages people to join your group***
    - *Flyers give people a good sense of what the group will be: nonjudgmental, positive, and caring. You also want to explain the purpose of the group, where it meets, and how to sign up*
    - *Plan to distribute or post the flyer in healthcare providers' offices, public health departments, hospitals, community health clinics, community-based organizations, bulletin boards, and any other office that may serve and support people with hepatitis C. First, request permission from these offices and organizations to post the flyer*
- ***Make a flyer that is upbeat and positive***
    - *Stress the purpose of the support group; be clear and to the point. For example, "The mission of our support group is to give people with hepatitis C peer support and education in an open, comfortable, and nonjudgmental environment"*
    - *List any healthcare providers and organizations that endorse or provide funding to the group. For example, "This support group is endorsed by the X Medical Center"*

- ***State the location, time, duration, and any other important information. For example:***
  - *Title: Hepatitis C Support Group*
  - *Time: Every Wednesday from 6:30 pm to 8:00 pm*
  - *Location: 191 Main Street, Any Town, Zip Code (provide a map)*
  - *Purpose: To provide community discussion and support for people living with hepatitis C*
  - *Please call 1 (XXX) XXX-XXXX for more information or e-mail Name@mail.com*
- ***For a drop-in support group**, list the exact address in the description. For example: "Would you like to meet others who have hepatitis C and learn how they live with their condition or handle treatment? Our support group meets every Wednesday from 6:30 pm to 8:00 pm at 191 Main Street, Room 337, Any Town, Any State, Zip Code. You are welcome to drop in and check us out!"*
- ***For a closed group**, include your phone number or e-mail address. That way, you can meet face to face or interview potential members over the phone. Either way can help ensure they are right for your group. Consider getting a new, non-home phone number for safety and privacy. If you put your phone number on the flyer, turn off your ringer when you don't want to be disturbed. Some people prefer having a voicemail box separate from their personal or home phone*

NOTE: A general media kit is available at the HCV Advocate website (www.hcvadvocate.org), and a sample flyer is on the next page.

Have Hepatitis C? You're Invited to Join Our NEW Support Group

Come meet other people who have hepatitis C. Learn how they live with their condition and handle treatment.

Our group's mission is to give people with hepatitis C peer-to-peer support and education in a nonjudgmental, caring environment.

To sign up: Call 1 (XXX) XXX-XXXX or
E-mail: Name@mail.com

Where: Community Center
191 Main Street, Room 337
Any Town, Any State, Zip Code

When: Wednesdays, 6:30 pm to 8 pm

This support group is endorsed by the Any Town Community Hospital.

Reach out to help promote your group.

Talk with other support groups that serve the needs of the hepatitis C community. Your group could offer a special type of support that no other group does.

After your group begins having meetings, post a new flyer listing upcoming speakers and topics. It may encourage others to join when they see who will be speaking. Other ideas are:

- ***E-mailing www.hcvadvocate.org:*** *They maintain and publish a national database of hepatitis C support groups. Contact them to see about listing your group*
- ***Creating a press or media kit:*** *This is a package of materials you send to the press. It may include a* press release*, which is a brief news article announcing your group and explaining how people can sign up. Typically, you mail or e-mail it to local radio stations and newspapers. You may also want to include your flyer. After you send it, follow up with a phone call to show it is important*
- ***Contacting local newspapers:*** *Look for newspapers that cover your community or the specific audience that your group wants to attract. It helps to call the newspaper and develop a relationship with the local editor, since they are always looking for news. Ask if they will run a free announcement. If not, consider taking out an advertisement*
- ***Checking with community websites:*** *Many of these websites list local events for free and run articles about nonprofit groups*
- ***Speaking with clearinghouses:*** *These are online links to nonprofit, self-help, and advocacy groups. Ask the clearinghouse to list your new group on its website. Here is one example of a clearinghouse: www.health.gov/nhic/pubs/2011clearinghouses/clearinghouses1.htm*
- ***Reaching out with social networking:*** *This is another easy way to advertise and keep group members informed of any changes. The 2 most popular social networking sites are Facebook and Twitter*
- ***Writing a blog:*** *Do a Web search for the leading hepatitis C blogs, and ask if any of them will write about your new group. Also, consider starting your own blog. Members of your group can contribute to it, and it may prove to be a great way to attract new members*
- ***Creating a Yahoo- or Google-type group list:*** *These electronic programs let you e-mail many people at once*
- ***Posting information to online bulletin boards:*** *Online, locally based websites may be helpful places to invite people to join*
- ***Creating a new e-mail*** *so that you can keep your personal life separate from the support group*

Mailing lists.

Establish a mailing list—preferably one with e-mail addresses. This will save on postage and it is quicker than regular mail. Some good things to include in your e-mails are:

- *Lists of future speakers and topics*
- *Requests that people* RSVP *(let you know if they'll be coming) for each meeting, so you know how many people to expect*
- *Flyers for people to share or post*

Do not send group e-mails to people unless you have their permission.

Meeting signs.

Make laminated signs that can be reused for each meeting. Place them in elevators and hallways so people can find their way to the meeting. You can buy them at an office supply store.

8: Confidentiality: Respecting People's Privacy

Trust is vital for a support group to be successful. Here's how you can help people in your group feel safe and secure.

To borrow from a popular ad campaign: "What happens in the group stays in the group."

The most important thing that your group can provide its members is a safe environment. People need to feel free to share their experiences and know it will stay within the group. They should never have to worry that anything said will be repeated outside the group.

At the start of each meeting, remind the group that privacy is important:

- *Building trust makes the group comfortable*
- *When they feel secure, people often open up*
- *Sharing experiences and feelings helps everyone in the group*

Talk to your group about the rules for privacy:

- *No one should talk outside of the group about what people said in the group, especially in a way that might reveal the identity of a group member. You may want to tell everyone in the group to only use first names*
- *It is okay to discuss the general subject of the group meeting with others. But do not disclose any personal information about group members. For example, it is not okay to say, "There's this guy in the group who writes for the local newspaper." It would be okay to say, "There's someone in the group who wore a blue shirt"*

Maintaining privacy outside of the group is important. If people see someone else from the group in public, it can be awkward. Remind the members to be discreet.

Discuss what members should do if they see someone from the group in public. For example:

- *Should they acknowledge the other member?*
- *Would it embarrass them?*
- *If they introduce the member to their friends, what is the best way?*

Everyone in the group may have a different feeling about these issues. It might be helpful to talk about these situations and figure out some rules. Then, you can all agree to follow those guidelines.

What are the ground rules?

A support group should have some ground rules. Without them, group meetings could become unruly and chaotic. Members need to feel safe enough to talk about personal issues and offer advice to others. Rules can help give everyone a chance to be heard.

So before your first meeting starts, think of some ground rules. Write them down, so that the group can then add to and improve on them during the meeting. Also:

- *Talk about the reasons for the ground rules and ask for comments from all the group members*
- *Feel free to add or make changes as people make suggestions*
- *Discuss the rules, then have the group vote on and adopt them*

It is much easier for people to follow guidelines when they have had a role in creating them. Ground rules can be changed as long as the majority of members agree. Here are 8 suggested ground rules:

1. *I will try my best to arrive on time and attend every meeting*
2. *I will respect the confidentiality of all group members*
3. *I will be honest*
4. *I am willing to talk, but it is also okay if I decide not to talk*
5. *I will not interrupt others or disrupt the meeting with side conversations. I respect that only one person talks at a time. I will not take over the conversation. I will listen carefully*
6. *I will accept all other group members without judgment. I will not give feedback or advice without the other person's permission*
7. *I will respect other members' feelings, whether positive or negative, and I will express my feelings in a nonjudgmental way. I will make "I" statements, such as, "I feel sad," rather than "You" statements, such as, "You make me feel sad"*
8. *I will not attend a meeting if I am under the influence of any non-prescribed drugs or alcohol*

Have each member sign the rules. This shows that the whole group adopts these guidelines. As the leader, remind everyone that these are the rules everyone agreed to.

9: Sample Support Group Format

Create a format for your group to follow.

Below is a sample of a support group format, where the support group meets on the first and third Monday of every month, from 7:00 pm to 8:30 pm.

Starting the group (the first 35 minutes, 7:00 pm–7:35 pm).

- *After arriving, the members take a few minutes to check in with each other. For the first few weeks, they may need to reintroduce themselves*
    - *The members discuss any important issues that have come up since the last meeting. Everyone gets to speak at this time*
    - *The check-in for each person is usually 2 to 3 minutes, but not longer than 5 minutes. During the check-in, some group members may ask for additional time to talk about topics or problems they would like to discuss with the entire group. No one should interrupt the person who is checking in*
- *The group leader may introduce a theme into the check-in, such as:*
    - *"When you check in, please describe how you are feeling." (Discourage members from using "fine" or other 1-word answers)*
    - *"When you check in, please tell us one thing that you feel good about or grateful for." (It helps group members to start out with a positive comment instead of a negative one. This can also be used for the check-out at the end of the meeting)*

Education or specific topic section (35 minutes, 7:35 pm–8:10 pm).

The second part of the meeting is for discussing a wide range of topics. Come to the meeting with an order in mind for these topics. At some meetings, you can arrange for a speaker to address the group.

Within the Lessons Manual, there is a series of 12 modules or lessons for you to use as discussion guides. Each one gives you a framework around which to build a meeting.

Short break (5 minutes).

Allow members to take a 5-minute break. This allows participants some time to collect themselves. It also helps keep people focused and it may help encourage participation in the rest of group.

Ending the group (15 minutes, 8:10 pm–8:25 pm).

It is important that each member finds *closure* during the check-out part of the meeting. This means that they can go home feeling that they've been able to express everything they needed to.

- *This is the time for members to have a final word or thought*
- *This could be a simple goodnight or a comment about the meeting*
- *The person checking out should be allowed to talk without interruption*

Some groups perform a closing ritual. Your group could close with prayer, meditation, a poem, or just holding hands for a moment of silence. Ask your members how they would like to close each week's meeting. They may choose to share a prayer or poem that helped them find inspiration and hope.

Here are some end-of-meeting examples:

- *Serenity prayer: "God, grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to know the difference"*
- *Silent meditation: All the members form a circle and silently say to themselves (2 times), "May I be well," (breathe in), "May others be well," (breathe out)*
- *"Thank you for coming. Be safe"*

Typical Support Group Meeting Format
Starting the group (35 minutes)
• Introduction and review of the rules
• Check-in: Each member talks for 2 to 3 minutes
Short break (5 minutes)
Education or specific topic (35 minutes)
• See lessons for ideas
Ending (15 minutes)
• Check-out: Each member shares a final word or thought
• Closing ritual (poem, prayer, or meditation)

To learn more about support groups, see Lesson 11: "Ways to Work Through Tough Problems."

10: Even the Smallest Steps Are Steps in the Right Direction

Your group can help improve members' quality of life, even if it is a little at a time.

When people are newly diagnosed with hepatitis C, their healthcare providers may recommend many lifestyle changes. Among these changes are:

- *Avoiding alcohol*
- *Eating a healthy diet*
- *Exercising*
- *Not taking street or illegal drugs*
- *Quitting smoking*

For more lifestyle changes, see Lesson 6: "Living With Hepatitis C," in the accompanying ***Hepatitis C Support Group Lessons***.

For many newly diagnosed people, making these changes to their lifestyles can be difficult. Too many of these changes at once often results in failure.

Group members can help people stay on track. Family, friends, and healthcare providers can also make these lifestyle changes easier to accept.

One way to help people adjust to these changes is through *harm reduction*. It's an approach where even the smallest steps in the right direction are celebrated, because even the smallest steps get you closer to your goal.

- *For example, it may be too difficult at this time for someone to stop smoking completely. So if he or she can cut back on the number of cigarettes each day, then it is a small step forward. Each time the person cuts back a few more, it's another successful step until he or she finally reaches the goal of completely stopping*
- *This approach can be used for any type of behavioral or lifestyle change, where the person can't go all the way at once*

Members of the group can encourage success using harm reduction. People in the group should openly share their own experiences about how they took small steps until being able to stop completely. They can also add how good they feel about themselves for sticking with their plans.

Others can talk about the small steps they are currently taking, and how they are looking forward to reaching their final goals.

Small steps do add up. Consider having a weekly celebration of small personal wins, such as making it to the halfway point for treatment, or not having a beer for a week. Ask your group members to make suggestions.

Setbacks are part of the process. Encourage people who are trying to keep trying. Ask the group members to make suggestions to the person who needs to get back on track.

11: Ways to Work Through Tough Problems

Dealing with people in support groups can be challenging. But it doesn't have to be a problem.

Every support group is unique. Each member brings his or her own issues and emotions to each meeting.

Sometimes, the different personalities and viewpoints of people in the group will clash. This is your chance to help members work out their differences.

It's not impossible. For starters, try not to worry about potential conflicts. They don't happen very often, if at all. Besides, you have the ground rules to help you avoid or handle such situations. Remember, the whole group voted on the ground rules, so you have the whole group on your side.

Keep in mind that no one likes to be directly challenged by the leader or anyone else. If you must interrupt or challenge someone, be gentle, but firm. Use a calm and reassuring voice in a non-threatening manner. Start off by making a positive comment to the person.

COMMON PROBLEMS

A member repeatedly shows up late for support group meetings:

- *Mention that the person is late and remind him or her that we are all responsible for showing up on time. Things happen that make people late. So be careful that you are not too rigid with him or her*
- *One good way to handle this is to say, "I have noticed that you have been late for the last 2 meetings. Is there anything we can do to help you join us on time?"*

A member is dominating the conversation:

This issue needs to be a part of your ground rules. One member dominating the group may frustrate others, which is unfair. If a member is dominating, rambling, or gets sidetracked, you can:

- *Summarize the main point and ask the other group members for their point of view. For example: "Thank you, Steve, for sharing how you were able to deal with the chills during treatment. How do you think you will be using that strategy if you need it, Peter?"*
- *If the speaker makes a number of good points, say so. Then, choose the most helpful one. Suggest that the group focus on it. You may have to interrupt the person. One way to do it is to say, "You bring up some interesting points. Do any others have any comments, or would others like to share how this relates to them?"*
- *Avoid direct eye contact with the person dominating. It is harder for people to dominate the conversation if the leader is not actively engaged*

A member keeps interrupting the guest speaker:

If you have an invited speaker giving a lecture, explain to the member that there is a lot of material to cover. Ask your group to hold questions until the end.

A member frequently makes comments only to, or asks questions of, the leader:

- *Look away from the member*
- *Repeat the questions back to the entire group*
- *After the meeting is over, talk with the person about directing comments or questions to the entire group*

There are silent moments:

Silent moments can be a positive sign. It can mean:

- *That the members are feeling comfortable with each other*
- *That people are digesting information, or may be trying to process some feelings*

If the silence runs on for too long, ask the members, "Does anyone have any other thoughts about what was just discussed?" Or, you can simply move along to the next topic.

A member never speaks up:

Some people may want to sit quietly and not participate. That's okay. If you feel that people want to talk but may be shy, you can make direct eye contact with them. Check out their body language for hints that they may want to jump into the discussion. You can also ask them:

- *"Do you have anything you would like to share about the discussion?"*
- *"Do you have any feelings about what we discussed?"*

There is incorrect information:

It is not a good idea to challenge members aggressively if they say something you know is false. Instead, try to speak in a calm and soothing voice:

- *"Hmm…that's not what I have heard or read. Maybe we can talk about it after group"*
- *"I have heard differently. Let's talk after group about how we can research this issue. Then, we can share with the group what we learned at a later time"*

Don't directly challenge the information as false, but if there is no scientific evidence to support the information, say so. Invite the participant to discuss the issue with you later: "I have another explanation I'd like to share with you after group."

Humor: What's appropriate and inappropriate?

Humor is a wonderful tool for breaking the tension within the group when the conversation becomes upsetting. However, it can also interfere with members coming to terms with their emotions. It may even get in the way of an important discussion. Try these strategies:

- *Ignore the humor and move on*
- *Make a comment, such as, "That was really funny, but I think we need to stick to our discussion"*
- *If a person continues to make inappropriate jokes, say, "This is a serious issue, and we really need to concentrate on working through it"*

There is anger in the group:

Anger is a necessary part of the support group process. This is especially true for people with a potentially life-threatening disease. People need to be able to release their anger in a safe way. Make sure no one directs their anger toward anyone in the group. Once the member voices his or her anger, the group should be able to move on.

If the anger continues, it can harm a support group meeting. It can make people feel that the group is unsafe. If anger continues to dominate a meeting, try one of these 5 approaches:

1. *Acknowledge the person's anger: "You have expressed some powerful emotions. How do you think these affect the other members?"*
2. *Ask for a time-out, so that you and the other members can deal with the anger: "I can see that you are really upset. Let's take a couple of minutes to cool down before we continue with this discussion"*
3. *Reassure the member that everyone in the group wants to help*
4. *If someone becomes too angry, ask the member to step outside for a minute to try to calm down*
5. *Try moving on to another topic, but make sure you come back to the member and check in when his or her emotions have calmed down*

There is arguing in the group:

People in groups will argue. If it gets out of hand, show that you respect the person's feelings. Then, encourage him or her to use the group to get additional information, or to give his or her perspective on the issue.

There is crying in the group:

Crying is an important and natural part of the grieving process. If someone starts to cry, reassure him or her that these feelings are normal. Acknowledge his or her feelings, and provide comfort (and tissues). Gently shift to talking to another group member, but come back to check in with the member when he or she has stopped crying.

If the person is upset to the point of concern, you could step out of the room with him or her until the person has settled down.

If the member is unable to continue to talk, move on to another topic, or ask the other members to check in.

There are side conversations in the group:

Side conversations are disruptive and disrespectful. They show that the member is not interested in the group discussion, and they can make other members feel like they are being left out. Some ways to deal with side conversations include:

- *Reminding the members about the ground rules at the beginning of the meeting. If need be, enforce the rules*
- *Walking over to the people having the sidebar. Sometimes, just by standing near, they will drop their conversations*
- *Calling for a time-out and stopping the group for a moment. This will help you make the point that a ground rule has been broken. You could also interrupt the offenders and ask if they have something to share with the group*
- *You can say, "Hold on for a minute," and wait for the people to stop talking*

12: How to Get Funding

Finding sources of cash to run your meetings can be a challenge. Here are simple tips that have been helpful for other groups.

You don't need a lot of money to run a meeting. You should not have to pay out of your own pocket to cover the costs—after all, you are donating your valuable time. It is even easier if other agencies are able to provide free space or donate materials and other services.

Your support group could decide to expand its mission to provide additional meeting times or offer other services. If that happens, you will need a fundraising strategy. Whether you plan to have a large or small group, it is a good idea to develop a budget.

Develop a budget.

Your first step to managing money for the group is developing a budget. You will need to do this before your first meeting. Start by thinking about all the possible expenses you might have for the first year of operation, such as:

- *Postage*
- *Copying*
- *Snacks/beverages*
- *Telephone bills*
- *Other charges*

Once you estimate the expenses, you will have a better idea of how much money you will need to raise for each year. Often, you can cover your group's expenses by raising money from volunteers and donations.

Ways to get funds.

Raising cash for your support group is easier if you keep the cost of running the group low. Here are some ways to cover the costs:

- *Cash donations: At the beginning or end of each support group meeting, pass around a jar or coffee can for donations. Don't be afraid to tell people that there are costs associated with running the group. Also, ask people to:*
    - *o Help fund the group, since they are participating in the group. Make sure members understand that they should only donate what they can afford. But if they don't have anything to give, they are still valued members of the group*
    - *o Bring in food and beverages on a rotating basis*
    - *o Volunteer to photocopy educational materials for the meetings*

- *Garage or sidewalk sales: One of the easiest ways to raise cash is by having a garage or sidewalk sale. You can:*
    - *o Get members and their families and friends to help organize and staff the sale*
    - *o Encourage members to donate items to sell*
    - *o Ask a group member who lives in an area where many people walk by if they can host the sale*

You might be surprised by how much money a sidewalk sale can bring in. Be sure to check with your town about any rules for these sales.

Can you get donations?

It never hurts to ask. For your support group meetings, ask local government healthcare organizations and companies to donate:

- *Services*
- *Space*
- *Food*

You could also ask bakeries, coffee houses, local healthcare provider offices, and anyone else you think might be willing to support the group.

If you want to seek grant funding.

If you want to seek grant funding, you will have to apply for commercial or nonprofit status with both the federal and the state government. Support groups usually apply for nonprofit status, since they do not intend to make money. You should know that:

- *It is not hard to apply for nonprofit status, but filling out the application can take time. You also need to manage the day-to-day business operations carefully*
- *All of your revenue and expenses must be recorded. You also must fill out a state and federal tax return*

Check with your local, state, and federal governments to learn more about the application process.

Another option is to focus on running the group instead of raising money for the group. If you choose this approach, you can use a nonprofit local government healthcare agency to act as a *fiscal agent* (an organization that will legally hold money and do all the accounting for your group). Some agencies will handle your money for free, but others will charge you a small percentage of the money you raise.

13: What Comes Next?

The first step was reading this handbook. The next steps are up to you.

Now that you have the information on how to start a support group, give the group some serious thought.

Many people have said that leading a support group has been one of the most rewarding experiences of their lives.

The majority of people who attend hepatitis C support group meetings say they enjoy the group experience. Being supported by their peers helped them to transform their lives from a state of ignorance, fear, and anger to one of more acceptance and greater self-esteem.

This process can also help you. Other group leaders have said it helped them develop strategies to move forward in their own lives and become better self-advocates (people who can speak up for themselves).

Good luck and much success to you and all of your future group members.

14: Resources and Glossary

Spend time with these resources to continue to learn more and share what you've learned.

Hepatitis C Resources

American Liver Foundation
1-800-GO-LIVER (1-800-465-4837)
www.liverfoundation.org
Information on liver disease, including hepatitis C

Caring Ambassadors Hepatitis C Program
www.hepcchallenge.org
Hepatitis C Choices book (free PDF); information and awareness

Centers for Disease Control and Prevention (CDC)
1-800-CDC-INFO (1-800-232-4636)
www.cdc.gov/hepatitis/index.htm
Fact sheets and answers to frequently asked questions about hepatitis

Hepatitis Education Project
www.hepeducation.org
A website for people with hepatitis C and their friends, family members, and healthcare providers. Information, advocacy, support, and other resources

Hep C Connection
1-800-522-HEPC (1-800-522-4372)
www.hepc-connection.org
Resources, education, and support for people affected by the hepatitis C virus

Hepatitis C Support Project
www.hcvadvocate.org
Provides resources and information on hepatitis C, from clinical trials to alternative treatments. Also includes complementary therapies and information about living well with hepatitis C

Hepatitis Foundation International
1-800-891-0707
www.hepfi.org
Information on viral hepatitis and liver disease

Mayo Clinic
www.mayoclinic.com
Up-to-date information and tools that reflect the expertise and standards of the Mayo Clinic

MedicineNet (owned by WebMD)
www.medicinenet.com/hepatitis_C
Medical information on hepatitis C

MedlinePlus Health Information
www.nlm.nih.gov/medlineplus/hepatitisc.html
An extensive health information website that includes a medical dictionary, information on prescription and nonprescription drugs, and an overview of hepatitis C

National AIDS Treatment Advocacy Project (NATAP)
www.natap.org
Educates people about HIV and hepatitis treatments, and advocates for those with these conditions. Provides hepatitis C news and conference coverage

National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
www.niddk.nih.gov
Contains a database of educational materials and a discussion of hepatitis C

National Institutes of Health (NIH)
www.nih.gov
Comprehensive health website with links to health publications and current research

United States Department of Veterans Affairs (VA)
www.hepatitis.va.gov
Information, brochures, and handbooks on hepatitis C

Drug Manufacturers and Other Resources

Better To Know C Program
Vertex Pharmaceuticals
1-888-552-2494
www.BetterToKnowC.com

Partnership for Prescription Assistance
1-888-4PPA-NOW (1-888-477-2669)
www.pparx.org

All About Hep C
Schering/Merck
www.AllAboutHepC.com

Tune In To Hep C
Schering/Merck
www.TuneInToHepC.com

Other Resources

Rules and regulations regarding medical conditions and the workplace can be obtained from:

Americans with Disabilities Act (ADA)
www.ada.gov

Federal Equal Employment Opportunity Commission (EEOC)
www.eeoc.gov/facts/qanda.html

Federal Family and Medical Leave Act of 1993 (FMLA)
www.afm.ars.usda.gov/hrd/payleave/family/FMLAentitlements.htm

New privacy laws about medical information and records can be found at:

US Department of Health and Human Services (HHS)
Health Insurance Portability and Accountability Act (HIPAA)
www.hhs.gov/ocr/privacy

GLOSSARY

Acetaminophen: The generic name for over-the-counter pain and fever relievers, such as Tylenol®. Large doses can cause liver failure. Ask your healthcare provider if you can take acetaminophen. It should never be taken with alcohol.

Acute: A term used to describe disease symptoms of a short period of time.

Acute hepatitis C: A short-term illness that usually occurs within the first 6 months after someone is exposed to the hepatitis C virus. About 75% to 85% of people who become infected with the hepatitis C virus will develop chronic, or long-term, hepatitis C.

Adverse event: An unwanted reaction you get from taking a medicine.

Alanine aminotransferase (ALT): A liver enzyme that plays a role in building up and breaking down protein. Healthcare providers check the serum level as part of a liver function test. If your liver cells are damaged, the serum levels of ALT may be high. Hepatitis C can cause your ALT level to go up.

Anemia: A condition in which your blood has a lower-than-normal number of red blood cells. Symptoms include feeling tired, having a shortness of breath, having a headache, and having your heart beat too fast or too slow for no reason.

Antiviral drug: A medicine that fights a virus.

Aspartate aminotransferase (AST): An enzyme normally present in liver, heart muscle, and red blood cells. It is released into the blood when you've been injured (including getting infected with the hepatitis C virus). Higher levels of AST in your blood may mean you have the hepatitis C virus.

Blood transfusion: The transfer of blood from one person into the bloodstream of another person. Before July 1992, people were at risk of getting infected with the hepatitis C virus through blood transfusions. Since then, blood is screened more carefully.

Blood-borne virus: A virus in your blood that can infect someone else through blood-to-blood contact (through shared needles when blood is exchanged, for example).

Body mass index (BMI): A measurement of body fat. It is calculated by the weight of your body and your height. Your healthcare provider can use it to help find out if you are overweight.

Chronic: A permanent or reoccurring disease or condition.

Chronic hepatitis C (CHC): A serious condition that inflames and damages the liver. It can lead to potentially fatal liver diseases, such as cirrhosis, liver failure, and liver cancer. About 75% to 85% of the people who are infected with the hepatitis C virus will develop chronic, or long-term, hepatitis C.

Cirrhosis: The late stage of liver disease. It's when the liver has scar tissue that has replaced normal liver tissue. As a result, the liver does not have enough blood flowing through it.

The liver has fibrosis (scar tissue that has replaced normal liver tissue), and has a bumpy surface from new growth. There are 2 types of cirrhosis—compensated and decompensated:

- *Compensated cirrhosis means that the liver is very scarred but can still do what it is supposed to do. People who have compensated cirrhosis can be treated with hepatitis C medicines*

- *Decompensated cirrhosis (also known as* end-stage liver disease*) means that the liver is so scarred that it can't work properly. The liver can no longer keep the person healthy. Decompensated cirrhosis is a life-threatening condition*

Clearing the virus (or being cured of the virus): Describes the best result after treating hepatitis C. You are cleared of the virus, or cured of the virus, when no virus is detected in your blood 6 months after you finish all treatment. This is also called a *Sustained Virologic Response* (SVR).

Combination therapy: 2 or more drugs used at the same time to treat a disease or condition.

Direct-acting antiviral (DAA): A type of medicine used in combination with other medicines to treat hepatitis C. It is a class of medicine that you swallow as a pill. DAAs directly target the hepatitis C virus as it multiplies.

Depression: A state of being when you may have problems concentrating, lose interest in things you once enjoyed, feel guilty or hopeless, or have thoughts about death or suicide.

End-stage liver disease: The last stage of liver disease. It happens when the liver is not getting enough blood flowing through it, when the liver has *fibrosis* (scar tissue that has replaced normal liver tissue), and when it has a bumpy surface from new growth. This disease is also known as *decompensated cirrhosis*, and it can cause death.

Fatty liver: Too much fat in the liver cells. It is the most common type of liver disease in the United States. Having diabetes, being overweight, and eating a diet with too much *cholesterol* (fat in food), all increase chances for getting fatty liver disease.

Fibrosis: Scar tissue that replaces healthy liver tissue. It can lead to cirrhosis, liver cancer, and even death.

Gastroenterologist: A medical doctor who is an expert on the digestive system, which includes the stomach, intestines, and liver.

Genotype: A virus type that has a special genetic makeup. There are at least 6 genotypes for hepatitis C. In the United States, genotype 1 is the most common: genotypes 2 and 3 are found in a smaller number of people with hepatitis C. Genotypes 4, 5, and 6 are not common in the United States.

Genotype 1: The most common type of the hepatitis C virus in the United States.

Hepatic portal vein: The main vein that carries nutrients from the digestive tract to the liver where the nutrients are processed. Liver disease, such as cirrhosis, increases blood pressure in the portal vein, which can lead to complications and even death.

Hepatitis: Inflammation (swelling) of the liver.

Hepatitis C disease: A liver disease caused by the hepatitis C virus. The hepatitis C virus lives in a person's blood. It inflames and can damage the liver, sometimes without any symptoms. It can only be transmitted through blood-to-blood contact. Hepatitis C is a major public health problem and the leading cause of chronic liver disease in the United States. It is also called *hep C* or *HCV*.

Hepatitis C virus: A virus that lives in a person's blood. It inflames and can damage the liver, sometimes without any symptoms. It can only be transmitted through blood-to-blood contact.

Hepatitis C is a major public health problem and the leading cause of chronic liver disease. It is also called *hep C* or *HCV*.

Hepatologist: A gastroenterologist who is an expert in treating people with liver diseases, such as hepatitis C.

Interferons: Proteins that our immune system makes to fight viruses and other inflammatory diseases. Interferon can also be a *synthetic* (man-made) medicine. It is an injection and is part of the treatment for hepatitis.

One type of interferon is called peginterferon alfa that is often combined with the drug ribavirin. They are both used together to treat hepatitis C, genotypes 2 and 3. Those 2 medicines are also used with another medicine, a DAA (direct-acting antiviral), to treat people who have genotype 1.

Jaundice: A yellow coloring of the skin and eyes. Jaundice can appear when the liver is not working normally. It is also one of the signs of end-stage liver disease.

Liver biopsy: A procedure where a small piece of liver tissue is taken out of the body by a long needle. Healthcare providers then study the tissue under a microscope to see if it is diseased.

Liver cancer: Develops when a cell or group of cells becomes damaged and begins growing in an unusual way. It often causes *liver tumors* (lumps of tissue). People with hepatitis C are at a higher risk of getting liver cancer. Between 1 and 5 people out of every 100 get liver cancer after having cirrhosis. Liver cancer is also called *hepatocellular carcinoma* (HCC).

Liver enzymes: These are proteins that the liver makes to help do some important tasks. We all have some enzymes in our blood, but too many enzymes may be a sign that the liver is damaged or sick.

Pegylated interferon alfa: A type of synthetic interferon that is given as a weekly injection. Pegylated means the interferon stays in the body longer.

Polymerase inhibitor: A class of compounds that work to inhibit (stop) the polymerase enzyme from working, in order to prevent a virus from multiplying.

Protease inhibitor: A class of compounds that work to inhibit (stop) the protease enzyme from working, in order to prevent a virus from multiplying.

Prothrombin time (PT): A test that measures blood clotting.

Rapid virological response (RVR): A term used for blood test results after 4 weeks of treatment that shows that the hepatitis C virus can no longer be detected.

Relapse: An instance in which illness symptoms of a disease return after showing improvement. A relapse of hepatitis C can happen after reducing the virus or after stopping therapy.

Ribavirin (RBV): A medicine used in combination with peginterferon alfa to treat hepatitis C. When used alone, it is not effective in the treatment of hepatitis C.

Ribonucleic acid (RNA): Genetic material. Hepatitis C virus RNA can be detected in the blood within 2 to 3 weeks after a person is infected. After treatment, if a blood test shows no hepatitis C virus RNA, the person is considered clear of the virus.

Support group: Small meetings of people who have hepatitis C. The people share information and help each other deal with the challenges of life and having hepatitis C.

Sustained virologic response (SVR): A term used when the hepatitis C virus does not show up in blood tests taken 24 weeks after treatment has stopped. SVR is also called "a cure," or "clearing the virus."

Undetectable: The virus can't be detected or found in viral blood tests.

Viral load: A measure of the amount of hepatitis C virus in the blood. Test results are usually written in international units per milliliter (IU/mL).

Virus: A tiny infectious "agent" or "germ" that causes diseases.

KANSAS CITY FREE HEALTH CLINIC
JOB DESCRIPTION

Position: Peer Educator	**Exempt Status:** Non- Exempt	**Work Status**: Part Time
Job Code:	**Division:** HIV Primary Care	
Reports To: - Treatment Adherence Specialist	**Date:** January 21, 2003 Revised January 31, 2006 Revised June 8, 2006	

Job Summary: The Peer Counselors are integral to the Treatment Adherence Program and provide specialized services in a professional environment. Peer Counselors work to encourage engagement into care and support adherence to treatment by providing education, resources, and mentorship.

Duties and Responsibilities:

Clinical

1. Adhere to confidentiality policies. It is a direct violation of Clinic policy to share the names or case facts concerning any client, patient or volunteer of the Clinic with any other person with the exception of those actually involved in the care of the patient/client. Any release of confidential information to any other entity shall be preformed by authorized personnel only and shall be accompanied by proper written authorization from the patient/client.
2. Peer counselors have scheduled office hours to complete office work, be available to meet with new clients, or provide one on one session with current clients.
3. Pull next day appointment charts, following the peer counselor standard operating procedures, complete patient reminder and DNKA calls.
4. Document information and relay pertinent information to treatment adherence specialist and/or provider.
5. Peer counselors carry a case load of individual clients and provide one on one support, education, and information.
6. Contact should be individually tailored to address treatment adherence issues of the client.
7. On average, peers should have weekly or bi-weekly contact with their clients.
8. Participate in continuing HIV/AIDS education and meetings.
9. Design and facilitate peer program-5 session groups that support treatment adherence issues.

Administrative

1. Follows all policies and procedures.
2. Completes all appropriate paper work in a timely manner (see Protocol and Operational Activities Manual).
3. Attends individual supervision meetings with Treatment Adherence Specialist.

4. Attends peer counselor team meetings.
5. Assists in providing education and training to other peers.

Education and Experience:

- Possess basic knowledge and understanding of HIV/AIDS treatment adherence related issues.
- Possess willingness and ability to acquire further HIV/AIDS education and training
- Must complete Peer Counselor training sessions.
- Must participate in ongoing peer counselor training
- Possess good communication skills: including verbal, phone, and written skills.
- Ability to interact with diverse groups.
- Strong interpersonal skills including the ability to demonstrate empathy.
- Ability to work independently and seek guidance or assistance when necessary.
- Ability to work with multidisciplinary team of medical professionals.

Physical Demands/Working Conditions:

1. Intermittent physical activity including walking, standing, sitting, lifting and supporting of patients.
2. Incumbent will be exposed to virus, disease and infection from patients in working environment.
3. Incumbent will be required to work at one of our two facilities and be responsible for own transportation.
4. Incumbent may experience traumatic situations including but not limited to psychiatric, dismembered and terminal patients.

The above information is intended to describe the most important aspects of the job. It is not intended to be construed as an exhaustive list of all responsibilities, duties and skills required in order to perform the work.

Approved:

_____	_____
Employee	Supervisor/Manager
_____	_____
Date	Date

SAMPLE
Peer Advocate Job Description

The role of the Peer Advocate is to provide a bridge between providers and clients (HIV-positive women) that facilitates the medical and psychosocial care of the client.

The Peer Advocate works in a team setting as one component of the clients coordinated care. However, the Peer Advocate is an advocate for the client, and maintains a relationship with the client that fosters trust and understanding distinct from a provider role.

The peer Advocate is expected to serve as a role model who provides reliable information, appropriate referrals, and emotional support to women who are infected with HIV or AIDS. Peer Advocates also help clients access services (medical, emotional, economic, and legal) and sometimes accompany clients to appointments or arrange for transportation as needed.

Required Qualifications:

1. First hand understanding of issues related to living with HIV or AIDS.
2. Familiarity with AIDS services in the city of _____.
3. Ability to work as part of a team, with other Peer Advocates at our Agency and with health care providers in clinical settings.
4. Honesty and genuine compassion for individuals living with HIV/AIDS.
5. Ability and willingness to accept direction from supervisor.
6. Good oral and written English communication skills.
7. Good telephone skills
8. Comfort with the diversity (ethnicity, sexual orientation, socioeconomic status, etc.) of our multicultural community.
9. Ability to maintain required work schedule, be on time, keep work area neat and be accountable for how time is used.
10. Ability to use good judgment regarding confidentiality issues.
11. At least one year clean and sober if addiction has been an issue.
12. Ability to advocate for clients by bringing concerns about services to providers' attention.
13. Ability to help clients identify risk reduction strategies (safer sex, drug treatment, needle exchange, etc.)
14. Strong knowledge of HIV disease, treatments, and substance abuse issues.

Preferred Qualifications:

1. Basic computer proficiency
2. Prior peer experience or peer education training.
3. Prior experience with record keeping.
4. Training certificate in HIV 101, Peer Education/Advocacy, HIV treatment is preferred but not required.

Peer Advocacy Program Manager

Reports to: Executive Director
Status: Part-time (30-32 Hours)
Salary: Depends on experience/ Full benefits

Description:

The Peer Advocacy Program Manager oversees the daily functioning of the WORLD Peer Advocate Program and reports directly to the Executive Director. The Program Manager provides administrative supervision by monitoring peer workloads and performance. WORLD peer advocates report directly to the Program Manager regarding work duties and daily attendance. She also provides mentoring to peers regarding client follow up, and other client-related activities. The Program Manager keeps program records and oversees the client database(s). She is the primary liaison between the Family Care Network, and monitors peer coverage of FCN clinics, providing troubleshooting between peers and clinic staff when needed. The Program Manager attends FCN case conference and Leadership Council Meetings to represent the WORLD peer program.

Job Duties:

1. Supervise peer advocates by tracking peer participation in the program, checking in with each peer regularly, and providing yearly work evaluations.
2. Track new client intakes by collecting from referral sources and/or peer advocates and following up with peers to ensure clients are being served.
3. Provide FCN documentation to FCN and/or oversee FCN-wide database.
4. Provide regular individual check-ins for each peer regarding client contact, mentoring peers regarding client follow-up and other client-related activities.
5. Maintain other documentation related to peer advocacy (e.g. Records of Contact).
6. Monitor FCN clinic coverage and communicate with peers and case managers regarding coverage.
7. Attend monthly FCN case conference task force meeting and quarterly FCN Leadership Council meeting.
8. Ensure that peer program is represented in WORLD staff meetings and events.
9. Attend weekly peer group meetings led by the program consultant and report to the peers regarding administrative items when necessary.
10. Meet regularly with program consultant to troubleshoot peer/program issues and receive support and training in management and peer supervision.

Qualifications:

1. High School diploma or equivalent.
2. Good verbal and written communication skills
3. Experience providing counseling, advocacy, supervision, leadership and/or mentoring to others.
4. Ability to keep a consistent schedule.
5. Minimum two years experience providing direct service or volunteer services to women living with HIV/AIDS or women who reflect the population of WORLD's community.
6. Experience, knowledge, and understanding of HIV/AIDS; living with HIV; and social and cultural issues related to living with HIV.
7. Experience with administrative duties such as computers, databases, filing, scheduling, and tracking services.
8. Attention to detail is a must.
9. Experience responding to clients in crisis.
10. Ability to work with peers using a problem-solving approach.
11. Ability to work with colleagues using a communicative and collaborative approach.
12. Team player and also able to work independently.

13. Experience collaborating with other professionals particularly in the medical and substance abuse/mental health systems.
14. Ability to embrace a community-based, peer-centered, harm reduction approach to working with WORLD's community of women and families living with HIV.
15. Demonstrated interest in self-reflection and awareness of cultural issues in our community.

Family Care Network (FCN) Consumer Input Taskforce & Retreat Coordinator

Report to: Executive Director
Status: Part-time (25 hours per week – hours will increase prior to, during and following retreats)
Salary:

Description:

WORLD is a member of a Ryan White Part D funded collaborative organization serving women, youth and children living with HIV/AIDS in Alameda and Contra Costa counties – the Family Care Network (FCN). The FCN has subcontracted with WORLD to facilitate and coordinate its Consumer Input Task Force (CITF). The CITF is comprised of women and youth living with HIV who are also consumers of the FCN services. The goal of the committee is to advise and give feedback to the FCN on their current services, identify unmet needs and issues that need attention or resolution, and help foster a sense of community among consumers receiving FCN services. Additionally, this part-time position with coordinate WORLD's semi-annual retreats for HIV –positive women.
The CITF Coordinator will be supervised by WORLD's Director of Training and Education and will work in cooperation with additional CITF support staff and the Peer Advocate team.

Duties and Responsibilities CITF:

1. Facilitate CITF meeting with members, in conjunction with co-chairs.
2. Meet regularly with CITF co-chairs to review agenda and upcoming activities.
3. Liaison role with FCN management regarding the work of the CITF and relevant communication. Includes occasional verbal report to FCN.
4. Assist in logistics and scheduling of community events that CITF is involved in, such as tabling, public speaking and social events.
5. Work with WORLD support staff on the CITF project.
6. Coordinate food for CITF meetings and events.
7. Identify training topics that may be useful for the CITF and coordinate scheduling.
8. Track member incentives and make requests to ED for these funds as needed.

Duties and Responsibilities Retreats:

1. With manager, determine and monitor the retreat budget;
2. Select and reserve a retreat site and transportation
3. Explore supportive and informative retreat activities
4. Recruit participants and qualified activity leaders (paid and volunteer service providers)
5. Enroll participants and process their applications
6. Organize the retreat schedule
7. Purchase necessary supplies and prizes
8. Prepare service providers and volunteers for retreat; supervise service providers and volunteers at the retreat
9. Print certificates for participants;
10. Prepare, supervise and analyze the evaluation segments with assistance from manager
11. Other duties as assigned based on needs of organization.

Desired Qualifications:

1. High school diploma or equivalent.
2. Bilingual Spanish/English; Bicultural preferred.
3. Excellent interpersonal, oral and written communications skills.
4. Team player, self-motivated, able to work independently and on a team.

5. Firsthand knowledge in HIV/AIDS issues.
6. Experience facilitating meetings and trainings.
7. Experience planning and implementing events.
8. California Driver's License and access to car preferred but not required.

HIV University Coordinator

Reports to: Executive Director
Status: Part-time (20 Hours/week)
Salary:

Responsibilities:

1. Outreach and recruitment of HIV U participants.
2. Prepare and administer applications and pre-test.
3. Coordinate planning meetings.
4. Plan and coordinate (or supervise volunteer coordination of) Open House.
5. Plan/mentor Deans' planning for classes.
6. Participate in classes
7. Mentor volunteer Deans (Dean of Instructors, Dean of Students, Dean of Nutrition) to ensure program has speakers, food, transportation and childcare
8. Ensure students get linked to case management and/or peer advocacy.
9. Plan and coordinate (or supervise volunteer coordination of) graduation event.
10. Maintain participant database
11. Prepare and print graduation program.
12. Prepare and print diplomas and certificates of thanks.
13. Oversee graduation celebration.
14. Conduct formal program evaluation. (In coordination with UC research team.)
15. Other duties as assigned based on needs of organization.

Qualifications:

1. Familiarity with and commitment to WORLD's mission (information, support, advocacy and education for HIV+ women and their loved ones)
2. Good at communicating with individuals
3. Good at communicating with and facilitating groups
4. Experience organizing/coordinating events
5. Knowledgeable about HIV disease, treatments and resources (or strong commitment to learn)
6. Must be courteous, friendly, and enthusiastic about learning and working with people from diverse backgrounds.
7. Must have basic computer skills (word processing, e-mail). Additional computer skills (i.e. database, graphic design) helpful but not required.
8. Bilingual (Spanish/English) a plus, but not required.
9. College-level education a plus, but not required.

WORLD is an Equal Opportunity employer. We actively seek applications from people living with HIV/AIDS and other disabilities, women, and people of color.

Peer Advocate Job Description

Reports to: Program Manager
Status:
Salary:

The role of the Peer Advocate is to provide a bridge between providers and clients (HIV-positive women) that facilitates the medical and psychosocial care of the client.

The Peer Advocate works in a team setting as one component of the clients coordinated care. However, the Peer Advocate is an advocate for the client, and maintains a relationship with the client that fosters trust and understanding distinct from a provider role.

The peer Advocate is expected to serve as a role model who provides reliable information, appropriate referrals, and emotional support to women who are infected with HIV or AIDS. Peer Advocates also help clients access services (medical, emotional, economic, and legal) and sometimes accompany clients to appointments or arrange for transportation as needed.

Required Qualifications:

1. First hand understanding of issues related to living with HIV or AIDS.
2. Familiarity with AIDS services in the city of _____.
3. Ability to work as part of a team, with other Peer Advocates at our Agency and with health care providers in clinical settings.
4. Honesty and genuine compassion for individuals living with HIV/AIDS.
5. Ability and willingness to accept direction from supervisor.
6. Good oral and written English communication skills.
7. Good telephone skills
8. Comfort with the diversity (ethnicity, sexual orientation, socioeconomic status, etc.) of our multicultural community.
9. Ability to maintain required work schedule, be on time, keep work area neat and be accountable for how time is used.
10. Ability to use good judgment regarding confidentiality issues.
11. At least one year clean and sober if addiction has been an issue.
12. Ability to advocate for clients by bringing concerns about services to providers' attention.
13. Ability to help clients identify risk reduction strategies (safer sex, drug treatment, needle exchange, etc.)
14. Strong knowledge of HIV disease, treatments, and substance abuse issues.

Preferred Qualifications:

1. Basic computer proficiency (email, word processing)
2. Prior peer experience or peer education training.
3. Prior experience with record keeping and documentation.
4. Training certificate in HIV 101, Peer Education/Advocacy, HIV treatment is preferred but not required.

WORLD is an Equal Opportunity employer. We actively seek applications from people living with HIV/AIDS and other disabilities, women, and people of color.

FAMILY CASEWORKER/PEER ADVOCATE (Christie's Place)

DESCRIPTION OF DUTIES:
This position reports to the Program Manager. Duties include outreach to HIV positive women of color who are newly diagnosed or have fallen out of care. Role includes conducting informal assessments of client's need for primary care/treatment and/or supportive services, early intervention/diagnosis information, peer based counseling, information based and hand-in-hand assistance in accessing appropriate services.

Specific Duties Include:

1. Conducting single session outreach groups/workshops to the target population throughout the County of San Diego.
2. Implementing a countywide outreach plan for women of color including venue based activities
3. Establishing and maintaining linkages with existing Access & Outreach providers and programs
4. Interviewing program participants at intake including client orientation, referrals, case documentation and follow-up
5. Conducting informal assessments of client's need for primary care/treatment and/or supportive services, early intervention/diagnosis information, peer based counseling, information based and hand-in-hand assistance in accessing appropriate services.
6. Providing service and/or referrals to clients and their families to social service activities designed to meet their needs. Identifying, developing and maintaining linkages within the system of care and outside of Ryan White.
7. Providing one-on-one emotional support for clients.
8. Assisting clients in navigating the Ryan White CARE Act service system and assisting clients in overcoming barriers to accessing services.
9. Working in coordination with case management services.
10. Preparing program materials and correspondence as required. Maintaining client demographic and service utilization data on automated systems.
11. Maintaining confidentiality of all materials

POSITION REQUIREMENTS:
The employee must be able to perform the following tasks, among others:

1. Knowledge of HIV infection related social and emotional issues
2. Demonstrated competency in working with culturally diverse, low income or no income clients and special populations required
3. Ability to work well with people and posses strong customer service skills
4. Well organized and detail oriented
5. Strong interpersonal and communication skills, in person and on the telephone
6. Experience in assisting clients in social services and health care access
7. Knowledge and experience in providing HIV/AIDS education and information is preferred.
8. Ability to speak and write Spanish fluently preferred.

Project ARK Treatment Adherence Counselor
Job Description

Background: The Treatment Adherence Counselor position is an extension of the existing Family Advisor Program (FAP) designed to respond both to needs identified by clients within the Part D Network and to HRSA mandates for support of peer involvement in HIV/AIDS service delivery to Part D populations (children, youth, women and families). The Treatment Adherence Counselor position, under the guidelines of the Missouri Department of Health, will expand services to Part C populations to enhance treatment adherence support programming amongst consumers.

Scope: FAP activities are focused on providing assistance to front-line care and retention staff in service delivery to clients. Treatment Adherence Counselors will assist clients in achieving optimum health outcomes through the identification and removal of barriers to medication adherence by: improving availability, accessibility and quality of core medical services; reducing unmet needs and barriers for people needed HIV/AIDS services in the TGA; & maximizing access and linkage to existing community resources for essential support services.

Supervision: FAP are conducted under the supervision of the Family Life Specialist, Stacey Slovacek, CCLS.

Activities:

1. Act as a member of the multidisciplinary team to address adherence needs of clients.
2. Provide support to referred clients by assisting with clinic orientation, peer support and collaborating on addressing the needs identified in the patient care plan.
3. Will work as part of the HATAP team, or other such existing programs, to assist clients in a comprehensive approach to adherence.
4. Will provide emotional (peer) support and assist with linkage needed to mental health services.
5. Complete initial client intake (completing goal planning) and maintain enrollment of 20-25 clients per year.
6. Complete 20 treatment adherence sessions with enrolled clients each month to improve client understanding of medication and lab values.
7. Participate as a member of the multidisciplinary team weekly staffing to represent 100% of your client enrollment.
8. Monitor kept medical appointments & CD4 counts quarterly to review each clients adherence.
9. Help remove barriers to attending medical appointments by referring to appropriate professionals as needed such as mental health services, case management, substance abuse treatment, coordination of transportation, & delivery of on-site child care.
10. Participate in home visits as appropriate to execute plan of care for clients.
11. Maintain and complete required documentation for the medical chart for each care plan & intervention completed.
12. Complete at least 8 continuing education hours per year.
13. Attend monthly Family Advisor staffing.
14. Participate in appropriate Consumer Advisory Board (CAB).

Minimum Qualifications:

1. 18 years of age or older
2. Patient of a Project ARK collaborative site - clinical program
3. High School diploma or GED recommended
4. HIV-related education peer counseling training course from a grantee approved site
5. Basic computer skills (familiarity with Microsoft Word and Excel, preferable)
6. Assess to reliable transportation (automobile preferred, but not required)
7. Have appropriate skills, relevant experience, cultural and linguistic competency, knowledge about HIV/AIDS & client confidentiality and knowledge of available health and social services related resources.

Peer Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____

Revised 5/2008

Project ARK Network Family Advisor
Job Description

Background: The Family Advisor Program (FAP) is a Project ARK program designed to respond both to needs identified by clients within the Title IV Network and to HRSA mandates for support of peer involvement in HIV/AIDS service delivery to Title IV populations (children, youth, women and families).

Scope: FAP activites are focused on providing assistance to front-line care and retention staff in service delivery to clients. Tasks are primarily time-limited projects and are related to ancillary services which are designed to improve patient retention in care, encourage client connectedness to ARK Network programming, and address identified client/family needs (ie, special events coordination, donation organization and distribution, Community Advisory Board recruitment, appointment reminder calls).

Supervision: FAP are conducted under the supervision of the Family Life Specialist, Stacey Slovacek, CCLS.

Activities:

1. Assist with the collection, organization, and distribution of donations received for the Title IV populations, to include annual school supply and toy drives for HIV-infected/affected children..
2. Assist with planning, coordination, and implementation of ARK Network special events such as Families Night Out, psychoeducational meetings ("Eat & Learn"), retreats, and holiday events.
3. Compile and publish quarterly newsletter and other informational materials targeted to Title IV populations served throughout the ARK Network. Advisors may also develop other mechanisms to educate Title IV populations about services available both within Network and in the larger community (ie Passport to Care, etc). Supervisor and/or other Project ARK management team members must approve all materials prior to dissemination to clients/families.
4. Recruit at least two clients per 12-month period representing Title IV populations (youth, women, and caregivers or pediatric clients) for participation in the Project ARK Community Advisory Board (CAB).
5. Attend a minimum of 75% of scheduled CAB meetings per 12-month period.
6. Participate in monthly group supervision meetings, and in individual supervision meetings with supervisor as appropriate. Additional meetings and/or training sessions may also be required within Project ARK, Washington University School of Medicine, or in the larger community.
7. Assist with Family/Childcare for Title IV women's clinic when childcare solutions is not available.
8. Perform other duties as deemed necessary and/or assigned.

Minimum Qualifications:

8. 18 years of age or older
9. Patient or affected family member of a Project ARK Network clinical program
10. High School diploma or GED
11. HIV-related education/training, or other HIV-related experience with clients/families
12. Basic computer skills (familiarity with Microsoft Word and Excel, preferable)
13. Assess to reliable transportation (automobile preferred, but not required)
14. Familiarity with issues related to individuals/families affected by HIV/AIDS and ability to maintain confidentiality regarding client/family medical history and other sensitive information.

Center for Training & Professional Development

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HIRING CHECKLIST

PROCESS	RESOURCE
❑ Conduct a job analysis (define the position)	❑ Job Description/Posting Guide
❑ Create or update a job description.	
❑ Create or update a job posting.	
❑ Have the job description& posting reviewed by current employees and supervisors (if needed).	
❑ Create a recruitment plan.	❑ Recruitment Planning Guide
❑ Post the job internally.	❑ Aspiring to Good Hiring Newsletter
❑ Place the job externally using a wide range of sources.	❑ Recruitment Resource List
❑ Accept and respond to job applications.	❑ Sample Acknowledgement Letter
❑ Screen applicants.	❑ Applicant Database Template
❑ Prepare interview process and questions.	❑ Sample Interview Questions
❑ Conduct interviews.	❑ Applicant Assessment Matrix
❑ Evaluate and decide on candidates.	❑ Do's/Don't's/MCAD Reference Chart
❑ Call references (employers, schools, etc.).	❑ Reference Check Form & Tips
❑ Perform background checks (CORI).	❑ Sample CORI Request Form ❑ Sample CORI Appropriateness for Hire ❑ Sample CORI Consent form

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PROCESS	RESOURCE
❑ Write the offer (preserve "at will employment status) or rejection letter.	❑ Sample Hire Letter and Rejection Letter
❑ Create orientation plan	❑ Orientation Checklist ❑ Sample Orientation Training Program ❑ Newsletter/10 Best Practices

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SAMPLE INTERVIEW QUESTIONS

General

- What interests you about this position?
- Tell me what you already know about our agency?
- What might you find challenging about this position?
- How would you describe your work style?
- How have your experiences prepared you for this position?
- What do you think it takes for a person to be successful in this position?
- What personal characteristics do you think are necessary for this job?
- How would you describe your ability to work as a member of a team?
- What do you expect to be doing in five years?
- Have you ever had difficulty with a supervisor? How did you resolve the conflict?
- Tell me about a problem you recently handled. Were you successful in resolving it?
- What personal weakness has caused you the greatest difficulty at work?
- Tell me about the salary range you are seeking?
- Describe an instance when you had to think on your feet to get out of a difficult situation?
- Tell me about a time when you had to go above and beyond the call of duty in order to get a job done?
- Describe some times when you were not very satisfied or pleased with your performance. What did you do about it?
- What kind of supervisor do you work best for? Provide examples.
- Describe a situation that required a number of things to be done at the same time. How did you handle it? What was the result?
- How do you determine priorities in scheduling your time? Give examples.

- Give an example of when you had to work with someone who was difficult to get along with. Why was this person difficult? How did you handle that person?
- What was the most significant contribution you have made at your last job?
- If you had to work with someone you did not like or did not like you, how would you handle it?
- What is your understanding of harm reduction? How would you apply the harm reduction approach to …(provide situation)?
- If you had a client who was resistant to using condoms what questions might you ask him/her? What options could you offer?
- What harm reduction options could you offer to an MSM that engages in unprotected anal sex when he is drunk or high?
- What would it be like for you to work with folks who are actively using drugs? Why do you think people use drugs?
- What would you talk about with an HIV-positive client who does not disclose his/her status to sexual and/or needle-sharing partners?

Behavioral

Decision Making and Problem Solving

- Give me an example of a time when you had to keep from speaking or making a decision because you did not have enough information.
- Give me an example of a time when you had to be quick in coming to a decision.
- Give me a specific example of a time when you used good judgment and logic in solving a problem.
- Give me an example of a time when you used your fact-finding skills to solve a problem.

Difficult Situations

- Tell me about a recent situation in which you had to deal with a very upset customer or co-worker.
- Tell me about a difficult decision you've made in the last year.
- Please tell me about a time you had to fire a friend.
- Describe an instance when you had to think on your feet to extricate yourself from a difficult situation.
- Describe a time when you set your sights too high (or too low).
- Tell me about a time when you missed an obvious solution to a problem.
- Give me an example of a time when you tried to accomplish something and failed.

Leadership

- Give me an example of a time when you motivated others.
- Tell me about a time when you delegated a project effectively.
- What is the toughest group that you have had to get cooperation from?
- Have you ever had difficulty getting others to accept your ideas? What was your approach? Did it work?
- Give me an example of when you showed initiative and took the lead.

Decision Making

- Give me an example of a time when you had to make a split second decision.
- Tell me about a time when you were forced to make an unpopular decision.
- Describe a time when you anticipated potential problems and developed preventive measures.

Motivation

- Describe a situation when you were able to have a positive influence on the action of others.
- Tell me about a time when you had to go above and beyond the call of duty in order to get a job done.

Communication

- Tell me about a situation when you had to speak up (be assertive) in order to get a point across that was important to you.
- Have you ever had to "sell" an idea to your co-workers or group? How did you do it? Did they "buy" it?
- Describe a situation in which you were able to use persuasion to successfully convince someone to see things your way.
- Tell me about a time you were able to successfully deal with another person even when that individual may not have personally liked you (or vice versa).

Conflict Resolution Skills

- What is your typical way of dealing with conflict? Give me an example.
- Tell me about a time you were able to successfully deal with another person even when that individual may not have personally liked you (or vice versa).
- Give me a specific example of a time when you had to conform to a policy with which you did not agree.

Interpersonal Skills

- What have you done in the past to contribute toward a teamwork environment?
- Describe a recent unpopular decision you made and what the result was.

Planning and Organization

- How do you decide what gets top priority when scheduling your time?
- What do you do when your schedule is suddenly interrupted? Give an example.
- Give me an example of a time when you set a goal and were able to meet or achieve it.
- Tell me about a time when you had too many things to do and you were required to prioritize your tasks.

Other Behavioral Questions

- Give me an example of an important goal which you had set in the past and tell me about your success in reaching it.
- Describe a time when you were faced with a stressful situation that demonstrated your coping skills.
- Please discuss an important written document you were required to complete.

Situational

- Describe a situation where there was conflict in the workplace? How did you respond and why?
- Describe a challenging client you had to work with. How did they challenge you? How did you respond and why?
- You are supervision a good performing employee who is chronically late. How would you intervene and why?
- You just spent 15 minutes doing risk reduction planning with someone in a club setting. When you are done, they ask you out for coffee. What would you do and why?
- DPH is coming to review your files. You are new to the job and discover that your predecessor did not keep good files. What would you do and why?

Interviewing Peers: Sample Questions and Possible Responses

Motivation

1. How did you decide to apply for a job as a peer advocate?
2. What brought you to this agency?
3. What are your goals?

Strong Responses:
Expresses readiness to "give back" and provide help to other HIV-positive people. Interviewee has received assistance from others in the past and would like to be able to do this with others. This may include positive experiences as a client of the organization.

Interviewee has had some experience in human services work and would now like to focus on HIV/AIDS work. This may include past volunteer experience.

HIV has changed the interviewee's life and he/she feels committed to work within the field.

Red Flags:
Interviewee is very newly "out" with HIV status and attended one organization event before deciding to apply for this job. He/she may be very excited but clearly new in process of discussing HIV status and meeting others who are also HIV-positive.

Describes the primary reason for seeking employment as financial stress.

Seems overly identified with their own "story" or experience in working with others with HIV – may not leave space for working with clients who have very different experiences and needs.

Capacity to Help:

4. What do you think causes people to change?
5. What has helped you to make changes?
6. What do you think prevents people from receiving help?
7. What would you do if you felt concerned about a client's safety? (e.g. suicidal feelings)

Strong Responses:
Expresses that people seem to change when they are ready to change, it cannot be forced. Some kinds of assistance may be more helpful than others in helping the process along. It's important to avoid judging people who are not ready to change and be consistent in offering support.

Ability to reflect on their own experience and what was helpful in their movement toward positive change. Able to see how they might offer similar assistance. Shares some

understanding of obstacles to change in people's lives – substance use, domestic violence, family issues, poverty.

Expresses that if a client were in a dangerous situation they would immediately ask for management assistance and guidance to reduce likelihood of harm to client.

Red Flags:
Overly identified with their own experience in a belief that they know exactly how to get people to change based on what worked for them.

States that "a relationship with God" is the true answer to making change happen.

Does not realize that he/she may need supervisory help in assessing a potentially dangerous situation and believes that he/she can solve it independently.

Relationship to HIV:

8. What is your experience with HIV/AIDS?
9. How have you learned to live with HIV? (If + status disclosed)

Strong Responses:
Expresses comfort in discussing their own HIV status and how it has impacted their life, both in negative and positive ways.

Has insight into what others may be going through in living with HIV/AIDS and that there is a range of experiences, including around comfort levels with disclosure.

Red Flags:
Shares personal strategies for living with HIV and belief that if others follow the exact same path, they too will find health and personal well-being.

Shares strong discomfort toward discussing their status and relationship to HIV/AIDS.

Relationship to Alcohol or Drugs:

10. What is your stance towards alcohol? Drugs?
11. How would you feel about working with clients who are using drugs?
12. How would you feel if you had a client who relapses frequently?

Strong Responses:
Expresses an understanding of harm reduction principles and "meeting people where they are at".

Acknowledges the difficulties of addiction – this may or may not include their own experience – and that it can be a lifelong struggle.

Shares that they may want to consult with someone who is more experienced in this area to provide best possible assistance.

Red Flags:
Expresses preference to not work with clients who are substance users, or is hesitant in working with them. May seem judgmental in answers or anxious about this population.

Only able to see an "all or nothing" answer to addiction and sobriety rather than harm reduction approach. May mention "faith in God" as answer to addiction.

Self-Awareness:

13. How would you describe your strengths? Weaknesses?
14. How would your best friend (or other) describe you?
15. Describe a situation where you were involved in a conflict and how you handled it.

Strong Answers:
Able to discuss this in a balanced manner, sharing both their own strengths that are helpful in peer work, and challenges where he/she may need support. Acknowledges that he/she has more to learn.

Able to share conflict experiences that show ability to manage conflict rather than being conflict avoidant. Realizes at times that they may need to consult with supervisor if conflict arises.

Red Flags:
Not able to share any areas that could be considered a weakness. Overly confident in existing knowledge and ability to solve myriad of challenging client situations.

Shares example of dealing with conflict that actually may not have been healthiest route to resolution.

Does not share any understanding of how dealing directly with conflict may be beneficial personally and professionally.

Stress Management:

16. What do you do to handle stress?
17. How do you take care of yourself?

Strong Responses:
Interviewee able to share some strategies that they actively use to alleviate stress (activities with friends, exercise, massage, movies, etc.).

Has an understanding that peer work can be quite stressful.

Red Flags:
Does not have an understanding of self-care and how it might be helpful in successful and sustainable peer work.
No awareness of how working with others with HIV/AIDS may be stressful for them personally.

Cultural Competency:

18. How would you feel about working with co-workers and peers of other cultures?
19. How would you feel about sharing your cultural background with a client? Co-worker?
20. How would you work with someone who did not share your beliefs?

Strong Responses:
Understands that clients come from a range of cultural backgrounds and life experiences and that this is a positive aspect of the work. Has had some exposure and experience with a range of community members and ethnicities. Expresses interest in learning more about particular groups impacted within the HIV/AIDS epidemic. Understands that he/she may have more to learn about particular groups, but is open and eager to do so.

Red Flags:
Anxious or uncertain of comfort level with particular groups (ex. Formerly incarcerated, transgender, gay, substance users).
Expresses belief that "everyone is the same" and no need to learn about differences.
Believes that they are completely culturally competent and would not require any ongoing education in this area.

Preferred Supervision Style:

21. How do you prefer to be supervised?
22. How will I know if you are worried or discontent about your work?
23. How do you like to receive feedback? Give feedback?
24. How would you describe your approach to organization? How would you organize paperwork?

Strong Responses:
Values supervision as a tool that is helpful in personal and professional growth and ability to excel as a peer. Able to reflect on helpful supervision techniques and styles. Able to see supervisor as a sounding board and support person, rather than simply an authority figure. Sees the value of feedback in process of professional development. Acknowledges that he/she may need supervision in client work that is new to them or presents difficult choices.
Shows some understanding of organizational skills and importance in peer work, including ability to complete paperwork. Has basic computer and report writing skills.

Red Flags:
Does not see two-way nature of supervision and potential benefit, but describes it more as a "I do what my boss says" relationship. This may indicate a lack of trust for supervisory staff and may lead to problems later.

Working with Others:

25. How best do you work—Alone, with others or both?
26. What is your style with working in groups?

Strong Responses:
Expresses an ability to work well within a group and alone at times. Enjoys different experiences and personalities within group work. Expresses some understanding of teamwork and collaboration.

Red Flags:
Strongly prefers group or alone work rather than a blend of the two – expresses either anxiety about working alone or seeing themselves as someone who works best when left alone.

HIV Status:

27. How are you private about your status?
28. How are you public about your status?
29. How have you processed your feeling around living with HIV?

Strong Responses:
Shows an appropriate understanding of the need for privacy and personal safety in disclosing their HIV status, but also is comfortable in doing so in professional settings as a peer. Has an understanding that disclosure is very personal and everyone handles it differently for different reasons. Based on personal experience, shows an understanding of the complexity and both the benefits and risks of disclosure.

Red Flags:
Expresses discomfort in disclosing their own HIV status in the workplace or feels that everyone should be "out" with their status. May be newly "out" with their own status and overly excited to take a high profile place in the organization as an HIV-positive person without consideration of long-term consequences.

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The DO's AND DON'TS OF INTERVIEWING

Topic	You may not ask questions like:	You may ask:
Personal Life	• Are you married or single? • Are you divorced? • Do you have any children, plan to have children, have child care arrangements? • Are you pregnant? Do you plan to become pregnant any time soon? • Does your spouse work? • What does your spouse do? • How are you planning to get to work? • What do you do with your time outside of work? • Do you own or rent? • With whom do you live? • Do you belong to any non-work related organizations?	• Is there anything that might interfere with your availability for work? • What skills or expertise do you have from previous employment or life experience that may be useful to you in this position?
Race	• What race are you? • Do you belong to any social clubs/organizations?	• No Questions

Age	• How old are you?
	• What year were you born?
	• When did you graduate from high school?
		• No Questions Except
		  • Are you under 18?
		  • Do you have a work permit?

Religion	• What religion are you? • What church do you belong to? • What religious holidays do you celebrate?	• Questions related to availability of work

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Topic	You may not ask questions like:	You may ask:
Disability	• Are you disabled? What is the nature of your disability? • Do you really think you can handle this job with your disability? • How limiting is your disability? • Will you ever get better? • Was this caused by an accident • Have you ever been treated for drug addiction? • Have you ever sought mental health counseling? • Do you consume alcohol? How much alcohol do you consume? • Do you currently take any medication? • Do you illegally use drugs? • How many days of leave from employment did you take last year?	• If the applicant has a visible disability, or voluntarily raises the existence of a disability in the inter-view, you can ask: • Are you able to perform job-related functions (use job description), with or without "reasonable accommodation"? Please describe or demonstrate how you would perform these functions. • Can you meet the attendance requirements of this job?
National Origin	• Where were you born? • How did you acquire your ability to read, speak and write [language] fluently? • Is your spouse/are your parents citizens of the United States? • Are you a naturalized or native born citizen? When did you acquire citizenship? • Can I have a copy of your citizenship papers?	• If offered employment, can you provide documentation that you have a legal right to work in the United States? • What languages do you read, speak and write fluently'? • Once you hire the employee, you must comply with immigration laws and verify the employee's legal work status.
Arrests/ Convictions	• Have you ever been arrested? • Have you ever been in jail?	• Have you ever been convicted of a crime?

Peer Selection Process

Staff Considerations:

- Was the candidate on time?
- Was the candidate able to share personal experiences during interview?
- Was the candidate able to communicate effectively?
- How did references perceive candidate?
- Does the candidate have the ability & resources to take on role?
- Can candidate work well with others?

Peer Considerations:

- Is this a good fit for me?
- Will earning wages decrease my current benefits? Was I able to communicate effectively?
- Do I have transportation to fulfill this commitment?
- Can I work with my peers without being judgmental?
- Can I avoid inflicting my own personal & religious views?
- Can I maintain confidentiality?
- How will this affect my overall well-being/health?

Contributed by Stacey Slovacek, CCLS
Family Life Specialist/Peer Supervisor
Project ARK/Washington University
Excerpt from HRSA Webcast presentation Recruiting, Hiring, and Supporting Peers, July 1, 2009

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GUIDE TO WRITING JOB DESCRIPTIONS AND JOB POSTINGS

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INDEX

3 Steps for Writing a Job Description (for internal use):

- **Step 1: Define the Position – What is needed?**
- **Step 2: Perform a Job Analysis – What is required to perform the job?**
- **Step 3: Write the Job Description – What should be included?**

The Purpose of a Job Description

A job description is an internal document that lays out in detail the exact roles and responsibilities of a particular position. A job description can be used as a tool for:

- New employee orientation to help set expectations
- supervision
- performance reviews

The primary purpose of a job description is to identify the **essential functions** of the position. According to the Equal Employment Opportunity Commission (EEOC), **essential functions** are those tasks or functions of a particular position that are **fundamental** to the position. Knowing the essential functions of the job will aid you in:

- Assuring compliance with legal requirements related to equal opportunity, equal pay, overtime eligibility, etc.
- Establishing a basis for recruitment, selection, and hiring
- Writing appropriate interview questions
- Determining whether a person is qualified to perform the essential functions
- Identifying reasonable accommodations to enable a disabled person to perform the essential functions
- Evaluating work distribution and departmental organization
- Analyzing jobs to determine appropriate pay ranges and classifications
- Training employees
- Allowing clear and accurate performance reviews

Step 1: Define the Position - What is needed?

Before beginning the process of writing a job description, you need to think carefully about what is **REALLY** needed. Do you need an experienced person who can come in and immediately start doing the job? Or is this an entry level position where it is expected that there will be a learning curve? Some questions to answer include:

- What are the key roles and responsibilities for the position?
- What are the opportunities and challenges presented by the position?
- What competencies are required for success in the role?
- What organizational values would an ideal candidate reflect?
- What kinds of people and personality traits are generally successful in this organization, and in this type of role? What kinds of people and personality traits are generally not successful in this organization, and in this type of role?
- Where does this position fit in the organization?
- What is the background of the ideal candidate for this role (e.g. educational background, professional experience, skills, cultural/personality characteristics)?

Step 2: Perform a Job Analysis - What is required to perform the job?

A Job analysis is a process of systematically collecting, analyzing and documenting the important facts about a job. The purpose is to provide you with the following information:

A. **WHAT THE WORKER DOES** **Duties** **Tasks**	**B. HOW THE WORKER DOES IT** **Methods** **Tools** **Techniques**
C. WHY THE WORKER DOES IT **Products** **Services**	**D. WORKER QUALIFICATIONS** **Knowledge** **Skills** **Attitude** **Experience**

Adapated from Aurora University Job description Manual

A. What a Worker Does: Duties and Tasks:

The basic function of a job is the performance of specific tasks and duties. Information to be collected about these items may include: frequency, duration, effort, skill, complexity, equipment, standards, etc. Example – Executive Administrative Assistant:

Duties	Tasks
A. Manage telephone calls B. Process supply orders **C. Coordinate and facilitate special events** D. Maintain office equipment	**C. Coordinate and facilitate special events** Under general direction, coordinate and plan special events as assigned. Schedule and maintain communication with vendors, volunteers and participants. Prepare materials and programs for events. Ensure proper implementation of setup, event registration and distribution of event materials

B. How The Worker Does it: Methods, Tools and Techniques:

Some duties and tasks are performed using specific equipment and tools. These items need to be specified in a Job Analysis.

C. Why the Worker Does it: Products and Services:

This includes the specific services to be provided and/or the specific population to be serviced.

D. Worker Qualifications: Knowledge, Sills, Attitude and Experience

- ***Qualifications*:** The knowledge, skills, attitude and experience required to perform the job

- ***Knowledge*:** The level of education, experience and training an individual must have **at a minimum** to be considered qualified for the position.

- ***Skills*:** Specific skills such as ability to create manipulate and utilize spreadsheets, word processing programs and so on.

- ***Attitude*:** The desired attitude given the organizational culture and client base.

- ***Experience***: Prior work and life experience that might be relevant to the job should be assessed along with knowledge and skills.

Step 3: Write the job description – What should be included?

Now that you thought through what is needed and gathered the information, it is time to write the job description.

A basic job description will include the following:

- ***A job summary*** – This section describes in very brief terms, the duties and responsibilities of a position. It explains the general reporting structure, what is done, how it is done and why it is done. For example:

Job Summary- ***Executive Administrative Assistant, Live Positive***
Provide administrative support to senior management team at large AIDS Service organization with 3 divisions and 100 employees. Duties include receiving and triaging telephone calls; managing correspondence, managing database systems; scheduling, coordinating and facilitating special events and meetings; processing supply orders; typing, filing and scheduling of appointments; and supervising office systems.

- ***Degree of Supervision*** **--** This section of the job description describes the way in which work is assigned, when it is reviewed, how it is reviewed, and what guidelines, prototypes and protocols are available. For example:

Staff member works independently to prioritize and complete assigned tasks. Assignments are periodically checked for progress by direct supervisors through regularly scheduled supervision meetings. In addition, supervisors will review work upon request, when tasks deviate from established guidelines.

- ***A list of job functions*** –There are two sections that make up the job function section: **Primary Duties and Responsibilities** and **Other Duties and Responsibilities.** The Primary Duties and Responsibilities covers the **essential functions** of the position.

    - ***What are Essential Functions?***

In identifying essential functions, be sure to consider (1) whether employees in the position actually are required to perform the function and (2) whether removing that function would fundamentally change the job.

The Americans with Disabilities Act (ADA) lists several reasons why a function could be considered essential:

- **The position exists to perform the function.** For example, if you hire someone to proofread documents, the ability to proofread accurately is an essential function, since this is the reason that the position exists.

- **There are a limited number of other employees available to perform the function or among whom the function can be distributed**. For example, it may be an essential function for a file clerk to answer the telephone if there are only three employees in a very busy office and each employee has to perform many different tasks.

- **A function is highly specialized and the person in the position is hired for special expertise or ability to perform it**. For example, an organization is expanding its training department is hiring new trainers, so it requires someone with the ability to train and preferably in the area of training needed.

The EEOC considers various forms of evidence to determine whether or not a particular function is essential. These include, but are not limited to:

- The employer's judgment;
- The amount of time spent on the job performing that function; and
- The availability of others in the department to fill in for the person who performs that function.

In defining the essential functions of a job, it is important to distinguish between **methods** and **results**. For example, is the essential function *moving* a 50 pound box from one part of the office to another, or is it *carrying* the box? While essential functions need to be performed, they often do not need to be performed in one particular manner (unless doing otherwise would create an undue hardship.

Sample Description of Primary Duties and Responsibilities:

Primary Duties and Responsibilities – ***Executive Administrative Assistant, Live Positive***

1. Screen incoming calls to 3 Division Directors and, as appropriate, provide requested information, take messages or redirect inquires to the appropriate staff member.
2. Schedule appointments
3. Schedule, coordinate and facilitate special events, fundraisers and meetings, as requested. Coordinate with vendors, volunteers and staff.
4. Manage database systems for mailings, fundraising efforts and CORI requests.
5. Collect, update and maintain information for grant applications
6. Compose routine correspondence for the directors from general oral instructions.
7. Proofread drafts of correspondence for correct grammar, punctuation and spelling and make corrections.
8. Create and maintain office filing system
9. Process all supply orders
10. Oversee maintenance of office equipment
11. Supervise mail services

- ***A qualifications section*** -- a list of the education, certifications, licenses, and experience necessary to do the job. For example:

Qualifications - *Executive Administrative Assistant, Live Positive*

- Experience working in a human services environment performed.
- Ability to interact with people from all walks of life and diverse populations, including gay, lesbian, bisexual, transgender, homeless and addicted individuals, people living with HIV/AIDS, people living with mental health issues, individuals from diverse ethnic backgrounds, and funders and donors.
- Excellent organizational skills, attention to detail, ability to problem solve, multi-task and prioritize.
- Strong initiative and excellent follow through
- Flexible and adaptable
- Willing and able to create record keeping and tracking systems
- Exceptional interpersonal, oral and written communication skills necessary
- Ability to work independently
- Proficiency in Microsoft Windows, Excel, Access, and PowerPoint; expertise in desktop publishing preferred
- Strong internet research skills
- Associate's degree or certificate of training in administration required; Bachelor's degree or equivalent experience strongly preferred

- ***A section for other important information and clear instructions*** about the position, such as location, working hours, travel requirements, reporting relationships, and so on.

- ***A statement describing your organization as an equal opportunity employer***. This is a legal requirement. For example:

Live Positive is an equal opportunity employer and actively seeks candidates from diverse background including women, communities of color, the LGBT community, and people with disabilities.

Sample Job Description

LIVE POSITIVE
Executive Administrative Assistant

Job Summary: Provide administrative support to senior management team at large AIDS Service organization with 3 divisions and 100 employees. Duties include receiving and triaging telephone calls; managing correspondence, managing database systems; scheduling, coordinating and facilitating special events and meetings; processing supply orders; typing, filing and scheduling of appointments; and supervising office systems.

Degree of Supervision: Staff member works independently to prioritize and complete assigned tasks. Assignments are periodically checked for progress by direct supervisor through regularly scheduled supervision meetings. In addition, the supervisor will review work upon request when tasks deviate from established guidelines.

Primary Responsibilities:

- Screen incoming calls to 3 Directors and, as appropriate, provide requested information, take messages or redirect inquires to the appropriate staff member.
- Schedule appointments
- Schedule, coordinate and facilitate special events, fundraisers and meetings, as requested. Coordinate with vendors, volunteers and staff.
- Manage database systems for mailings, fundraising efforts and CORI requests.
- Collect, update and maintain information for grant applications
- Compose routine correspondence for the directors from general oral instructions.
- Proofread drafts of correspondence for correct grammar, punctuation and spelling and make corrections.
- Create and maintain office filing system
- Process all supply orders
- Oversee maintenance of office equipment
- Supervise mail services

Qualifications:

- Experience working in a human services environment preferred.
- Ability to interact with people from all walks of life and diverse populations, including gay, lesbian, bisexual, transgender, homeless and addicted individuals, people living with HIV/AIDS, people living with mental health issues, individuals from diverse ethnic backgrounds, and funders and donors.
- Excellent organizational skills, attention to detail, ability to problem solve, multi-task and prioritize.
- Strong initiative and excellent follow through
- Flexible and adaptable
- Willing and able to create record keeping and tracking systems
- Exceptional interpersonal, oral and written communication skills necessary
- Ability to work independently
- Proficiency in Microsoft Windows, Excel, Access, and PowerPoint; expertise in desktop publishing preferred
- Strong internet research skills
- Associate's degree or certificate of training in administration required; Bachelor's degree or equivalent experience strongly preferred

EEOC Statement:

Live Positive is an equal opportunity employer and actively seeks candidates from diverse background including women, communities of color, the LGBT community, and people with disabilities

Elements of a Job Posting (For external use)

A job posting is an external document that is created to motivate candidates to apply to the open position. As such, it is viewed as a marketing tool. Because this will be the first thing applicants read, it's a great place to sell the job to the candidates you're trying to attract (and to weed out those who won't be able to meet your expectations).

- ***A compelling but concise description*** of the organization's history, mission, and key programs. Communicate what an exciting place it is to work.

- ***An overview of the position*** that summarizes the key responsibilities while demonstrating the importance of the role to the overall success of the organization.

- ***A well-constructed and organized list of key roles and responsibilities.*** An exhaustive list is not required but do provide some detail about what the role entails, including highlighting the appealing aspects of the position, such as decision-making authority, participation in strategic planning, etc.

- ***A list of the required qualifications.*** Focus more on the competencies required than specific levels and types of experience. For example, "exceptional relationship-management skills, especially working with high net worth individuals" is better than "4 years of experience leading major donor campaigns" because it encourages non-traditional candidates with transferable skills to apply.

- ***Clear instructions on how to apply.*** Receiving applications only through email is recommended to control and manage the recruitment process

- ***A brief description of benefits (optional).*** This can be a useful tool for marketing the organization. For example, "medical and dental insurance coverage and 3 weeks vacation."

- ***A statement describing your organization as an equal opportunity employer***. This is a legal requirement

Sample Job Posting - *Executive Administrative Assistant, Live Positive*

Live Positive has an exciting opportunity for the right administrative professional. A full-time executive administrative assistant is being hired to provide administrative support to senior management team at a large, dynamic AIDS Service organization with a 15 year history of providing improved access to services and care for people living with and at risk for HIV/AIDS.

Successful candidates will have experience working in a human services environment, the ability to interact with people from all walks of life and diverse populations, excellent organizational skills, attention to detail, ability to problem solve and multi-task, strong initiative, and excellent follow through.

Duties include managing telephone calls, database systems, and mailings; scheduling, coordinating and facilitating special events, fundraisers and meetings; coordinating with vendors, volunteers and staff; collecting, updating and maintaining information for grant applications; processing of all supply orders; overseeing maintenance of office equipment; typing, filing and scheduling of appointments; and supervising mail services.

Proficiency in Microsoft Windows, Excel, Access, and PowerPoint; expertise in desktop publishing and strong internet research skills. Associate's degree or certificate of training in administration required; Bachelor's degree or equivalent experience strongly preferred.

Application deadline is December 31, 20XX. Interested applicants should send a cover letter and resume to Jane Doe, Live Positive, 20 Johnson Road, Any town, Any state, 00000 or email the information to j.doe@livepositive.org. No phone calls, please.

Live Positive is an equal opportunity employer and actively seeks candidates from diverse background including women, communities of color, the LGBT community, and people with disabilities

References

Guide to Writing Job Descriptions, http://www.college.ucla.edu/personnel/jobdesc/

Developing a Search Strategy: Your Roadmap for Hiring, Commongood Knowledge Center, http://www.cgcareers.org/knowledgecenter/

Job Description Manual, Aurora University, www.aurora.edu/hr/forms/job-descr-manual-AU.pdf

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CREATING A RECRUITMENT PLAN[1]

A strategic recruitment plan outlines the methods you will use to solicit qualified applications for your open position. The plan includes three key components:

Internal Distribution	Send a thoughtful email to your organization's staff. This email should include a brief and appealing description of the role and the ideal candidate and should have the full job posting attached and/or included in the body. Your staff is a very good source of referral candidates because they know your organization best and have an idea of what it takes to succeed there. Be sure to thank them in advance for their willingness to distribute the posting to their personal networks.
Distribution to Your Stakeholders	Next, share the job description with your stakeholders. Post the job to an appropriate section of your organization's web site and include information about the position in any newsletters or other external communications. If this is a new position, use it as an opportunity to highlight your organization's growth and development. If appropriate, contact donors, board members, partners, and other contacts; you never know who may be the source of a great referral.
External Posting	Broaden your reach beyond your inner circles by advertising the position externally. For most positions, gone are the days of relying exclusively on placing a want ad in the local newspaper; these days, it is usually more cost-effective to post positions on multiple online job boards. Even so, you should budget at least $500-700 for external postings. In order to determine how to most efficiently spend your recruiting dollars, research the relevant job boards or publications where you would find similar postings. Ask staff who have similar roles where they would look for jobs. Find out what professional associations people in the field belong to and see if those organizations have a job board or listserv. There are also job boards based on geographic region or job function (such as accounting, development, or IT) that may be appropriate, but are typically more expensive. When evaluating posting channels, consider both flow and quality; most hiring managers would rather have a smaller pool of qualified candidates than a larger pool of unqualified candidates. While job boards without a nonprofit focus may result in a large number of resumes, more targeted posting for candidates interested in nonprofit positions is often more effective. Sites such as Idealist.org and OpportunityKnocks.org are excellent nonprofit-focused job boards. Local papers could also be a good source for posting job ads. For example, placing an ad in the local Spanish language newspaper for a Spanish speaking position.

[1] Excerpted and adapted from *Developing a Search Strategy: Your Roadmap for Hiring*, Commongood Careers, http://www.cgcareers.org/knowledgecenter/searchstrategies.php

Expanding the Pool of Candidates

When recruiting, spread the word about your nonprofit's open position(s) by casting as wide a net as possible. The following recruitment activities can help you attract a diverse pool of applicants:[2]

- Ask your local unemployment office to post your jobs. (For example, the Massachusetts Department of Workforce Development, www.mass.gov/dwd.)
- Diversify your recruitment efforts. Use websites that specialize in diversity recruitment, such as www.diversityinc.com www.latpro.com, www.nbmbaa.org, www.asia-net.com, www.careerwomen.com, www.minorities-jb.com.
- Seek assistance from organizations such as your local National Urban League or Private Industry Council, and by all means, don't forget to consider sources that cater to the military like www.vetjobs.com or disabled individuals or retirees, www.aarp.org.
- You may find it helpful to build a relationship with your local colleges and universities. Remember, students will graduate and alumni may use the career center. Websites such as www.jobtrak.com and www.jobweb.org also target graduates.
- If seeking professionals in a specific field, such as for hospitals, try www.etrcc.com/hospital_directory.html; high tech, www.dice.com; education, www.educationplanet.com; social work, www.socialservice.com; and religious professionals, www.christianjobs.com or www.ministryconnect.org.
- Develop a standard list of recipients to receive your job announcements, including:
    - Associations
    - Career centers
    - Nonprofit, capacity building and nongovernmental organizations
    - Past applicants (in some cases it is possible to consider a past applicant)
    - Other organizations that will accept your job announcement and possibly provide you with a referral.

[2] Excerpt from *Develop an Effective Hiring Plan for Your Nonprofit*, Jennetta Hyatt, TSNE Human Resources Manager for Fiscal Sponsorship and Employment. http://www.tsne.org/site/c.ghLUK3PCLoF/b.1778733/k.611/Articles__Nonprofit_Hiring_Process__Part_I.htm

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Update your standard lists periodically. If your job announcements are sent to other organizations, check with the organization, if possible, regarding their preferred receipt method. Remember, some organizations may still prefer receiving your announcement via fax or mail, as opposed to email.

Tip: Keep track of those sources that you find useful. Avoid wasted effort – and money – on sources that don't produce quality applicants.

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APPLICANT ASSESSMENT TEMPLATE

Rate each category:
0 = no experience, does not meet job requirements
1 = some experience, meets some job requirements
2 = experience meets job requirements
3 = experience exceeds job requirements

Name	Human Service experience	Experience working with diverse individuals	Attention to detail	Writing skills	Oral communication skills	Computer skills	Education

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Avoid Common Interview Mistakes[i]

It's important to remember that there are two decisions being made at the close of every interview: Is this the person you want working for you? And, just as important, is this a place where I want to work? Avoid these common errors, and hire the right person for the job.

Mistake 1: *The wrong venue*. An airless, windowless conference room can drain the energy out of any interview. Try a clean office with some natural light or move to a coffee shop or even a park bench for a more relaxed conversation.

Mistake 2: *The wrong people.* Make sure the candidate meets with people who can answer his or her questions about the specific job and with whom he or she will work directly.

Mistake 3: *Relying on memory alone*. Take good notes so you stay focused on the conversation and appear organized when you call the person back.

Mistake 4: *Disorganization*. Know what questions you want to ask and the order in which you wish to discuss topics. Write down an outline so you don't repeat yourself or lose track.

Mistake 5: *Doing all the talking*. Be an active listener as well as speaker. When the candidate talks, it's your opportunity to learn about the person.

Mistake 6: *Asking the wrong questions*. Avoid leading questions that make it too clear what you want the answer to be ("You speak Spanish, right?"). Instead, keep questions open-ended.

Mistake 7: *Gossiping*. Don't use interviews as a forum for talking about others in your workplace or other companies. It makes your workplace seem less professional.

Mistake 8: *Getting too personal*. Asking questions about an interviewee's personal life isn't only uncomfortable, it's illegal. Avoid topics such as family, home, or nationality.

Mistake 9: *Being too high-pressure*. A stressed-out candidate can't answer your questions accurately. Ask tough questions, but do so calmly and give the person time to think and answer.

Mistake 10: *Cutting it too short*. When you have a full plate of interviews, it's tempting to rush through them. But you can't get to know a person's full range of qualities in just a few minutes. Schedule adequate time to talk.

The bottom line: Conducting a good interview helps put your workplace in the best light and ensures that qualified candidates won't turn you down.

[i] Source unknown

The Interview Process: Sample Scenarios to ask a potential peer

Interview Scenario

The following scenario may be used to assess the candidates's general approach to being a peer. The interviewer should be sure to observe if the candidate listens and asks open-ended questions, gives too much information, talks too much about him or herself, and is able to establish rapport.

Scenario: First Meeting between the Peer and the Client

A newly diagnosed HIV-positive female (known for 2 weeks) comes in for a second office visit with the doctor to discuss lab tests. The client understandably is distraught, scared, ashamed, and is trying to make sense of the diagnosis. The client shares with the doctor that she is not telling anyone about her diagnosis but also feels isolated by her decision not to disclose. The doctor refers her to you.

What would you talk about in your first visit with this woman, and why?

SAMPLE PEER SCREENING QUESTIONS

Motivation	How did you decide to apply for a job as a peer advocate?
	What brought you to this agency?
	What are your goals?
Capacity to Help	What do you think causes people to change?
	What has helped you to make changes?
	What do you think prevents people from receiving help?
	What would you do if you felt concerned about a client's safety? (e.g. suicidal feelings)
Relationship to HIV	What is your experience with HIV/AIDS?
	How have you learned to live with HIV? (If + status disclosed)
Relationship to AOD	What is your stance towards alcohol? Drugs?
	How would you feel about working with clients who are using drugs?
	How would you feel if you had a client who relapses frequently?
Self-Awareness	How would you describe your strengths? Weaknesses?
	How would your best friend (or other) describe you?
	Describe a situation where you were involved in a conflict and how you handled it.
Stress Management	What do you do to handle stress?
	How do you take care of yourself?
Cultural Competency	How would you feel about working with co-workers and peers of other cultures?
	How would you feel about sharing your cultural background with a client? Co-worker?
	How would you work with someone who did not share your beliefs?
Preferred Supervision Style	How do you prefer to be supervised?
	How will I know if you are worried or discontent about your work?
	How do you like to receive feedback? Give feedback?
	How would you describe your approach to organization? How would you organize paperwork?
Working with Others	How best do you work—Alone, with others or both?
	What is your style with working in groups?
HIV Status	How are you private about your status?
	How are you public about your status?
	How have you processed your feeling around living with HIV?

Center for Training & Professional Development

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Orientation Checklist

	Yes	*Scheduled/Date*	*Initials*
Introduced new hire			
Reviewed benefits/probationary period			
Reviewed policies/procedures			
Reviewed mission of agency			
Reviewed job description/contract information			
Reviewed supervision schedule and management style			
Reviewed training/ development plan			
Reviewed organizational structure			
Reviewed agency protocol: boundaries, professionalism, confidentiality, expectations			
Outlined 2-4 week job orientation plan			
Other			

Employee Name: _____ Conducted By: _____

Employee Signature: _____ Date: _____

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SAMPLE ORIENTATION TRAINING PLAN

Orientation Training Plan
Lila Morgan
Executive Administrative Assistant, Live Positive

Monday 2/24

- ✓ Meet with supervisor
  - Get tour of organization/ meet staff
  - Discuss orientation training plan
  - Review job description
  - Review human resource policies and procedures (written manual or verbally)
- ✓ Equipment training by supervisor or other staff
  - Phone and voicemail systems and protocol
  - Mail systems
  - Xerox machine
- ✓ Begin answering phone, relaying messages, copying jobs

Tuesday 2/25

- ✓ Meet with supervisor to review first day on job
- ✓ Equipment training by supervisor or other staff (continued)
  - Computer and paper filing systems
  - Database systems, Email, and online calendar scheduling
- ✓ Start 1-to-1 meetings with key staff to get oriented to your position and work in the organization
- ✓ Start reading organizational materials, related web material etc.
- ✓ Begin re-organizing paper files

Wednesday 2/26

- ✓ Meet with supervisor
  - Review supervision and management style
  - Review how performance will be measured when review time comes and on ongoing basis
- ✓ Equipment training by supervisor or other staff (continued)
  - Supply closet and ordering systems
  - Equipment vendors and protocols
- ✓ Continue 1-to-1 meetings with staff

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Thursday 2/27

- ✓ Meet briefly with supervisor for check-in
- ✓ Order needed supplies
- ✓ Update mailing database

Friday 2/28

- ✓ Meet with supervisor
  - Outline supervision schedule for 1st month and beyond
  - Discuss professional development and training needs
- ✓ Continue ongoing work

Monday 3/3

- ✓ Meet with supervisor
  - Review what went well and what could have been better for 1st week
- ✓ Continue 1-on-1 meetings with staff as needed (all week)
- ✓ Continue reading relevant materials (all week)
- ✓ Continue ongoing work projects (all week)

Tuesday 3/4

- ✓ All day database training

Wednesday 3/5

- ✓ Staff meeting
- ✓ Begin on-line research and gathering data for grant application

Thursday 3/6

- ✓ Quick check in with supervisor
  - Review progress on training, reading, projects etc.

Friday 3/7

- ✓ Meet with supervisor
  - Plan out the next 2-4 weeks of work

SAMPLE ORIENTATION
(Kansas City Free Health Clinic)

Objectives:

- **Understand the vision, mission and philosophy of the Clinic**
- **Understand team roles of members of the Clinic**
- **Understand front office functions and processes**
- **Understand Clinic programs**

First Day

Meeting With	Topics to Include	Time
Treatment Adherence Specialist	Welcome, orientation packet Logistics, door codes, keys etc.	9:00 – 10:00
	BREAK	10:00 – 10:15
Treatment Adherence Specialist	Peer educator roles and responsibilities	10:15 – 11:45
	LUNCH	11:45 – 12:45
Finance Director	Payroll, benefits	12:45 – 1:45
Director of HIV Primary Care	HIV primary care, peer treatment adherence	1:45 – 3:00

Second Day

Meeting With	Topics to Include	Time
Treatment Adherence Specialist	Review KCFHC's protocol and operations manual; Review resource list of brochures, pamphlets, websites, other reading material and videos to be shared with clients	9:00 – 10:45
	BREAK	10:45 – 11:00
Treatment Adherence Specialist	Daily activities and responsibilities, client issues, State Health Program, etc.	11:00 – 12:00
	LUNCH	12:00 – 1:00
Manager of HIV Case Management Services	Overview of case management systems for HIV+ and affected individuals	1:00 – 2:30
	FREE TIME to review materials and videos	

Third Day

Meeting With	Topics to Include	Time
Treatment Adherence	Client communication	9:00 – 10:45

Specialist	(verbal/nonverbal)	
	BREAK	10:45 – 11:00
Treatment Adherence Specialist	Clinic communication	11:00 – 12:00
	LUNCH	12:00 – 1:00
Treatment Adherence Specialist	Core Components of education	1:00 – 2:00
	Review HIV/AIDS – Starter fact book (American Red Cross)	

Fourth Day

Meeting With	Topics to Include	Time
Current Peer	Discuss daily activities, general office procedures	9:00 – 10:45
	Shadow peer when meeting with clients (with permission)	

KC Free Peer Counseling Program: 777-2723 *Call for support.*

Suggested sites: Feel free to take one of these sheets home.

	Search engine
1. http://www.yahoo/	
2. http://www.metacrawler.com/	Mega search engine
3. http://ww.harmreduction.org	For IV Drug Users
4. http://www.mapblast.com/	Create a map to any U.S. address
5.http://www.cdc.gov/tobacco/how2quit.htm	CDC Tobacco Information and prevention source
6. http://www.womenHIV.org	Information and support by, for and about women with HIV/AIDS
7. http://www.4healthyliving.org	Educational and Social activities for MSM
8. http://www.thewellproject.com	The Well Project is a community for women with HIV and the people who care for them
9. http://www.hivandhepatitis.com	Doc-run site answers patient questions and stays on top of co-infection
10. http://www.webmd.com	WebMD Health
11. http://www.LGCC-KC.Org	Lesbian and Gay Community Center
12. http://www.HRSA.gov	Health and Human Services Administration (Ryan White)
13. http://www.nmac.org	National Minority AIDS Council
14. http://www.nih.gov/od/oar	Office of AIDS Research
15. http://www.thebody.com	Health info AIDS and HIV information Resource
16. http://www.gmhc.org	Gay Men's Health Treatment Issues
17. http://www.poz.com	Positive Magazine for HIV + people
18. http://www.AIDSINFONET.ORG	An HIV Information Resource
19. http://www.natap.org	National AIDS Treatment Advocacy Project (NATAP)
20. http://www.aidsmeds.com	HIV medication information
21. http://www.lola-national.org	Latino Organization for Liver Awareness
22. http://www.hcvadvocate.org	Hepatitis C Support Project
23. http://www.thebody.com	An HIV Information Resource
24. http://www.americanheart.org	Hypertension info
25. http://www.diabetes.org	Diabetes info
26. http://www.nal.usda.gov/fnic/	Nutrition info
27. http://www.eatright.org	Nutrition info

Revised 4/18/05

Peer Protocol and Operations Manual

For use by employees in the peer counseling program at the Kansas City Free Health Clinic peer program

Please Note: This policies and procedures described in this manual are specific to the Kansas City Free Health Clinic. Not all of them may be appropriate to your organization—please consider the goals of your organization when developing orientation materials for your peer program.

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TABLE OF CONTENTS

Section I. Program Description

KANSAS CITY FREE HEALTH CLINIC VISON AND MISSION

VISION

Creating solutions for a healthy community.

MISSION

The purpose of Kansas City Free Health Clinic is to promote health and wellness by providing quality services, at no charge, to people without access to basic care.

CLINIC BACKGROUND

Kansas City Free Health Clinic was founded in 1971 as a non-profit agency to serve the youth who were flocking to the Westport area during the hippie era. The Clinic has a strong history of implementing programs to meet our mission to promote health and wellness by providing quality services, at no charge, to people without access to basic care.

The Clinic provides comprehensive services-HIV prevention and care, general medical, dental and mental health care with over 39,000 encounters for 15,270 patients in FY 04/05.

Section I. Program Description

THE PEER COUNSELING PROGRAM

The Peer Counseling Program targets HIV+ individuals and addresses the need of those who are living with a complex disease. The program became operational in 2000 with 5-6 peer counselors.

The goal of the Peer Program is to provide HIV+ persons with treatment education, resources, and Peer support to successfully engage in HIV Primary Care and adherence to HIV treatment regimens.

The program is designed to empower patients through Peer support to be living examples that even though HIV disease is chronic – it is manageable.

Currently there are 5 peer counselors; 4 males 1 female, 2 peers are bilingual. Peer support is accomplished through the following:

- one-on-one intervention (individual sessions);
- short-term treatment education;
- resources (internet pamphlets etc…);
- preventive and proactive healthcare.

In 2004, peers provided 2,296 encounters which included patient reminder calls, follow-up calls and face-to-face meetings. Training provided to Peers include:

- Listening/Communication skills;
- HIV 101;
- Medication management;
- Resistance and adherence;
- Coping with long-term side effects and others.

Section I. Program Description

DEFINING A PEER COUNSELOR

Proficient peer counselors must be educated and informed on as many factors as possible in order to provide the consumer with the information, tools, resources and personal attributes necessary to successfully manage this chronic disease.

Peers currently work 25 hours per month with 4-5 hours weekly in clinic and have 9 hours available to meet with clients by phone, e-mail or in the community. Duties encompass reminder phone calls for appointments, follow-up calls to clients who missed appointments and scheduling meetings with clients on their caseload either by in office visit or after office phone contact to work on treatment adherence issues.

Peers address barriers and factors that prevent adherence by being creative, using alarm watches, pillboxes, appointment calendars and informational resources that emphasize adherence. A job description for the Peer Counselor position is on Attachment I.

KANSAS CITY FREE HEALTH CLINIC
JOB DESCRIPTION

Position: Peer Counselor	**Exempt Status:** Non- Exempt	**Work Status**: Volunteer (stipend)
Job Code:	**Division:** HIV Primary Care	
Reports To: La Trischa Miles- Treatment Adherence Specialist	**Date:** January 21, 2003 Revised January 31, 2006	

Job Summary: The Peer Counselors are integral to the Treatment Adherence Program and provide specialized services in a professional environment. Peer Counselors work to encourage engagement into care and support adherence to treatment by providing education, resources, and mentorship.

Duties and Responsibilities:

Clinical

1. Adhere to confidentiality policies. It is a direct violation of Clinic policy to share the names or case facts concerning any client, patient or volunteer of the Clinic with any other person with the exception of those actually involved in the care of the patient/client. Any release of confidential information to any other entity shall be preformed by authorized personnel only and shall be accompanied by proper written authorization from the patient/client.
2. Peer counselors have scheduled office hours to complete office work, be available to meet with new clients, or provide one on one session with current clients.
3. Pull next day appointment charts, following the peer counselor standard operating procedures, complete patient reminder and DNKA calls.
4. Document information and relay pertinent information to treatment adherence specialist and/or provider.
5. Peer counselors carry a case load of individual clients and provide one on one support, education, and information.
6. Contact should be individually tailored to address treatment adherence issues of the client.
7. On average, peers should have weekly or bi-weekly contact with their clients.
8. Participate in continuing HIV/AIDS education and meetings.
9. Design and facilitate peer program-5 session groups that support treatment adherence issues.

Administrative

1. Follows all policies and procedures.
2. Completes all appropriate paper work in a timely manner (see Protocol and Operational Activities Manual).
3. Attends individual supervision meetings with Treatment Adherence Specialist.

KANSAS CITY FREE HEALTH CLINIC
JOB DESCRIPTION

(continued)

Position: Peer Counselor	**Exempt Status:** Non- Exempt	**Work Status**: Volunteer (stipend)
Job Code:	**Division:** HIV Primary Care	
Reports To: La Trischa Miles- Treatment Adherence Specialist	**Date:** January 21, 2003 Revised January 31, 2006	

Administrative

4. Attends peer counselor team meetings.
5. Assists in providing education and training to other peers.

Education and Experience:

- Possess basic knowledge and understanding of HIV/AIDS treatment adherence related issues.
- Possess willingness and ability to acquire further HIV/AIDS education and training
- Must complete Peer Counselor training sessions.
- Must participate in ongoing peer counselor training
- Possess good communication skills: including verbal, phone, and written skills.
- Ability to interact with diverse groups.
- Strong interpersonal skills including the ability to demonstrate empathy.
- Ability to work independently and seek guidance or assistance when necessary.
- Ability to work with multidisciplinary team of medical professionals.

Physical Demands/Working Conditions:

1. Intermittent physical activity including walking, standing, sitting, lifting and supporting of patients.
2. Incumbent will be exposed to virus, disease and infection from patients in working environment.
3. Incumbent will be required to work at one of our two facilities and be responsible for own transportation.
4. Incumbent may experience traumatic situations including but not limited to psychiatric, dismembered and terminal patients.

The above information is intended to describe the most important aspects of the job. It is not intended to be construed as an exhaustive list of all responsibilities, duties and skills required in order to perform the work.

Approved:

_____	_____
Employee	Supervisor/Manager
_____	_____
Date	Date

KANSAS CITY FREE HEALTH CLINIC
JOB DESCRIPTION

Position: Treatment Adherence Specialist	**Exempt status:** EXEMPT	**Work Status**: 1.0 FTE
Job Code: OSHA – 3 Low Exposure	**Division:** HIV Primary Care	
Reports To: Peer Ed Training Site Manager		**Date:** 4/2005

Job Summary:
The Treatment Adherence Specialist is responsible for the development, implementation and evaluation of the Clinic's HIV Peer to Peer Treatment Adherence program and for implementing the goals, objectives, activities and evaluations of the level 1, 2 and 3 peer trainings for the Peer Education Training Site (PETS) grant with the St. Louis chapter of the American Red Cross.

Duties and Responsibilities:
- Implement goals, objectives, activities, and outcome evaluation of the Clinic's Peer to Peer Treatment Adherence and the Peer Education Training Site (PETS) programs.
- Develops policies and procedures relevant to the implementation of the both programs.
- Recruits, trains and supervises peer to peer counselors for the Clinic's program.
- Mentors Clinic peer counselor to ensure adherence to all relevant state and federal laws, and Clinic policy regarding privacy and confidentiality.
- Mentors and monitors Clinic peer counselors to ensure provision of appropriate services within professional boundaries.
- Develops effective communication methods between Clinic peer counselors and HIV Primary Care staff to best identify candidates for the program and to meet the needs of those candidates.
- Collaborates with American Red Cross staff in the development of learning objectives, program content and teaching methods related to HIV treatment for Level 1 and 2 peer trainings.
- Collaborates with the Clinic's PETS Manager and MATEC in the development of learning objectives, program content and teaching methods for Level 3 peer trainings.
- Provides Level 3 trainings (shadowing and reverse shadowing experiences) and on-going technical support for peers in training from PETS participant organizations.
- In a timely manner, prepares and submits monthly reports as requested by funding sources.
- Regularly conducts program evaluation and quality assurance activities.

Education/Experience:
- Bachelor's degree in social work, nursing, health education or related field required. Experience in peer programs and/or HIV/AIDS a plus. Two years experience in program supervision and administration and experience working with volunteers/peers preferred.

Physical Demands/Work Conditions:
- While performing the duties of this job, the employee is required to regularly walk, talk and hear. The employee is frequently required to sit.
- While performing the duties of this job, the employee frequently travels by automobile and is exposed to changing weather conditions.
- The employee must occasionally lift and/or move up to 10 pounds.
- May experience traumatic situations including psychiatric, dismembered and deceased patients.

Approved:

_____
_____
Employee Signature
Date _____

Supervisor Signature
Date _____

Section I. Program Description

KC FREE PEER COUNSELOR PRINCIPLES, GOALS, OBJECTIVES AND ACTIVITIES

HIV is a life altering, complicated medical condition that can be managed with engagement in care and knowledge about the disease.

Guiding Principles

- HIV disease is chronic and manageable
- HIV Treatment works
- Greater than 90% adherence is the minimum necessary for effective adherence
- Achieving this is possible for everyone
- Adherence is a complex behavioral process influenced by many factors such as medication regimen, health care team relationships with the individual and individual attitudes and beliefs about taking medication and disease.
- Successful adherence is a collaboration between the patient, the Multidisciplinary Team that encompasses the Primary Care Team contact with Peer Treatment Adherence counselor, Mental Health Counseling, Substance Abuse Counseling, and Case Management Staff.
- Different interventions work for different people

Goal:

The goal of the program is to provide HIV+ persons with education, skills, resources and support to successfully engage in HIV primary care and adhere to HIV treatment regimens.

Objectives:

1. Communicate a message of hope, wellness and a holistic approach to help HIV Primary care patients live a long and healthy life.

2. Provide treatment education and support to improve patient engagement in care, adherence to medication and to reduce cultural barriers to care.

3. Provide individual and group level education to help HIV Primary Care patients understand the challenges of living with HIV which is a life altering, complex and complicated medical condition.

4. Provide individual and group level education to help HIV Primary Care patients learn to effectively manage their health care in partnership with their health care providers.

Section I. Program Description

E. KC Free Peer Counselor Principles, Goal, Objectives and Activities

(Continued)

5. Provide individual and group level educational and skills building opportunities for HIV Primary Care patients preparing to begin anti-retroviral (ARV) regimens, experiencing difficulty in adhering to ARV regimens or requiring additional support to maintain, improve and understand medication adherence.

6. Empower individuals to identify and reduce barriers to engagement in care and adherence to treatment through one-on-one interventions, short-term treatment education, advocacy, and support.

7. Provide population based individual and group level education and training to facilitate and/or improve general health maintenance.

Activities

Activities to meet the above objectives include but are not limited to the following:

Peer counselors available during HIV Primary Care clinic hours to meet with newly diagnosed, new patients, patients expected to begin ARV regimens, and/or patients who are referred to the Peer Program.

Peer counselors will provide individual interventions with selected patients in collaboration with HIV Primary Care, Case Management, and the Peer Adherence Treatment Specialist.

Peer counselors contact clients to remind them about appointments, if they missed the appointment, make follow-up phone calls, and/or schedule meetings with clients to work on treatment adherence issues.

Peer Counselors will maintain the bulletin boards in patient exam and the consultation rooms with appropriate health promotion and disease prevention literature.

Peer counselors receive ongoing training regarding HIV disease, treatment and management of side effects.

Peer counselors will conduct the Peer Program base line assessment tool once the client is enrolled in the program to evaluate and guide the counselor in determining knowledge level of the HIV Primary Care patient. This assessment tool is completed by the client at the completion of all required educational components of the Program.

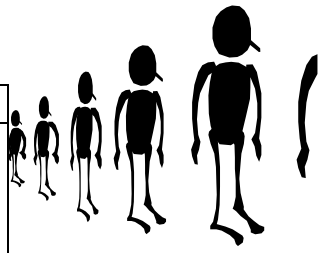
Peer counselors will provide training to clients on topics such as HIV 101 (viral life cycle), understanding basic lab tests (CD4 and viral load), resistance and adherence, understanding HAART, understanding and managing side effects, HIV terminology and effective communication with your Health Care Provider.

Section II. Protocols, Forms and Reports

Client Referral Form	
Description	A Referral Form initiates the Peer Counseling Process. A Referral Form must be completed by one of the following individuals or teams listed in the "task performed by" section below when one or more of the reasons for referral listed on the sample form on back and Appendix A apply. Pertinent information such as: Client name, date referred, date of birth, and phone contact is provided by the individual or team completing the referral.
Task Performed By	Individuals and/or teams that can refer clients to the Peer Counseling Program are: 1. Primary Care Team 2. Treatment Adherence Program Manager 3. Treatment Adherence Specialist 4. Ryan White Case Manager 5. Self-Referred
Time Frame	Peer Counselors respond with a phone call or office visit with the Client within 7-14 business days of the referral date. If the Peer Counselor assigned is unable to make contact with the client the Treatment Adherence Specialist will make contact.
Updates Needed	None
Additional Comments	Sample form on back, also available–see Appendix A. Referrals may be completed by e-mail, fax, regular mail, phone contact, or verbally requested by the client. Additional comments regarding the client on the reason for referral are always helpful in the selection of a Peer to Client match. The goal of the Peer Program Team and the referral Agent is that the client will engage in care by becoming an active participant in the education, and skills building to improve adherence and accomplish treatment goals.

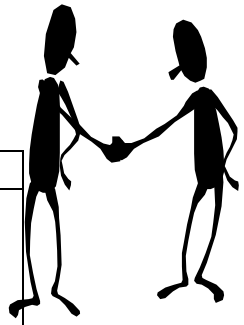
The Referral Form is part of the clients chart.

Section II. Protocols, Forms and Reports



Intake Form	
Description	The Intake Form is the first snapshot that indicates the clients medical status. Clients CD4 and VL numbers are recorded on the form along with list of medications-see sample form on back or Appendix B. The Intake Form is completed for clients when one or more of the reasons for referral listed on the Referral Form in Appendix A apply. Pertinent information such as: date intake completed, Peer Counselor assigned, Client name, address information, phone contact, employer, client work schedule, Case Manager assigned, race/gender, CD4, Viral load and date labs taken, Antiretrovirals and other medications taken are included.
Task Performed By	1. Peer Counselor 2. Treatment Adherence Specialist 3. Treatment Adherence Program Manager
Time Frame	Completed on site at Client's first visit for a new client or can be done prior to the Client visit for an existing client if all pertinent information in the "description" section above is available in the client's medical chart.
Updates Needed	Quarterly, by the assigned Peer Counselor as routine information is available in the client's medical chart.
Additional Comments	Sample form on back, also available–see Appendix B.

The Intake Form is part of the clients chart.



Section II. Protocols, Forms and Reports

Consent/Confidentiality Agreement	
Description	The Consent/Confidentiality Agreement ensures that the client gives consent for participation in the Peer Counseling Program. The Peer Counseling Program is voluntary, the Peer Counselors serve as client advocates and are not licensed professional counselors or therapists. The Consent/Confidentiality Agreement is divided into three sections: 1. Peer Counselors Roles and Responsibilities 2. Client Roles and Responsibilities 3. Confidentiality Pertinent information such as: Client name, date, date of birth, Client and Staff signatures and date signed are included.
Task Performed By	1. Client 2. Peer Counselor The Treatment Adherence Specialist or Treatment Adherence Program Manager are generally present to meet the client and give an explanation of the Peer/Client roles, responsibilities and reiterate Confidentiality.
Time Frame	Completed on site at Client's enrollment in the Peer Counseling Program.
Updates Needed	None
Additional Comments	Sample form on back, also available–see Appendix C. The Consent/Confidentiality Agreement is an interactive agreement between the Peer Counselor and the Client. The Confidentiality section gives the Peer permission to share and exchange information for the sole purpose of providing the best healthcare and wellness services available. In addition, the Peer agrees to hold such information in strict confidence. The Program is "free" and all inclusive whereas it encourages family, friends or significant others participation. A copy of the Consent/Confidentiality Agreement will only be given to the client upon request due to confidentiality concerns.

The Consent/Confidentiality Agreement is part of the clients chart.

Section II. Protocols, Forms and Reports

Peer Treatment Adherence Checklist-Client First Meeting	
Description	The Peer Treatment Adherence Checklist is used at a Client First Meeting for: • newly diagnosed, • new patients to care at the clinic, • patients interested in the SHP program, • patients expected to begin ARV regimens, and/or • patients who report or are identified to the Peer Program that may be experiencing problems with adherence. The Checklist serves as a guide and provides some consistency for all Peer Counselors to follow in the Client's first meeting. The checklist is designed to accomplish the following: 1. complete all necessary paperwork required; 2. advise the client of resources and services available at the clinic; 3. engage the client in communication about the disease with open-ended sample questions; 4. the Peer Counselor - at their discretion may share their story or give background of working in the field; and 5. Review the Treatment Adherence Peer Education Checklist on Appendix H to give the client an overview of Peer education training. Depending on the Client's "readiness" and availability, the Peer will make a determination to proceed with HIV 101 education at a first meeting or schedule the next meeting to begin the education.
Task Performed By	1. Peer Counselor 2. Treatment Adherence Specialist or 3. Treatment Adherence Program Manager
Time Frame	Completed on site at Client's first visit and/or within 7 days of the Client visit. (Peers work 1 day a week for 4 hours and if time does not allow same day documentation on site, the Peer is expected to document by their next work day the following week.)
Updates Needed	None
Additional Comments	Always ask the client about medical appointments: 1. When was your last medical appointment 2. When is your next medical appointment A more detailed explanation of the purpose is given on the sample form on back, also available-see Appendix D.

The Peer Treatment Adherence Checklist-Client First Meeting is part of the clients file.

Section II. Protocols, Forms and Reports

Peer Treatment Adherence Goals Plans	
Description	Treatment Plans are designed to develop a plan of reaching the goals of a client. Treatment goals are very client-centered and therefore should be tailored to fit what the client wishes to meet with regards to short and long term goals. The SMART format in writing goals and objectives is currently being used along with goal planning worksheets. Pertinent information such as: Client, Peer name, Assessment, Plan of Action-Goal, Objectives and Rewards, signatures and Follow-up with the Peer are included .
Task Performed By	1. Client 2. Peer Counselor 3. Treatment Adherence Specialist or 4. Treatment Adherence Program Manager
Time Frame	Completed on site during Client office visits – signatures are required to make the goal and objectives valid. Depending on the client a treatment plan can take an estimated 1 to 2 office visits before a plan of action is determined, based on the participation, interest and time the client is willing to engage in the process.
Updates Needed	Updates will be completed to review status of goals and accomplishes by Client and Peer. Goals can be set at any interval such as weekly, bi-weekly, monthly, or quarterly.
Additional Comments	A more detailed explanation of the overview, guidelines for goals and objectives are in Appendix E. Examples of goals, objectives, rewards and a sample of goals cheat sheet are available in Appendixes E1. – E.4.

The Peer Treatment Adherence Program Plan of Action is part of the clients file.

Section II. Protocols, Forms and Reports

Peer Daily Activity Operations

1. First, sign the time log to document in office hours worked.

2. Check your e-mail.

3. Then, sign on to Ridgemark, from the desktop. Ridgemark is a scheduling program at the Clinic. Peers use the program to print schedules of daily appointments.

   Next, Click on Ridgemark icon.
   a) Type "Peer" in the User ID box and then click OK.
   b) Click OK in the Ticklers Box
   c) Click on the 1-2 icon (for scheduling)
   d) On the bottom right corner of the screen you will barely see the top of the word Utility, bring that up and click on Utility
   e) Then click on daily schedule
   f) In the provider code space, type in 300 and next to that replace the 4 zzzz's and type 399.
   g) Then click on Receptionist copy and print your schedule.
   h) Then click on Provider copy and print the providers copy.
   i) Now, get your Receptionist copy ready to write on:
   Cover the side of the page that indicates remarks, $copay% and balance then tape on or copy the race/gender insert per each patient scheduling page.

4 Pull Charts. Check charts for updated phone numbers, race, enrollment in Care Link system and any special comments.

5 After all charts are pulled, shelve those charts for the provider and hang up the Doctor's schedule in front of the charts.

6 Reminder calls to clients about appointments. On your copy (put a "Y or N" to indicate if you can leave a message). You can also leave yourself special instructions on your copy of the schedule. Remember to indicate client's race or ethnicity on your copy of schedule (for example AA = African American, H= Hispanic, C= Caucasian, etc.) After getting the information you need to place the chart in the next day appointment spot and hang the Provider's copy up in front of the charts.

An example of the Receptionist copy is on back of this page.

As clients are called document any special notes by using a footnote at the bottom of the schedule or leave a note in the message column on the right hand side of the schedule. Highlight all names you have either contacted or left messages for.
Person to person contact = Highlight name & number in YELLOW.
Left a message = Highlight name & number in in BLUE.

Indicate who you left message with i.e.: L/M with partner Joe or L/M on answering machine. Remember to put your initials next to each person you contacted or a left message.

If you need to relay any information back to the providers, such as: patient canceled, or can't find chart, etc. put that information on a sticky note and stick it on the Providers schedule that you hung up in front of the charts or document it on the Providers schedule.

7 Calls to DNKA clients. Did Not Keep Appointment "DNKA's": If DNKA list is not in the DNKA folder you will need to go down stairs to the provider room and ask one of the nurses for the list. Then make a copy for yourself.

Cross reference the DNKA list with that day's appointment schedule so you can get the phone numbers and any special instructions without having to go back to through the charts. (This is a short cut for you).

Call all the DNKA clients and identify yourself as a peer counselor. Ask if they realized they missed their appointment. Try to engage them in conversation, you can ask if they are ok on their medication refills or if there is anything you can do to assist them in keeping their appointments. Document information on the DNKA call back sheet.

8. Just In Time appointments. You will be contacted by either Primary Care staff or Case Managers if they would like you to meet with a client who is newly diagnosed or interested in the Peer Program. Please see protocol on page 20.

9 Meet with clients on your case load.

10 Call/make contact with clients you have not seen or with whom you need to schedule appointments.

11 Be available to meet with clients of other Peer Counselors if needed.

Section II. Protocols, Forms and Reports

Peer to Peer Monthly Report	
Description	The Peer to Peer Monthly Report is a summary of Peer to Peer activity and is calculated at the end of each month. The monthly report consist of the following: • Courtesy contact calls by race and gender (appointment reminder calls) • DNKA contact calls (Did Not Keep Appointment contact calls) • Peer to Peer contact calls by race and gender (monthly Peer contact by phone, office visit or correspondence) • Patient Computer sign in sheet (located in the waiting area for clinic patients to use.)
Task Performed By	1. Peer Counselor 2. Treatment Adherence Specialist
Time Frame	Completed at end of month from daily appointment reminder schedules, daily missed appointment schedules and daily Computer sign-in sheets. The blue folder in the Peer office is used to tabulate the types of contact calls captured monthly in the "description" section above. Generally, it takes approximately 1 hour to tabulate.
Updates Needed	Monthly
Additional Comments	The Peer to Peer Monthly Report is provided as input to the Peer to Peer Program Monthly Report completed by the Treatment Adherence Specialist. Copies of the monthly report are kept in the Peer office. Specific procedures for calculating the monthly report, are documented in Attachment I.

The ***FLOW*** of paperwork in the Peer Counseling Program

Referral Form

Officially initiates the Peer Counseling Process

Intake Form

First "snapshot" of client medically

Consent / Confidentiality Form

Allows client to be a part of Peer Counseling Program

Peer Treatment Adherence Checklist

A guide for the first meeting

Peer Education Checklist

A checklist of all the topics to be covered in education

Pre- and Post-Tests

A way to gather the level of understanding of client before and after educational

Progress Notes

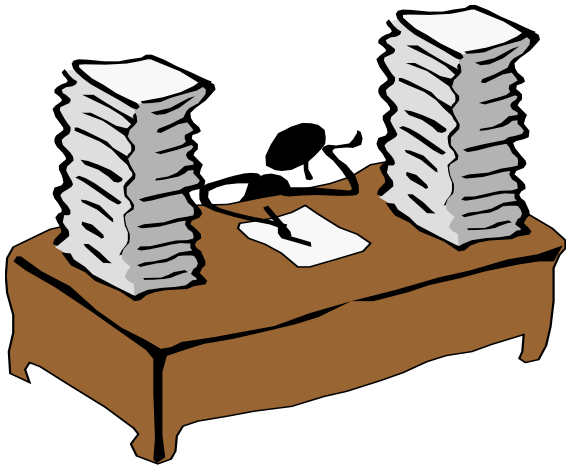
Documentation of meetings with clients and any other information that is relevant to client care

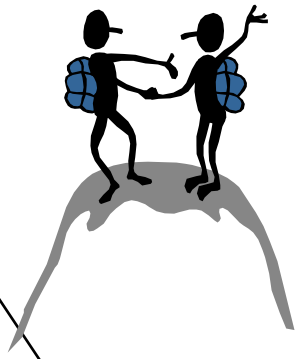
Treatment Plans

Client-centered approach to assisting clients in achieving their goals

Contract for Continued Care

This is completed after the first year of education is completed. This provides the client with an understanding of his / her responsibilities to the Save Housing Program





Section III. Procedures

"Just In Time Meeting"

The "Just In Time Meeting" is unscheduled and designed to meet the needs of individual primary care clients that meet the following criteria:

- Newly diagnosed
- New patients to care at the clinic
- Patients interested the SHP program
- Patients expected to begin ARV regimens or
- Patients who report or are identified to the Peer Program that may be experiencing problems with adherence.

The meeting is conducted upon referral from the Primary Care Team or Case Manager as a one-time intervention when the client is present for a medical or case management appointment.

The task is performed by the Peer Counselor on staff for the day, Treatment Adherence Specialist, or Treatment Adherence Program Manager.

The meeting is informational only. During the meeting the Peer's role is to focus on the reason for referral and the client's feedback in order to meet the client "where they are". The "Just in Time meeting" seeks to give the Client a message of hope, wellness and engage them in their own healthcare. The Peer will also discuss the Peer Counseling Program, its' benefits and will give the client an opportunity to enroll.

Section III. Procedures

Transferring/Changing Peers

The Peer/Client relationship has to work within a realm of trust and respect. For this reason, usually the Peer/Client relationship is built over time.

Clients are matched to Peer Counselors using a "best fit" approach. Factors considered for a "best fit" in matching a client to a Peer are client's psychosocial issues, language, times the client is available to meet with Peers, gender and treatment issues. Generally, the Client and Peer Counselor are able to establish a good professional working relationship where barriers do not exist; however there are situations when transferring a client to another Peer are considered when there are unresolved concerns such as personality conflicts, gender differences and boundary issues are not respected in the relationship between a Peer and a Client.

In the event that mediation is not successful or an option a Client can:

- Contact the Peer Counselor and advise that Peer Counseling services are no longer needed;
- Contact the Peer Counselor and request that another Peer Counselor be assigned
- Contact the Treatment Adherence Specialist and advise of the situation or
- Contact the Treatment Adherence Program Manager and advise of the situation.

In such cases where personnel changes occur in the peer program the client can expect to continued to received peer counseling from another member of the Peer Program

Section III. Procedures

Discharge from the Peer Program

Clients can be discharged from the Peer Program based on the following:

A. Client initiated:

1. Client has communicated that goals are achieved
2. Client feels that they are no longer willing to work on treatment adherence issues
3. There has been a breach in client confidentiality – client can report situation to the Treatment Adherence Manager, or Treatment Adherence Specialist.

   Note: If the client does not feel that the situation can be resolved with Personnel listed above, he or she has the right to file a grievance with the Clinic about the Peer Program. Forms are available at the Clinic Reception Desk.

B. Peer initiated:

1. Client education goals have been met;
2. Client treatment goals have been met;
3. Client has not complied with the roles and responsibilities of the Consent/Confidentiality Agreement
4. Client has been terminated from Peer services for the purpose of investigation of suspicion of breach of confidentiality.
5. Client has displayed verbal or threatening behavior.

C. Other:

1. Client is no longer a patient at the Clinic
2. Specific client services are not available at the clinic (e.g. services are not provided to pregnant clients but referred to an appropriate provider).
3. Client has relocated.

Sample discharge letters are on Attachments II, II-1, II-2

Section III. Procedures

Re-enrollment to the Peer Program

Clients can be re-enrolled to the Peer Program based on the following:

A. Client initiated:

1) Client can request to be re-enrolled to the Peer Program if they are ready to work on treatment adherence issues. The client's previous peer chart will be reviewed as a point of reference for re-engagement.
2) Client has agreed to follow the roles and responsibilities of the Consent/Confidentiality Agreement.
3) Client has expressed a new interest in working on treatment goals and objectives.
4) Client has successfully worked on verbal or threatening behavior that resulted in discharge

Section IV. Program Components

HIV Adherence Survey in English/Spanish Pre-Post Test Administration

The pre-post test is administered as a baseline assessment to gauge a client's knowledge level of HIV disease. It is also used to dispel myths that the client may have heard about HIV that are not true. The pre-post test can be administered in English and Spanish either written or oral to the client by the Peer Counselor. Generally, the pre-test is given at a first or second visit with a Peer Counselor. The instructions on the survey indicate that some of the statements are true and some are false. The client has to answer true, false or not sure then check the answer beside each statement that most closely reflects their opinion or belief.

A sample form is on back, also available see Appendix G.

The survey is divided into four parts:
Part 1 - HIV and Transmission
Part 2 - HIV Education, lab tests, health problems and information
Part 3 - HIV Medications
Part 4 - Health Maintenance

The post-test is given after the client has satisfactorily completed Peer education and has covered all subject areas from the *Treatment Adherence Peer Education Check List – see Appendix H.*.

Note: If the client is enrolled in SHP and has completed the education component of the Program, it is the responsibility of the client to continue follow up and contact by phone or office visit in order to remain active in the Peer Adherence Treatment Program and the Save Housing Program.(see Appendix E - Contract for Continued Care for more details).

Section IV. Program Components

Treatment Adherence Peer Education Checklist

The purpose of the Treatment Adherence Peer Education - Checklist is to structure a consistent education training process of topics most significant to enhancing patient knowledge of HIV successful to health maintenance. The checklist also assist the client with keeping track of the educational material covered for the Peer/Client meetings.

Pertinent information such as the type of medium communicated (i.e. discussion, handouts, video, CD/internet and/or workshop) is documented on the checklist by indicating the date the material was covered with the client or placing a check mark beside the topic.

A sample form is on back, also available see Appendix H.

A more detailed explanation of the purpose is on back of this page and on the appendix listed above.

There are seven educational components required for clients participating in the Peer Counseling Program which are:

1. HIV 101
2. Understanding Basic Labs
3. Resistance and Adherence
4. Understanding HAART Medication
5. Understanding and Managing Side Effects
6. Understanding HIV Terminology
7. Effective Communication with Health Care Provider

The educational components offered are designed to build upon each other and to provide a comprehensive HIV Treatment Adherence Education for the client.

All educational components will consist of one of the following:

- discussion points – an interactive format between Peer and client
- handouts
- video
- CD/Internet
- Workshop

Section IV. Program Components

Review HIV 101 (Viral Life Cycle)

HIV 101 is one of seven educational components required for clients participating in the Peer Counseling Program.

HIV 101 seeks to dispel myths and misinformation about the disease.

Objectives:

- Understand how the HIV lifecycle works; that is how it enters a CD4 cell, replicates and damages the immune system.
- Review the stages of HIV infection.
- Understand where in the viral life cycle the different classes of medications work to slow replication.
- Understand that adherence is important.
- Understand how HIV is transmitted.
- Begin to become familiar with terminology used in HIV treatment

Section IV. Program Components

Understanding of Basic Lab Tests: CD4 & Viral Load

Understanding of Basic lab tests: CD4 and Viral Load is one of seven educational components required for clients participating in the Peer Counseling Program.

Objectives:

- Understand the importance of having regular lab work done by knowing what tests are being ordered when blood is drawn by the lab.
- Understand the importance of having regular lab work done by knowing what specific HIV test results mean such as viral load, CD4, resistance tests.
- Understand what CD4 percentage and T-cell ratio indicate and review other significant subset tests.
- Understand what CBC and blood chemistry tests such as liver, kidney etc.. and why they are checked.
- Understand the importance of having cholesterol, triglycerides, blood pressure, and glucose levels tested and how they may related to HIV treatment adherence and care.
- Overview healthy heart and the effects of HIV disease with regard to testing,
- Learn how to find more information on tests (i.e. via internet, pamphlets etc…)
- Always ask for a copy and keep a diary of your own labs

Section IV. Program Components

Review Resistance & Adherence: Importance of Taking Medication Correctly

Review Resistance & Adherence: Importance of Taking Medication Correctly is one of seven educational components required for clients participating in the Peer Counseling Program.

Objectives:

- Understand what is resistance.
- Understand how and why resistance occurs and its impact on HIV treatment.
- Understand how adherence can reduce the chances of resistance
- Identify barriers to adherence
- Review what methods and tools are available dependent on client's preference (e.g. single dose, daily and weekly pill boxes, calendars, note cards, alarm wrist watches, water bottles, magnets)

Section IV. Program Components

Understanding HAART Medication

Understanding HAART Medication is one of seven educational components required for clients participating in the Peer Counseling Program.

Objectives:

- Give an overview of current approved FDA HAART medications.
- Understand that combination therapy has benefits and possible side effects.
- Identify ways to minimize short and long term side effects.
- Recognize serious life threatening side effects that must be reported to the doctor.
- Understand that medication falls into classes and that "standard of care" calls for using combination therapy.
- Discuss new medications that are currently in clinical trials.

Section IV. Program Components

Understanding and Managing Side Effects

Understanding and Managing Side Effects is one of seven educational components required for clients participating in the Peer Counseling Program.

Objectives:

- Review the current approved medications to treat HIV/AIDS and heir possible side effects.
- Identify ways to minimize short-term and long term side effects
- Recognize serious and even life threatening side effects which must be reported.
- Recognize what "standard of care" with regard to medication regimes means.
- Gain an understanding and awareness that new medications and clinical trials may be available options.

Section IV. Program Components

Understanding HIV Terminology

Understanding HIV Terminology is one of seven educational components required for clients participating in the Peer Counseling Program.

Objectives:

- Understand common HIV/AIDS terms such as CD4/T-cells, Viral Load, resistance, adherence etc…
- Recognize and understand what the terms mean in relation to health status.

Key terms are listed on back of this page.

Section IV. Program Components

Effective Communication with Your Health Care Provider

Effective Communication with your Healthcare Provider is one of seven educational components required for clients participating in the Peer Counseling Program.

Objectives:

- Acknowledge to the client that they can advocate for themselves and that they play a significant role in their own healthcare and treatment decisions by encouraging them to participate by:
  - writing down their questions and concerns
    new health questions or problems
  - voicing their opinion
  - seek information on their own
  - being assertive
  - make sure that important issues are written in their chart
  - ask for a copy of labs
  - Tests?
    - Why is this test being done?
    - What will the results tell us?
    - If you are not clear, ask again when you get the results.
  - Medications?
    - Dosage: how much, how often?
    - Food requirements?
    - Storage requirements?
  - Take notes, get handouts, fact sheets
    - Bring a friend to take notes and help understand what was said
  - If you don't understand, tell your provider, its not rude to insist on getting an answer

  If there are problems consider switching providers

Section IV. Program Components

Other Training and Resources

Section V. Supportive Housing Program

SHP Program	
Description	The SHP Program is designed to engage HIV/AIDS infected homeless individuals and families into care given the support of rental assistance and Peer Counseling in scattered site housing for up to 2 years. A more detailed explanation of the Program is on back-also on Appendix I. Clients are assigned and will meet with a Peer Counselor prior to enrollment in SHP. Eligibility for SHP once a client is enrolled constitutes the following: <u>Year 1</u> Clients will meet with their assigned Peer Counselor monthly for the educational component of the Peer program and attend scheduled medical appointments. <u>Year 2</u> Clients who continue beyond Year 1 will review and sign a Contract for Continued Care at the beginning of Year 2 and the contract affirms satisfactory completion of the educational component of the Peer program. Clients are expected to meet quarterly either in office visit or by phone contact.
Task Performed By	1. Peer Counselor and Client are responsible for adhering to the roles and responsibilities listed on Appendix C. 2. Treatment Adherence Specialist is responsible for confirmation of the following via e-mail, regular mail and/or by phone contact to SHP Program Manager, Case Managers, Clinic Account Manager and Peer Counselors: • Enrollment letters • Urgent Contact letters • SHP Year 1 verification monthly letters • SHP Year 2 verification quarterly letters • Monthly SHP and Non-SHP Active client lists Samples of the enrollment, contact and verification letters can be viewed on Attachments I-3, I-4, I-5
Time Frame	Varies from 5 minute letters to an estimated 8 hours to update SHP and Non-SHP client list depending on task performed
Updates Needed	Monthly, Quarterly, and on an as needed basis (i.e. enrollment, contact letters)

Section V. Supportive Housing Program

Peer Treatment Adherence Program Contract for Continued Care	
Description	The Peer Treatment Adherence Program Contract for Continued Care is a contract with the Supportive Housing Program (SHP) clients that have satisfactorily completed the educational component of the Peer Program. After the client has successfully completed year 1 of the Peer program, then it is the responsibility of the SHP client to maintain contact with the assigned Peer Counselor, medical provider, or other support service providers every three months after the second year by phone or office visit to remain active in both the Peer Treatment Adherence Program and SHP. Pertinent information such as: Peer and Client signatures and the date are included .
Task Performed By	1. Peer Counselor 2. Treatment Adherence Specialist
Time Frame	Completed on site during Client office visit Generally it takes 10 minutes to explain the contract, answer the questions, schedule the next three month meeting, sign and date.
Updates Needed	Every three months
Additional Comments	Sample form on back, also available – Appendix F. The contract clearly states that failure to comply with the requirements risks enrollment in the Peer and SHP Program. Additional information regarding the SHP Program is detailed in Section V of this manual

The Peer Treatment Adherence Program Contract for Continued Care is for SHP Clients only is part of the clients file.

Attachment I

Peer to Peer Monthly Report Calculation

To count client data:

Courtesy calls are logged in the blue folder kept on the peer desk.

Count all courtesy calls by race and gender.

Count all names highlighted in blue (for left message).

Count all names highlighted in yellow (for person to person contact).

Tally DNKA contacts located in the light blue DNKA folder on the peer desk (some DNKAs are highlighted in yellow).

DNKAs that have been called are listed on the right side of the folder under DNKA No Show Call Back List with Date called, Client Name & number, comments and the Peer Counselor initials.

To count individual Peer contacts.

Count the contacts logged in the blue folder.

Count contacts in peer client folder (do not tally encounter from chart only the fact that There was at least one contact for that month).

Tally the patient computer users from the Patient Computer sign in sheet found at the Computer on 1st floor.

Treatment Adherence Program Referral Form
Kansas City Free Health Clinic

ATTN: LaTrischa Miles
Phone: 777-2745 Fax: 753-0804 Email: latrischam@kcfree.org

Please complete all pertinent referral information below:

Client name: _____Date referred to peer_____

Date of birth: _____ Race: _____ Gender: □ Male □ Female □ Other

Clt. Phone _____ May we leave a message at this number? _____

Referred by: _____

Organization: _____

Phone: _____ Fax: _____

Reason for referral: (Please check all that apply)

- ❑ initial assessment
- ❑ new diagnosis
- ❑ new patient
- ❑ encourage adherence
- ❑ reminder phone calls
- ❑ adherence evaluation
- ❑ recurring missed appointments
- ❑ help patient prepare to start TX
- ❑ SHP / Peer counseling
- ❑ patient requests peer counselor
- ❑ peer support
- ❑ complex regimen
- ❑ rescue/salvage therapy
- ❑ change in therapy
- ❑ starting first line regimen
- ❑ provide patient education

Additional comments: _____

_____

_____

_____

Peer Treatment Supervisor Information:

Date Received: _____

Peer Counselor: _____

Peer follow up : _____

_____

_____

Appendix B

Intake Form

Date _____ Peer Counselor _____

Name _____

May we send mail to this address? _____Yes _____No

Address _____

City _____State_____ Zip_____

Home phone _____Other phone _____

May we call you at this number? _____Yes _____No

E-mail _____ Employer _____

Work schedule _____Case Manager_____

Race/Ethnicity _____Male ____ Female ____ Other _____ DoB_____

Cd4	VL	Date
Cd4	VL	Date
Cd4	VL	Date
Cd4	VL	Date

On Medications: YES _____ NO _____

Antiretroviral	Other medications

Appendix C

Consent/Confidentiality Form

Client Name _____ Date: _____

Date of Birth: _____

I agree and understand that the Peer Counseling Program is voluntary. Peer Counselors serve as advocates to provide peer support and help improve patient care. I understand that the Peer Counselors are not licensed professional counselors or therapists.

Peer Counselors Role and Responsibilities

Peer Counselors will:

- Establish contact with you, via phone, e-mail, or individual visits.
- Provide treatment education and peer support.
- Work collaboratively with you, your case manager, and your health care providers.

Client Role and Responsibilities

I agree to:

- Return calls via e-mail or phone to the Peer Counselor.
- Contact the Peer Counselor and/or Treatment Adherence Specialist if the Peer Counseling support is no longer needed or helpful.
- Work in partnership with the peer Counselor, my case manager, and health care provider.

CONFIDENTALITY:

- By agreeing to participate in the Peer Counseling Program I give my permission for the Peer Counselor and Program Coordinator to share and exchange information with the health care providers and case manager for the purpose of providing quality services to promote my health and wellness.

- If I reveal information that indicates a clear threat of harm to myself or others, the Counselor will need to contact appropriate authorities, warn the potential victim or take other reasonable action to prevent harm from occurring.

- My Peer Counselor is required by law to report to the appropriate authority information about suspected abuse or neglect of a child, an incompetent or disabled person or elderly person.

- By signing this document I agree to maintain strict confidentiality of personal information shared in the Peer relationship (e.g. personal information about my Peer Counselor).

  Peer Counseling services are provided "free" and are of no cost to you, your family members, friends or significant others. We encourage family participation and involvement in the healing process. I agree to the above contract and if I have any concerns that I may call my Peer Counselor at (816) 777-2723 or the Treatment Adherence Specialist, LaTrischa Miles at (816) 777-2745.

  Client Signature: _____ Date: _____

  Staff: _____ Date: _____

Appendix D

Check List
Peer Treatment Adherence – Client First Meeting

The purpose:

1. Ensure that patient gives consent for participation in peer program.)
2. Ensure that contact information is up to date and correct for continued follow-up.
3. Ensure that client understands that confidentiality is held at its highest standards.
4. Inform client of resources/services available at the clinic.
5. Improve patient's involvement in their HIV care by determining knowledge level with pre-post test.
6. Assist patients in making healthy life choices
7. Improve patients attitudes toward antiretroviral therapies
8. Reduce patient fears regarding antiretroviral therapy
9. Reduce patient isolation and decrease stigma

Service	DATE COMPLETED
1. Client referral form	
2. Complete Intake form. Ensure all information is correct (address, phone numbers, email etc…)	
3.Consent form Treatment Adherence Specialist and Peer will review consent form with client and Explain confidentiality (private/not public information in any setting)	
4. Inform client of resources/services available at the clinic.	
5. Client health (sample questions to engage communication about disease) • How is client coping with the disease (medically, home life) • Family (kids names, ages, husband/wife supportive/not?) • Do you have family or any other support other than the clinic? • What have you heard about HIV? • Have you known someone with HIV? • Do you have concerns/questions? *Always ask the client about medical appointments:* *1. When was your last medical appointment* *2. When is your next medical appointment* Please be aware that this format will not fit the profile for all clients.	
6. Ensure that client understands the role of a peer.	
7. Share your story/background working in the field etc…	
8. Review Treatment Adherence Peer Education Checklist. **ONLY PROCEED TO HIV 101-EDUCATION IF YOU FEEL CLIENT IS READY AND TIME ALLOWS**	
8. HIV 101 Chart	

Appendix E

Peer Treatment Adherence Plans
Kansas City Free Health Clinic

Overview

The purpose of a treatment plan is to develop a structured plan of reaching the goals of a client. The goals must reflect what the client would like to reach, not what the peer wishes for the client to develop. Therefore, the treatment plan is very client-centered. After the client has decided upon his or her *specific* and *detailed* short and long term goals, the peer and client work together to outline the objectives the client would need to accomplish in order to meet his or her goals.

Guidelines for Goals and Objectives:

Peers are encouraged to use the SMART format in writing goals and objectives. This will help maintain consistency across all peers. The following describes the characteristics of goals and objectives using the SMART format:

S	Specific	Exact and Concrete
M	Measurable	Observable or tangible
A	Achievable	The client is willing to work towards the goal
R	Realistic	The client is able to accomplish the goal
T	Time	Have a deadline for each goal

Please note that the goals may not always be related to Adherence. They may pertain to having a client follow through with a goal they must accomplish and you are there to help develop the plan for accomplishing the goal. For example, the client may express feelings of depression and instead of taking on the role of a mental health professional; you refer the client to his or her case manager to seek mental health assistance. With the client, you may develop a plan of action to help them see an end to this goal.

For each client, there should be between 3 to 7 goals established which are dependent on the client's needs, ability, and level of motivation.

Treatment plans often neglect the rewards of accomplishing goals. Be sure to help your client understand the rewards of accomplishing his or her goals and further, you may suggest that he or she actually rewards him or herself for accomplishing the goal.

If a client does not complete the goals listed on his or her treatment plan by the goal date, then the peer and client are to meet and discuss the reasons as to why the goal was not met. Then, the peer and client are to develop a new treatment plan that may be more realistic and achievable for the client.

Remember, the goal is that the client achieves his or her goals to feel proud of his or her success.

Appendix E.1.

Examples of Goals, Objectives, and Rewards

Goal:
Client X would benefit from increasing his knowledge of HIV by completing the Peer Adherence Education Program by May 15, 2006.

Objectives:

1. Client X will meet with his peer counselor every two weeks for 30 minutes to receive education related to HIV.
2. Client X will complete the 7 learning modules of the peer program.
3. Client X is encouraged to ask questions of his or her peer related to HIV.
4. Client X will complete post-test with a grade of at least 95%.

Rewards:

1. Client gains the reward of learning more about his or her illness and how to maintain a better quality of life for him or herself.
2. Client X will reward himself for his success in learning more about HIV by enjoying a movie with a friend by May 20, 2006.

Goal:
Client X will adhere to her medication regimen at least 95% of the time by February 15, 2006. 95% adherence means that Client X may not miss more than one dose of medication per week.

Short Term Objectives:

1. Client X works with peer to identify barriers to adherence.
2. Client X identifies ways around barriers to adherence.
3. Client X tracks adherence to medication.
4. Client X reports to peer about problems with medication adherence.
5. Client X reports to doctor if she experiences problematic side effects.
6. Client X reports to case manager if she experiences any problems with obtaining her medications.
7. Client X to increase her medication regimen to 95%.

Rewards:

1. Client X gains a feeling of empowerment by becoming 95% adherent to medication and also resulting in a better quality of life.
2. Client X will reward herself by taking a bubble bath by February 20, 2006.

Sample Goals / Cheat Sheet:

Purpose: This *cheat sheet* may be useful if clients are having difficulty in developing goals that they wish to work on as part of the adherence program.

Disclaimer: The purpose of the treatment plan is for clients to work on goals that *they* wish to work on, NOT what the peer counselor thinks they need to work on. Therefore, this list should NOT be used for everyone as every client you meet will have different expectations, goals, life situations, that may prevent him or her from working on certain goals and further having the opportunities to achieve success.
Remember, the goal is for clients to achieve success, *not* failure.

Sample Goals at Intake:

- ❑ Client X wants to increase his knowledge of HIV by completing the Peer Adherence Education Program
- ❑ Client X wants to adhere to his or medication regimen at least 95% of the time.
- ❑ Client X wants to increase confidence at medical appointments by preparing a list of concerns to discuss with his or her physician.
- ❑ Client X wants to improve communication between he and his medical provider (i.e., physician)
- ❑ Client X wants to work on his/her mental health issues.
- ❑ Client X wants to work on his/her substance abuse/dependence issues.

Sample of More Advanced Goals:

- ❑ Client X wants to increase confidence in disclosing HIV status to new partners
- ❑ Client X wants to become more active in community organizations to increase level of social support.
- ❑ Client X wants to work on developing appropriate boundaries with health care providers.
- ❑ Client X wants to increase his/her level of physical activity to decrease his/her level of cholesterol and blood pressure.
- ❑ Client X wants to learn more about HIV, beyond that of the peer program, by attending LIFE or HIV University.
- ❑ Client X wants to attend the group sessions related to HIV at the Kansas City Free Health Clinic.

Appendix E.3.

Date: _____

Peer Treatment Adherence Program
Treatment Plan
Kansas City Free Health Clinic

Client Name: _____ Peer Counselor: _____

Assessment: {Description of Presenting Problem(s) and Observations}

Plan of Action: {Goal(s) *If more than one goal, please use goal addendum*}

- Goal : _____

_____

- Objectives:

1. _____
2. _____
3. _____
4. _____

- Rewards:

1. _____
2. _____

I, _____, developed the above treatment plan with my peer counselor and agree to follow the objectives in order to achieve my goals. I further agree to seek assistance from my peer counselor if I experience any barriers to achieving my goals.

_____ _____ _____
Client Date Peer Counselor

Follow-up by Peer Counselor and Client.

☐_____ completed the above treatment plan successfully.

☐_____ did not complete the above treatment plan and the peer counselor and client have developed a new treatment plan to assist client with reaching his/her goals.

_____ _____ _____
Client Date Peer Counselor

Goal Addendum to _____ Treatment Plan

Date: _____

❖ Goal #2 : _____

_____

❖ Objectives:

1. _____
2. _____
3. _____
4. _____

❖ Rewards:

1. _____
2. _____

❖ Goal # 3: _____

_____

❖ Objectives:

1. _____
2. _____
3. _____
4. _____

❖ Rewards:

1. _____
2. _____

Appendix F

Peer Treatment Adherence Program

Contract for Continued Care

Peer: _____ Client: _____

As a client of the Peer Treatment Adherence Program for the Kansas City Free Health Clinic, I understand that after I have completed the education component of the Program, it is my responsibility to follow through with the following in order to maintain an active status in the Peer Treatment Adherence Program and the Supportive Housing Program.

To remain active in both the Peer Treatment Adherence Program and the Supportive Housing Program, I will commit to maintaining contact with my peer counselor, my medical provider, *and* if necessary, other support service providers (ex: mental health counselors, substance abuse counselors, support or wellness groups, etc.) at least one time every three months. To be counted as a contact, I must be in touch with my peer counselor by phone or by office visit.

My last contact with my peer was: _____ and my next contact should be made by: _____ in order to remain active in the program. I understand that failure to follow through with this requirement risks my enrollment in the Peer Adherence Treatment Program and the Supportive Housing Program.

I agree to the above contract and if I have any concerns I may call my peer counselor at: (816) 777-2723 or the treatment adherence specialist, LaTrischa Miles at 777-2745.

_____ _____
Client Date

_____ _____
Peer Counselor Date

Don't Forget!

My next meeting with _____

is scheduled for: _____

at: _____

HIV Adherence Survey in English

Pre: ____ Post: _____Client _____ Peer Counselor: _____Date _____

Some of the following statements are true and some are false. Please read the statements and check answer that most closely that most closely reflects your opinion or belief.

HIV and Transmission Part 1:	**True**	**False**	**Not Sure**
1. You can tell if a person has HIV because they look sick.			
2. Condoms help prevent transmission of HIV.			
3. HIV is present in blood, semen, vaginal fluid, and breast milk.			
4. A person can get HIV from sharing an injection needle with someone who has HIV.			
5. It is not harmful for an HIV positive person to have unprotected anal or vaginal sex with another HIV positive person because they are both already HIV positive.			
HIV education, lab tests, health problems and information Part 2:	**True**	**False**	**Not Sure**
6. HIV destroys the immune system by attacking cells called CD4 or T helper cells.			
7. As CD4 count go down a person is more likely to have HIV related infections and illnesses.			
8. Viral load is measure of how many copies of HIV were detected in your blood test.			
9. If your viral load is undetected, you do not have HIV infection any longer.			
10. Ideally, anti-HIV drug treatment should cause the CD4 count to go up and the viral load should go down.			
HIV medications Part 3:	**True**	**False**	**Not Sure**
11. HIV treatments can help a person live longer and healthier life by suppressing the virus.			
12. Supportive family or friends can help improve adherence to your medication.			
13. It is not a big deal if you miss some of your doses of anti-HIV medications.			
14. Missing doses of anti-HIV medications can cause your HIV to become resistant to medications.			
15. If you have side effects from your anti-HIV medications you should stop taking them and tell your doctor at the next visit.			
Health Maintenance Part 4:	**True**	**False**	**Not Sure**
16. Good nutrition plays a vital role in the ability of the immune system to fight HIV and prevent AIDS related infections.			
17. Using tobacco caffeine, recreational drugs, and alcohol does not have an impact on the immune system. .			
18. Moderate exercise may help lessen some of the side effects associated with HIV and HIV treatments.			
19. If you have problems with your appetite or digesting your food you should talk to your health care provider about that.			
20. People who are HIV positive should avoid eating undercooked meats or dairy products such as eggs with un -cooked yokes.			

Appendix H

Check List
Treatment Adherence Peer Education

The purpose:

1. Pre test (base line assessment)
2. Facilitate continuity of care
3. Enhance knowledge of patient in health maintenance activities for the management of HIV
4. Improve patient's involvement in their HIV care
5. Assist patients in making healthy life choices
6. Improve patients attitudes toward antiretroviral therapies
7. Reduce patient fears regarding antiretroviral therapy
8. Reduce patient isolation and decrease stigma

Service	Discussion	Handouts	Video	CD / Internet	Workshop
1. Administer Pre test					
2. Review HIV 101 (viral life cycle)					
3. Review understanding of basic lab tests: CD 4 & Viral Load					
4. Review Resistance & Adherence (Importance of taking medications correctly)					
5. Understanding HAART Medication classes					
6. Understanding and Managing side effects					
7. Understanding HIV terminology					
8. Effective communication with Health Care Provider					
Other:					

SUPPORTIVE HOUSING PROGRAM (SHP)
RENTAL ASSISTANCE GUIDELINES

Goal: Engage 33 HIV/AIDS infected homeless individuals/families in primary medical care with the support of rental assistance and peer counseling in scattered site housing for up to 2 years.

Criteria:
HIV+ or AIDS diagnosis
Individual or family
Homeless as defined by HUD
Willing to live in Missouri
Enrolled in Ryan White Case Management system
Willing to work with a peer counselor at Kansas City Free Health Clinic (KCFHC)
Willing to get medical care at KCFHC in either of following cases:

1. New to medical care (has not been seen anywhere for medical care in KC in the last 2 years and has no 3rd party insurance, e.g. Medicaid, Medicare, private insurance.)
2. Currently receiving medical care (has been seen once within the last year) at KCFHC (3rd party insurance does not apply in this case.)

Participant responsibilities:
Apply for all other permanent subsidy programs, e.g. section 8 and Shelter Plus Care.
Find housing in Missouri that is within Fair Market Rent for household composition.
Pay 30% of their adjusted gross income toward rent and utilities.
Abide by the terms of the lease for minimum of one year.

Program Verification
This collaboration between Save Inc-Supportive Housing Program and KCFHC-Peer Treatment Adherence Program to support housing and treatment adherence for clients will be verified quarterly based on client engagement in services.

SHP Year 1 Verification:
Upon enrollment in SHP and KCFHC's peer treatment adherence program a client will meet with their assigned Peer Counselor **monthly** for the educational component of the peer program and attend scheduled medical appointments. Clients are encouraged to engage in additional support services to meet their identified psychosocial needs such as mental health counseling, substance abuse services, the L.I.F.E. program etc.

Verification of client engagement is completed **quarterly** upon client enrollment in the program and Verification Letters will be completed and sent to case managers by the Peer Program's Treatment Adherence Specialist.

SHP Year 2 Verification:
Clients who continue in the program beyond year 1 will review and sign a Contract for Continued Care at the beginning of year 2. The contract between the peer program and client affirms completion of the peer program's educational component and encourages clients to meet with their assigned peer counselor quarterly (face to face or by phone) and attend scheduled medical appointments. Clients are encouraged to engage in additional support services to meet their identified psychosocial needs such as mental health counseling, substance abuse services, the L.I.F.E. program etc.

Verification of client engagement is completed **quarterly** upon client enrollment in the program and Verification Letters will be completed and sent to case managers by the Peer Program's Treatment Adherence Specialist.

For additional questions/clarification please contact Charity Hope at 816-531-8378 ext. 21 or La Trischa Miles at 816-777-2745.

Appendix I.1.

Supportive Housing Program Verification (Year 1)

Date:

To: Case Manager Name

Regarding: Client Name

_____(Client)has successfully engaged in the following peer sponsored Treatment Adherence services at Kansas City Free Health Clinic within the last quarter.

- ❑ Monthly contact with a Peer Treatment Adherence Counselor
- ❑ Attended a scheduled medical appointment

Additional support services

- ❑ Treatment Adherence Group
- ❑ Mental Health Counseling
- ❑ Substance Abuse Counseling
- ❑ L.I.F.E. Program
- ❑ Cardiovascular Health Promotion and Disease Prevention Program
- ❑ Support or Wellness Group (_____)

Your client may have participated in services related to treatment adherence at a location other than Kansas City Free Health Clinic, such as a L.I.F.E. program offered by another agency or mental health/substance abuse counseling at another location. These services are considered engagement in Treatment Adherence services but can not be verified by Kansas City Free Health Clinic. Verification of these services is the responsibility of the Ryan White Case Manager.

Sincerely,

Peer Treatment Adherence Program

Appendix I.2.

Supportive Housing Program Verification (Year 2)

Date:

To: Case Manager Name

Regarding: Client Name

_____(Client)has successfully engaged in the following Treatment Adherence services at Kansas City Free Health Clinic within the quarter _____(3mth period).

- ❑ Face to Face contact with a Peer Treatment Adherence counselor
- ❑ Attended a scheduled medical appointment
- ❑ Treatment Adherence Group
- ❑ Mental Health Counseling
- ❑ Substance Abuse Counseling
- ❑ L.I.F.E. Program
- ❑ Cardiovascular Health Promotion and Disease Prevention Program
- ❑ Support or Wellness Group

Your client may have participated in services related to treatment adherence at a location other than Kansas City Free Health Clinic, such as a L.I.F.E. program offered by another agency or mental health/substance abuse counseling at another location. These services are considered engagement in Treatment Adherence services but can not be verified by Kansas City Free Health Clinic. Verification of these services is the responsibility of the Ryan White Case Manager.

Sincerely,

Peer Treatment Adherence Program

Attachment II

Discharge Letter

Date

Address

Dear :

Because you are not officially a patient at KC Free, we will have to close you from the peer counseling program. If you would like to discus this matter further, please feel free to contact LaTrischa Miles at (816) 777-2745.

It has been our pleasure working with you.

Sincerely,
Peer Counselor

Attachment II-1

Discharge Letter

Date

Address

Dear :

This letter is to inform you that we are closing your file from the peer counseling program. Since you have not contacted me or my supervisor in over four weeks we are unable to provide adequate peer support. If you would like to discus this matter further, please feel free to contact my supervisor. LaTrischa's number is (816) 777-2745.

I wish you the best and regret that this program did not meet your needs.

Sincerely,
Peer Educator

Attachment II- 2

Discharge Letter

Date

Dear :

We are closing your file from the peer counseling program, however this does not affect any other services you may receive at the Kansas City Free Health Clinic. If you are interested in participating in upcoming support or educational groups please call the peer counseling office for more information (816) 777-2723. It has been our pleasure to provide peer counseling services to you.

Best Wishes,

Peer Educator

Appendix I.3.
Enrollment Letter

Date

RE: Supportive Housing/ Peer Counseling

To whom it may concern:

_____. was enrolled in the Kansas City Free Health Clinic Peer Counseling program on _____. His peer counselor will be _____. We will begin working with _____ in the next week to schedule training and further peer counselor appointments.

If you have any questions please feel free to call the peer counselor at 777-2723 or you may call me at (816) 777-2745

Thank you,

LaTrischa C. Miles.
Treatment Adherence Specialist

Cc: SHP Program Manager
Case Manager
Peer Counselor

Appendix I.4.
Contact Letter-SHP-Year 1

Date

Address

Dear:

I am writing this letter to make contact with you regarding the Peer Counseling Program. As Peer Counselors, we are here to support you as much as we can.
We work as a team with you and other professionals to insure that you receive Quality healthcare and in addition, so that you remain eligible for Supportive Housing assistance by meeting the requirements.

Please call me as soon as possible since we are required to meet at least one time each month.

If you have any questions please feel free to call the Peer Counselor office at 777-2723 or you may call me at (816) 777-2745

Thank you,

LaTrischa C. Miles.
Treatment Adherence Specialist

Cc: SHP Program Manager
Case Manager
Peer Counselor

Appendix I.5.
Contact Letter-SHP-Year 2

Date

Address

Dear:

I am writing this letter to make contact with you regarding the Peer Counseling Program. As Peer Counselors, we are here to support you as much as we can.
We work as a team with you and other professionals to insure that you receive Quality healthcare and in addition, so that you remain eligible for Supportive Housing assistance by meeting the requirements.

Please call me as soon as possible since we are required to meet at least one time every three months.

If you have any questions please feel free to call the Peer Counselor office at 777-2723 or you may call me at (816) 777-2745

Thank you,

LaTrischa C. Miles.
Treatment Adherence Specialist

Cc: SHP Program Manager
Case Manager
Peer Counselor

THE KANSAS CITY FREE HEALTH CLINIC

Policy and Procedure Manual for Treatment Adherence Program

TABLE OF CONTENTS

Vision

Creating solutions for a healthy community

Mission Statement

The purpose of The Kansas City Free Health Clinic is to promote health and wellness by providing quality services, at no charge, to people without access to basic care.

We accomplish this by:

- respecting the dignity of each individual
- serving a diverse community
- providing outreach services within the community
- working collaboratively with volunteers
- fostering individual and community partnerships
- responding to the changing health and wellness needs of the community
- maximizing our financial resources

PATIENT'S BILL OF RIGHTS

These patient rights below have been adopted by the Kansas City Free Health Clinic to ensure collaboration between patients, physicians, volunteers, staff and other health care professionals. The Clinic recognizes that open and honest communication, respect for personal values, and sensitivity to differences is integral to optimal patient care. The Clinic believes that:

- The patient has the right to considerate and respectful care.
- The patient has the right to and is encouraged to obtain from physicians and other direct caregivers relevant, current, and understandable information concerning diagnosis, treatment, and prognosis.
- The patient has the right to make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care and to be informed of the medical consequences of this action.
- The patient has the right to an advanced directive (i.e., a living will, health care proxy, or durable power of attorney) concerning treatment or designating a surrogate decision maker with the expectation of honoring the intent of the directive.
- The patient has the right to every consideration of privacy. Case discussion, consultation, examination, and treatment should be conducted so as to protect each patient's privacy.
- The patient has the right to expect that all communications and records pertaining to his/her private health information and care will be treated as confidential and protected as described in the Clinic's Notice of Privacy Practices
- The patient has the right to consent to or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement and to have studies fully explained prior to consent.
- The patient has the right to review the records pertaining to his/her medical care and to have the information explained or interpreted.
- The Patient has the right to file a grievance if he or she believes any of these rights have been violated.

Patient Confidentiality Policy

Original Policy Date: 12/1999	Policy Number:	Director of Operations:
Policy Title: Patient Confidentiality Policy		Executive Director:
Revised Policy Date: 4/2003	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

Under no circumstances are staff members or volunteers to give out any information regarding the Kansas City Free Health Clinic's patients or former patients to anyone requesting information, unless they have a specific signed release or the Clinic is compelled to do so by law.

In the case of the latter, records requested by law will be handled by the HIPAA Privacy Officer. Discussion of clients for the purpose of case conferencing is intended to be for the purpose of client benefit only, and is not appropriate outside of the facility.

Patient Grievance Policy

Original Policy Date: 12/1999	Policy Number:	Director of Operations:
Policy Title: Patient Grievance Policy		Executive Director:
Revised Policy Date: 4/2003	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

Patients have a right to be satisfied with the services they received through the Kansas City Free Health Clinic. Patients may report complaints, concerns, or problems to any provider, volunteer or staff member.

The staff member receiving the complaint, concern or problem will complete an incident report and forward that report to their supervisor. The supervisor will assure that the appropriate Program Director will receive the report.

The Program Director will discuss the incident with the relevant individuals involved and every effort is made to resolve the issue. The Program Director will note the resolution on the incident report and will discuss the situation with the Executive Director and Director of Operations. The Director of Operations is responsible for maintaining a record of all complaints, concerns or problems.

Complaints not resolved at the Program Director level will be referred to the Executive Director. Complaints not resolved through the Executive Director will be referred to the Director of the Board of Directors.

Interpretive Services Policy

Original Policy Date: 12/1999	Policy Number:	Director of Operations:
Policy Title: Interpretive Services Policy		Executive Director:
Revised Policy Date: 4/2003	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

In an attempt to meet the needs of our diverse patient population, The Kansas City Free Health Clinic will evaluate all patients for interpretive services needs when receiving any services.

Procedure

- Initial evaluation of interpretive services needs may be done during the course of scheduling an appointment. If a patient is identified as speaking any language other than English (including American Sign Language), the scheduler will attempt to identify if the patient will need interpretive services at the time of their appointment.
- The need for and type of interpretive services will be noted in the schedule by reason for visit and reported to the provider with whom the patient is scheduled to see or to the respective Program Director. A note will be written on the contact sheet regarding the need for interpretive services when the chart is pulled for clinic.
- Interpretive Services for Spanish speaking clients are available through volunteers and staff for respective programs or through use of Interlingua.
- Interpretive Services for all other languages are available through a telephone based company called Interlingua.
- The use of an interpreter will be noted in the patient's progress note for that day including name of interpreter and/or interpreter service.
- The provision of interpretative services provided by patient's family or friends is discouraged in order to ensure patient confidentiality.

Policy Statement Regarding the Health Insurance Portability and Accountability Act (HIPAA)

Original Policy Date: 4/2003	Policy Number:	Director of Operations:
Policy Title: HIPAA Policy		Executive Director:
Revised Policy Date: 7/10/2006	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

The Health Insurance Portability and Accountability Act (HIPAA) is a Federal legislation which governs patient privacy and security for all Protected Health Information (PHI). This legislation was written in 1996 and effective for all covered entities April 14, 2003. This Clinic is classified as a covered entity and thus required to follow the guidelines outlined by HIPAA.

The goal of HIPAA is to protect all patient information from unauthorized disclosures to any party not utilizing the information for treatment, payment or operations. When disclosing information for the above, disclose only the minimum amount of PH1 necessary for the party to complete their task. This rule should be recognized when disclosing externally as well as internally. The Clinic has undergone a risk assessment and compliance readiness by Versant Group, Inc., in preparation for HIPAA implementation. Clinic management and employees have had training and education regarding HIPAA. The Clinic has made changes in the physical facility, patient flow and procedure to become compliant with these regulations.

Procedure

HIPAA regulations affect every aspect of the Clinic including but not limited to appointment setting, check-in, patient exams, counseling sessions and medical charting. Any HIPAA procedure would be too vast to outline in this policy and procedure handbook.

Each patient/client of the Kansas City Free Health Clinic will be given a copy of our Notice of Privacy Practices prior to their initial exam or visit. Each person is asked to read and acknowledge their understanding with a signature. This notice outlines the HIPAA legislation and the patient's right to privacy therein.

For specific procedures including the Clinic risk assessment, training handouts, patient flow diagrams and HIPAA policy and procedures, see the Director of Operations for the complete HIPAA guidebook. Issues regarding the check-in and appointments, please refer to the Front Office Policy and Procedure Manual.

Termination of Patient/Client from Clinic Services

Original Policy Date: January 2007	Policy Number:	
Policy Title: Termination of Patient/Client from Clinic Services		Executive Director:
Revised Policy Date:	Policy Relevant to: All Staff and Volunteers	Addendum:

Purpose

This policy delineates the circumstances under which a patient or client may be terminated from all Clinic services. Please see separate policy for discharge from specific programs for eligibility issues, behavioral problems, and non-adherence to treatment plans.

Policy

It is the responsibility of the Clinic to assure that all Clinic services are provided within a safe and secure environment.

Patients/clients may exhibit behavior which threatens the safety and security of the environment and may threaten the safety of staff, volunteers, visitors and other patients/clients. Such behavior may include but is not limited to: threats of physical violence towards staff, volunteers, patients, clients, visitors; possession of or brandishing a weapon in the Clinic buildings or on Clinic property; threats of property damage; or other behavior which threatens the safety and security of the Clinic environment.

Patients/clients exhibiting such behavior may be terminated from all services at the Clinic.

The decision to terminate a patient/client from services will be the responsibility of the Director of Finance and Administration.

Procedure

1. Incident/behavior/threat is observed by staff.
2. Staff member reports the situation to immediate supervisor. Immediate supervisor determines if situation poses a threat to the safety and security of the Clinic environment or to staff, volunteers, visitors or other patients/clients. If so, the immediate supervisor reports the situation to the department director.
3. Department Director takes immediate action, which may include suspension of services pending further investigation, notification of authorities or other appropriate action, to secure the environment and the safety of staff, volunteers, visitors and patients/clients.

4. Department Director reports situation to the Director of Finance and Administration and requests that the Termination of Services committee meets to review the situation.
5. Department Director determines if other departments are providing services to the patient/client and informs the appropriate Director(s) of the situation and request for termination of services.
6. Termination of Services committee meets within 3 working days of the request.
7. Termination of Services committee reviews the incident. Information the committee may consider will include, but is not limited to:
    - Observation of incident by staff, volunteers, visitors or other patients/clients
    - Reports from program staff providing services to patient/client
    - Reports from other staff with first hand knowledge of the patient or client being considered for termination
8. Termination of Services committee makes recommendation to the Director of Finance and Administration regarding action to be taken.
9. Director of Finance and Administration makes final decision and reports to Executive Director.
10. Director of Finance and Administration reports action to all programs providing services to the patient/client.
11. Director of Finance and Administration notifies patient/client of termination from services by sending a certified letter. Patient/client is informed of the Clinic's grievance policy and a copy of the policy is included in this letter.
12. Documentation of incident, work of the Termination of Services committee and recommended action is kept on file in the Department of Finance and Administration.
13. Events leading to termination from services and the actions taken as a result of these events are documented in patient/client's program files or records.
14. Return to services at the Clinic may be considered on a case by case basis after a minimum of 6 months termination based upon the date of the termination letter.

Composition of Termination of Services committee

Chair: Director of Finance and Administration

Members: At least 1 Department Director
At least 1 Manager
At least 2 staff member
At least one Consumer Advisory Council member

Advisor: Human Resources Manager

Integration of Peer to Peer Treatment Adherence Program with HIV Primary Care Services

HIV Clinical Director	Policy Number:	Original Policy Date: January 2003
Executive Director:		Revised Policy Date: September 2, 2009
Policy Title: Integration of Peer Treatment Adherence Program with HIV Primary Care Services	Policy Relevant to: All Primary Care staff and volunteers	Addendum:

Policy

The Peer Treatment Adherence Program is an integral part of HIV Primary Care Services. Successful self management of HIV disease requires many interventions, supports, tools and resources. Peer to Peer Treatment Adherence is available to every client of HIV Primary Care Services.

Procedure

- The Treatment Adherence Specialist is a member of the HIV Primary Care Services staff and attends staff meetings and Primary Care/Case Management Case Conferences.
- The Treatment Adherence Specialist is responsible for the delivery of all Treatment Adherence Services either directly or through the Peer Educators.
- Peer Educators communicate directly with HIV Primary Care Services staff, students and volunteers regarding their individual clients or other assigned duties.
- The Treatment Adherence Specialist acts as a liaison between the Peer Educators and Primary Care staff, students and volunteers when needed.
- Peer Educators are available on site daily.

Recruitment and Training of Peer Educators

Director of Operations	Policy Number:	Original Policy Date: January 2003
Executive Director:		Revised Policy Date: September 2, 2009
Policy Title: Recruitment and Training of Peer Educators	Policy Relevant to: Primary Care staff, volunteers, Human Resource Manager and Volunteer Manager	Addendum:

Policy

Peer Educators are integral to the Treatment Adherence Program and provide specialized services in a professional environment.

Procedure

- Recruitment and hiring of Peer Educators follows the standard processes and is the responsibility of the Human Resources Manager.
- Recruitment of volunteer Peer Educators is a collaborative effort between the Volunteer Manager and Treatment Adherence Specialist.
- Recruitment will occur in collaboration with the Treatment Adherence Specialist and will include a variety of methods to reach communities reflective of the demographics of the HIV epidemic. These may include, but are not limited to, personal recruitment, advertisements in community publications, flyers, announcements at meetings and other community events, and targeted community recruitment.
- The Treatment Adherence Specialist is responsible for training and supervising staff and volunteer Peer Educators. Training of new Peer Educators will include the following:
- Peer Educator expectations including program guidelines, and confidentiality
- Training of FACTORS and Ridgemark Database
- People to People level I and II curriculum that includes:
  - HIV 101
  - Viral Life Cycle
  - Understanding HAART, common and long term side effects to medications
  - Understanding Drug Resistance and Problem Solving Adherence Strategies
  - Understanding and Making sense of Lab Values
  - Communication Skills
  - Impact of Stigma and Engagement in Care
  - Cultural Competency
  - Workplace Expectations

- Role Playing application of skills acquired
- Continued education for Peer Educators occurs in the following ways:
- Onsite training
- State and National Conferences
- Community Forums
- Assigned readings with Q&A assignments
- Video
- Teleconference

Roles and Responsibilities of Peer Treatment Educators

Director of Operations	Policy Number:	Original Policy Date: January 2003
Executive Director:		Revised Policy Date: September 3, 2009
Policy Title: Roles and Responsibilities of Peer Treatment Educators	Policy Relevant to: All Peer Staff	Addendum:

Policy

Peer Educators provide specialized, professional services designed to enhance adherence to treatment and engagement in HIV primary care. These services are individual, population and community based.

Procedure

- Each Peer Educator is assigned a case load of clients by the Treatment Adherence Specialist.
- Peer Educators are part of the health care team and participate in the clinic's weekly multidisciplinary team meeting
- Under the supervision of the Treatment Adherence Specialist and in collaboration with the client, a plan of care is developed.
- This plan is documented on the FACTORS database and is updated at regular intervals.
- Peer Educators document in the FACTORS database after each individual or group client level intervention
- Requirements for client contact are tailored to meet the individualized needs of the client.
- Clients will receive information related to HIV disease and its treatment, including treatment options, risks, benefits, expected outcomes, potential side effects, adherence strategies and educational resources as determined.
- A variety of education information and modalities are available dependent upon the client's learning style and preference. These include:
  - Written materials (pamphlets and books) in English and Spanish
  - Videos and CD's in English and Spanish
  - Computer with Internet access
  - Audiotapes in English and Spanish
  - One on one education with Peer Educators
  - Educational and informational group meetings and training opportunities
  - A variety of adherence tools are available for use dependent upon the client's preference. These include:
  - Single dose, daily and weekly pill boxes

    - Calendars
    - Alarm wrist watches
    - Water Bottles
    - Magnets with clinic contact information
- Peer Educators prepare medical charts for next day HIV Primary Care appointments
- Peer Educators perform appointment reminders and did not keep appointment follow up phone calls for all patients of HIV Primary Care Services.
- Peer Educators provide *Just In Time* meetings with clients who want one time emotional support
- Peer Educators plan, market and prepare for facilitation of group level education-*Adhering to Wellness Groups (*quarterly*)*
- Peer Educators plan and co-facilitate the *Monthly Support Group*
- Peer Educators provide staff support at the weekly *Substance Abuse Group*
- Peer Educators update clinic examination rooms with educational materials
- Each Peer Educator maintains at least 5-32 office hours per week.

Peer Program Hours of Operation

Original Policy Date: 1/2003	Policy Number:	Director of HIV Primary Care:
Policy Title: Peer Program Hours of Operation		Executive Director:
Revised Policy Date:	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

To define set hours of operation for Peer Program Services.

Procedure

- Peer Program Services are available Monday through Friday 9:00 am to 5:00 pm and Wednesday until 7:00 pm.
- Services are provided preferable by appointment; however are offered as requested during business hours.

Policy for Appointment Reminder and Follow up Phone Calls for HIV Primary Care Services

HIV Clinical Director	Policy Number:	Original Policy Date: January 2003
Executive Director:		Revised Policy Date:
Policy Title: Appointment Reminder and Follow up Phone Calls for HIV Primary Care Services	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

Patient privacy and confidentiality is a priority of HIV Primary Care Services. Therefore, all patients at each visit are asked to verify phone numbers and permission to call and/or leave messages. All patients, from whom we have received permission, will receive appointment reminder phone calls. All patients, from whom we have received permission, will receive a follow up phone call for all missed appointments.

Procedure

- The Peer to Peer Treatment Coordinator is responsible for assuring that all reminder and follow up phone calls occur.
- Peer to Peer Treatment Advocates will place reminder phone calls to all scheduled patients.
- The Treatment Advocates will obtain a listing of the next day's scheduled patients from the HIV Primary Care Services clinical assistant.
- Treatment Advocates will pull each patient's chart and review patient information sheet (See Attached) to determine appropriate phone number to call and ascertain if we have permission to call.
- Treatment Advocates will place the call.
- Treatment Advocates will check the previous day's appointment log and schedule to determine any patient who did not keep their appointment.
- Treatment Advocates will pull each patient who did not keep an appointment chart and review patient information sheet to determine appropriate phone number to call and ascertain if we have permission to call.
- Treatment Advocate will place the call. In their conversation with the patient, or in the message left for the patient, they will ask the patient to call and reschedule the appointment. They will also offer to discuss barriers to not keeping the appointment and offer to assist the patient in eliminating those barriers.

KANSAS CITY FREE HEALTH CLINIC
HIV SERVICES
PATIENT INFORMATION RECORD

Please Print your name, address and phone numbers and answer the questions on the following lines.

NAME: _____ NICKNAME:_____
(please print)

ADDRESS: _____
(Street)

_____ OK to receive mail: yes___ no___
(City, Zip)

PHONE: Home: _____ OK to leave a message: yes____ no____
Work:_____ OK to leave a message: yes____
no____

May we have the name of someone to contact in case of emergency?
Do they know of your HIV status? Yes___ No ___

Name: _____

Address:_____

_____

Phone:_____

Do you have insurance? no___ yes____ Name and insurance
#_____

Do you have Medicaid? no___ yes___ Medicaid
#_____

Do you have Medicare? no___ yes___ Medicare
#_____

Referral of Clients to Treatment Adherence Program

HIV Clinical Director	Policy Number:	Original Policy Date: 2-3-09
Executive Director:		Revised Policy Date: September 3, 2009
Policy Title: Referral of Clients to Treatment Adherence Peer Program	Policy Relevant to: Primary Care and Case Management Staff	Addendum:

Policy

All HIV Primary Care Services patients benefit from the Treatment Adherence Program and some may benefit from the establishment of a Peer Educator to client relationship.

Procedure

- HIV Primary Care (including Pharmacist), Case Management and Behavioral Health staff may refer clients to the Peer Treatment Adherence program.
- Clients may self refer to the Peer Treatment Adherence program
- All new patients are referred to the Treatment Adherence Specialist by the second visit for assessment of need for services.
- Referrals are communicated verbally or through a FACTORS referral to the Treatment Adherence Specialist.
- The Treatment Adherence Specialist is responsible for the assessment of referred clients to determine their suitability for the program, identification of needs to be met by the program, and assignment to the appropriate Peer Educator.

Client Intake for Treatment Adherence Program

HIV Clinical Director	Policy Number:	Original Policy Date: 2-3-09
Executive Director:		Revised Policy Date: September 3, 2009
Policy Title: Client Intake for Treatment Adherence Program	Policy Relevant to: All Staff	Addendum:

Policy

To define the intake process for all patient referrals received by the Treatment Adherence Specialist and establishment of a Peer Educator to client relationship.

Procedure

- HIV Primary Care (including Pharmacist), Case Management and Behavioral Health staff refer clients to the Peer Treatment Adherence program
- The Treatment Adherence Specialist accepts referrals in the FACTORS database after client assessment to determine their suitability for the program and identification of needs to be met by the program, and assigns to a Peer Educator
- The assigned peer educator makes contact with the referred client within 5 business dates. Contact with the client is documented in FACTORS database.

Documentation of Peer Program Services

Original Policy Date: 1/2006	Policy Number:	Director of HIV Primary Care:
Policy Title: Documentation of Peer Program Services		Executive Director:
Revised Policy Date:	Policy Relevant to: Peer Program Staff and Volunteers	Addendum:

Policy

To identify structure for documentation of services provided to clients in the peer program.

Procedure

- Peer Educators will maintain confidentiality of physical files in a protected lock system.
- Peer Educators will maintain confidentiality of computer files with a password protected system
- Peer educators will document program services rendered to clients in electronic client record (FACTORS) within five (5) business days. Services not recorded on the day they occur are delayed entries. They will be entered as soon as possible.
- Client records cannot be altered after the notes screen is closed. If any errors are found in a client's electronic record, a notation should be made that it is not a part of that client's record and should not be considered.
- Safeguard the confidentiality of clients at all times by keeping files closed, turning computer screen away from public view, using fax covers sheets marked "confidential", and included client names only in password protected emails.
- Documentation of time with clients will be completed in the encounter log. Time is recorded in 10-minute increments. Multiple interactions with a client in a single day maybe bundled in a single encounter that records total time expended. Peer Educators should only use J-Codes to record their time encounters.

Documentation of Client Treatment Adherence Goals

Original Policy Date: 12-2008	Policy Number:	Director of HIV Primary Care:
Policy Title: Documentation of Treatment Adherence Goals		Executive Director:
Revised Policy Date:	Policy Relevant to: Peer Program Staff and Volunteers	Addendum:

Policy

To identify structure for documentation of Client Treatment Adherence Goals that is the tool for delivery of client services.

Procedure

- Peer Educator will meet with client to assess client needs based on program services over the 3-6 month program timeline.
- The client and Peer Educator will work collaboratively to identify goals to work towards in the peer/client working relationship.
- The client and Peer Educator will explore interventions to meet client goals such as individual interventions, groups-Support Group, Adhering to Wellness and other Community Educational Programs.
- Goals will be reviewed every 3 months to assess achievement, revision and identification of additional goals.

Supervision of Peer Educators

Director of Operations		Policy Number:	Original Policy Date: January 2003
Executive Director:			Revised Policy Date: September 2, 2009
Policy Title: Supervision of Peer Educators	Policy Relevant to: Peer Program		Addendum:

Policy

Peer Educators will receive supervision by the Treatment Adherence Specialist to support provision of quality client services.

Procedure

- The Treatment Adherence Specialist will provide weekly supervision to Peer Educators to review their client case load.
- Supervision will include review of administrative duties, clinical support given to patients and assess peer educator needs in delivery of client services.
- The Treatment Adherence Specialist will randomly audit peer educator encounters in FACTORS for quality management purposes. Outcome from audit will be utilized for quality improvement.
- The Treatment Adherence Specialist will plan and coordinate monthly team meetings to increase communication with team members, plan client groups, identify gaps in peer program services and conduct client case conferences.

Supervision of Treatment Adherence Specialist

Director of Operations		Policy Number:	Original Policy Date: January 2003
Executive Director:			Revised Policy Date: September 2, 2009
Policy Title: Supervision of Peer Treatment Adherence Specialist	Policy Relevant to: Peer Program		Addendum:

Policy

The Treatment Adherence Specialist will receive supervision from Peer Program Manager to encourage quality delivery of supervision to Peer Educators and client services.

Procedure

- The Peer Program Manager will provide weekly supervision to the Treatment Adherence Specialist.
- Supervision will include review of administrative duties, assess delivery of services by peer educators to clients and identify program needs.
- The Peer Program Manager will randomly audit peer educator encounters in FACTORS for quality management purposes. Outcome from audit will be utilized for quality improvement.
- The Peer Program Manager will attend monthly team meeting to increase communication with team members, assess delivery of peer program services and conduct client case conferences.

Multidisciplinary Team Meeting

Original Policy Date: 1/1/2003	Policy Number:	Director of Operations:
Policy Title: HIV Case Conference/Consultation		Executive Director:
Revised Policy Date: 7/1/2006, 10/22/09	Policy Relevant to: HIV Primary Care	Addendum:

Purpose

Multidisciplinary care is the hallmark of high quality HIV comprehensive care and is demonstrated in the Multidisciplinary team meeting. The Kansas City Free Health Clinic hosts "Multi-D", a crucial element for the Clinic's comprehensive care model.

The intent of Multi-D is to prospectively review client care and make professional recommendations on how to best support engagement in care and ability to adhere to treatment.

Regardless of the location of the client's Case Management services, all HIV Primary Care clients should have the opportunity to have their care services reviewed in a Multi-D meeting.

PRIMARY FUNTIONS

- Gain a comprehensive picture of the client's HIV care and progress. This contributes to collaboration among providers to ensure appropriate referrals, timely coordination and accountability (including client's own accountability)
- Contribute to providers' knowledge of the client's abilities, resources and past success related to self-management of health care. These "strengths" can be recruited to support the client's engagement in care and treatment;
- Contribute to team's knowledge of the client's current or potential barriers to care. Barriers include:
    - health and medically related diagnosis,
    - psychosocial concerns that inhibit the client's ability or motivation to engage in care (i.e. substance use, mental illness, basic needs, informal supports, living arrangements, transportation, payor sources);
- Track accountability to communicate concerns to the client, recruit for support services, or enroll in programs.

SECONDARY FUNCTIONS

- Provide a forum for the continuing education of multidisciplinary team of health and social service professionals
- Share data for program requirements (i.e. lab results, access to ARVs, risk reduction activities, adherence assessment, eligibility criteria review, etc)
- Contribute to innovation, research and participation in HIV programs and services

Participation for Peer Educators

IDENTIFY CLIENTS

1. Identify the clients in HIV Primary Care at the Kansas City Free Health Clinic.
2. Identify clients to be "case conferenced" and provide list to one of the Multi-D Facilitators
3. Clients "case conferenced" are chosen based on:
    a. Newly enrolled (since last meeting)
    b. 6-month time span since last formal case conference
    c. Update/Change in client's status, care or eligibility

PREPARING FOR AND ATTENDING MULTI-D

1. Multi-D meeting s-Wednesday at 11:00am
2. Peer Educators are expected to be knowledgeable of the client's psychosocial situation, financial access to care, services accessed, treatment adherence, transmission risks, etc.

Continuing Education for HIV Primary Care Services Staff

HIV Clinical Director	Policy Number:	Original Policy Date: January 2003
Executive Director:		Revised Policy Date:
Policy Title: Continuing Education for HIV Primary Care Services	Policy Relevant to: All Staff and Volunteers	Addendum:

Policy

Continuing Education is a responsibility of all HIV Primary Care Services staff. Education relevant to HIV disease, its treatment, co-morbidities, psycho-social aspects, public policy issues and professional development will be encouraged and supported by the Clinic.

Procedure

- Each staff member is responsible for identifying their learning needs and registering and attending appropriate activities.
- Each staff member is responsible for reporting this activity on a monthly basis to the Director of HIV Primary Care.
- Each staff member is responsible for maintaining records of their educational activities.
- Educational activities may include academic classes, on line classes or seminars, video tapes, written continuing education materials, pharmaceutical company sponsored events, seminars or other educational activities.
- Each staff member will receive up to 16 hours of paid leave per year to attend these activities.
- Registration fees for local educational activities will be paid for by the Clinic as funding permits and as approved by the Director of HIV Primary Care.
- Out of state activities will be approved on a case by case basis by the Director of HIV Primary Care Services. Relevance to the practice, availability of funding and previous attendance at out of state activities will be considered in the decision making.

Peer Program Completion or Discharge Policy and Procedure

HIV Clinical Director	Policy Number:	Original Policy Date:
Executive Director:		Revised Policy Date: September 2009
Policy Title: Peer Program completion or discharge Policy and Procedure.	Policy Relevant to: Peer Program Staff	Addendum:

Policy

Client completion or discharge from the peer program is a client driven process. The decision will be made collaboratively between the client and peer educator, unless the client is unresponsive to attempts made by peer educators to engage in the program. All clients, from whom we have received permission, will receive a discharge letter in the mail. Peer Educators will notify the health care team of discharge.

Procedure

- The peer educator and client will assess client's success and challenges with achievement of identified goals. If all goals are achieved client will be discharged and invited to receive group level program support.
- If client is no longer willing to work towards achievement of goals, the client and peer educator will agree to discharge from the program with option to re-engage in the program at another time.
- Peer educators will make 4 attempts to engage the client in the program upon receipt of program referrals. At the last attempt it will be documented that client is unresponsive and referral source will be notified of discharge.
- Client will be discharged upon relocation outside of the Kansas City TGA
- Client will be discharged from the program if terminated from all agency services.
- Peer educators will send discharge letter to clients with whom there is permission to receive mail.
- Peer Educators will notify the health care team (Case Manager, BH Team, and Primary Care Team) of discharge from the program.
- Discharge from the program will be documented in the FACTORS database

Completion of the program is a client driven process.

Sample Confidentiality Agreement

As a client of _____ and a participant in the _____ Peer Advocate Program, you can expect to receive peer support that is professional, respectful, and trustworthy.

Professional peer support means that you can expect your Peer Advocate to maintain a confidential relationship with you. She will not share information about you with anyone outside of WORLD without your consent. There is, however, an exception to this rule. Confidentiality may be waived if your safety or the safety of someone close to you is in question. If questions of safety arise, she will contact either your FCN case manager or another professional for assistance. In most cases, the peer advocate will let you know if she plans to speak with your case manager.

Respectful peer support means that you can expect your Peer Advocate to honor your privacy. You may choose to share many personal topics with your Peer Advocate; however, you need only to share personal information if and when you feel comfortable.
At times, she may offer advice or suggestions, but she will keep in mind that you know what is best for you.

Trustworthy peer support means that you can expect your Peer Advocate to follow through with the support that she offers to you. She will be on time and listen to you during your time together. Time spent together may include peer counseling, accompaniment to doctor visits, visits to your home, phone check-ins, and other activities as decided upon by you and your Peer Advocate.

<u>As a client of our organization, you are encouraged to speak with your Peer Advocate if you have questions, concerns or complaints about the program.</u>

By signing below, you and your Peer Advocate are agreeing to the above guidelines. You also are indicating your understanding of the standards inherent in the peer advocate/client relationship:

Client:
Print Name _____

Signature _____ Date _____

Peer Advocate:
Print Name _____

Signature _____ Date _____

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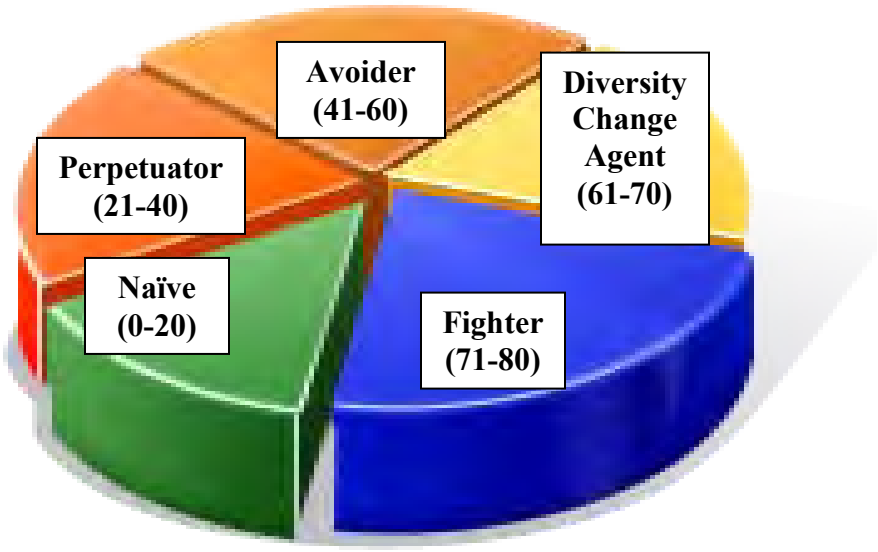
Awareness Spectrum[1]



Naïve – Acts with no knowledge or awareness of biases and prejudices and their impact.

Perpetuator – Aware of biases and prejudices, but continues behaviors and reinforces and rewards bigotry.

Avoider – Aware of biases and prejudices, but does nothing and plays it safe. Tolerates unjust behavior. Silently condones continuation of inappropriate behavior.

Fighter – Attacks all actions and confronts all behaviors. On the lookout for prejudice.

DIVERSITY CHANGE AGENT - Acts as a role model. Takes action when appropriate and addresses behaviors when important. Takes risks. Generates dialogues for connections

[1] http://wastatecouncil.shrm.org/webmodules/webarticlesnet/articlefiles/8-Awareness Spectrum.doc

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Diversity Change Agent[2]

A diversity change agent takes action when appropriate and addresses inappropriate behaviors when important. A diversity change agent acts as a role model. Becoming a diversity change agent often takes personal courage.

Talk to yourself about it….first ***Ask yourself:*** Are any of my biases getting in the way? Am I overreacting? Is a response appropriate? Am I prepared to focus on specific behavior?	**Address the issue…the real issue** Set up a private meeting Be direct and honest Demonstrate empathy Describe the facts as you know them Voice your perceptions and feelings clearly Be specific. Have hard data. Describe your feelings, thoughts, and perceptions Explain Impact Make "I" statements ("you" statements place blame). Avoid reprimand "I don't feel like we are working together as well as we could. Do you?"
Listen and ask "What is your perception of the situation?" Listen without judging. "What do you need from me in order to succeed?" What in the environment is getting in the way? Observe behaviors and listen to conversations of your co-workers. Respect different points of view.	**Keep an open mind** Acknowledge your mistakes and learn from them. Be forgiving when others make mistakes. Determine level of comfort with the interaction Establish ongoing communications Appreciate differences…all kinds of differences Don't take yourself too seriously. Realize that risk taking is a big part of being a Diversity Change Agent.

[2] http://wastatecouncil.shrm.org/webmodules/webarticlesnet/articlefiles/8-Awareness Spectrum.doc

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Cultural Competence Model by Terry L. Cross

1. Cultural destructiveness is at the far negative end of the spectrum while cultural proficiency represents the positive end of the continuum.

2. Cultural Destructiveness: It refers to the blatant attempts to destroy the culture of a given group. There is also an assumption that one group is superior to another."[1] It acknowledges only one way of being and purposefully denies or outlaws any other cultural approaches.

3. Cultural incapacity: "An individual or organization lacks the capacity to be responsive to different groups, but this is not intentional. Ignorance and unfounded fear is often the underpinning of the problem."[2] Incapacity might consist of the failure to recognize when mistreatment is due to cultural differences thereby perpetuating its occurrence.

4. Cultural Blindness: "People who are culturally blind are ignorant of cultural differences and often perceive themselves as "unbiased". This is due to the fact that they believe that "culture makes no difference" in relation to the way the group acts or reacts."[3] Cultural blindness fosters the assumption that people are all basically alike, so what works with members of one culture should work with members of all other cultures.

5. Cultural Pre-competence: "This implies the movement towards cultural sensitivity. In this phase individuals actively pursue knowledge about differences and attempt to integrate this information into delivery of services. There is a recognition that cultural differences exist but those differences are acknowledged as "differences" and nothing more.[4]

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Cultural pre-competence encourages learning and understanding of new ideas and solutions to improve performance or services.

6. Cultural competence:
"In this phase the organization or individual has the capacity to function in an effective manner within the context of the targeted group. Acceptance and respect of differences, continual self-assessment, attention to dynamics of differences, and continual expansion of knowledge about the target group are important factors of competency."[i] Cultural competency involves actively seeking advice and consultation and a commitment to incorporating new knowledge and experiences into a wider range of practice.

7. Cultural Proficiency: Cultural proficiency is at the positive end of the continuum. It is where health and human service providers should strive to be. It involves pro-actively regarding cultural differences and promotes improved cultural relations among diverse groups. "Individuals in this category hold culture in very high esteem and they are regarded as specialist in developing culturally sensitive practices."[ii]

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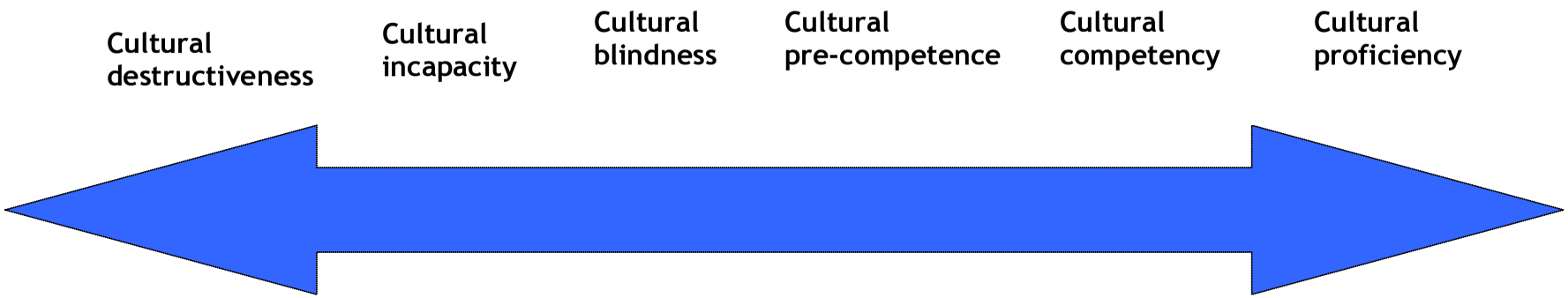
Cultural Competence Model by Terry L. Cross



Material taken from Building Bridges to Cultural Competency NYSDOH – AIDS Institute

Diversity and Human Rights Consortium:

What is Cultural Competency?

by Jason Mak, Lane Community College E-mail: makj@lanecc.edu

Cultural competence is defined as an **ongoing process** by which *individuals* and *systems* respond respectfully and effectively to people of all cultures, languages, classes, races, sexes, ethnic backgrounds, religions, sexual orientations, abilities and other diversity factors "in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each." (NASW, 2001)

Operationally speaking, culturally competent organizations and individuals are able to integrate and transform knowledge about diverse groups of people into "specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes." (Davis & Donald, 1997)

There are many developmental models of cultural competency in the multi-disciplinary field of diversity. However, a commonly used and referenced model has been the Cross Model. The Cross Model of Cultural Competence by Terry Cross (1988) offers both an institutional and individual framework to help gauge progress on various diversity initiatives. It describes cultural competency as movement along a continuum that is based on the premise of respect and appreciation of individuals and cultural differences. It is important to note that institutions and individuals can be at different stages of development *simultaneously* on the Cross continuum. For example, an institution or an individual may be at the Basic Culturally Competent stage with reference to race, but be at the Cultural Incapacity stage with regard to sexual orientation issues. Striving to approach the stage of "Advanced Cultural Competency" for all dimensions of diversity should be the goal of all DHRC partners as we seek to meet the needs of all of our clients and constituents.

Below is the continuum of the Cross Model. Note that while some of the labels used by Cross for the stages of cultural competence are inappropriate (e.g., "blindness"), the model is still useful to help guide the development of cultural competency trainings, policies and other action plan items for the DHRC as it addresses both the personal and systemic characteristics of each stage.

The Cross Model consists of six stages:

1. Cultural Destructiveness;
2. Cultural Incapacity;
3. Cultural Blindness;
4. Cultural Pre-Competence;
5. Basic Cultural Competence; and
6. Advanced Cultural Competence.

1. Cultural Destructiveness

This is the most negative end of the continuum. Individuals in this phase:

a) view culture as a problem;
b) believe that if culture or population can be suppressed or destroyed, people will be better off;
c) believe that people should be more like the "mainstream"; and
d) assume that one culture is superior and should eradicate "lesser" cultures.

At the organizational level, this viewpoint taken to the extreme leads to such things as genocide and the boarding schools mandated in the late nineteenth and early twentieth centuries by the Bureau of Indian Affairs. These schools attempted to destroy the cultures of many Native American tribes.

2. Cultural Incapacity

Individuals in this phase:

a) lack cultural awareness and skills;
b) may have been brought up in a homogeneous society, been taught to behave in certain
ways, and never questioned what they were taught;
c) believe in the racial superiority of a dominant group and assume a paternalistic posture toward others; and
d) maintain stereotypes.

At the organizational level this translates into supporting segregation or having lower expectations of persons from other cultures.

3. Cultural Blindness

Individuals in this phase:

a) see others in terms of their own culture and claim that all people are exactly alike;
b) believe that culture makes no difference ("we are all the same"); and
c) believe that all people should be treated in the same way regardless of race, etc.

At the organizational level, services are so ethnocentric that they are virtually useless to all but the most assimilated.

4. Cultural Pre-Competence

Individuals in this phase:

a) recognize that there are cultural differences and start to educate themselves and others concerning these differences;
b) realize their shortcomings in interacting within a diverse environment; but
c) may become complacent in their efforts.

At the organizational level, this phase leads institutions to attempt to address diversity issues by, for instance, hiring a diverse staff, offering cultural sensitivity training, promoting diverse staff to upper management, and so on.

5. Basic Cultural Competence

Individuals in this phase:

a) accept, appreciate, and accommodate cultural differences;
b) value diversity and accept and respect differences;
c) accept the influence of their own culture in relation to other cultures;
d) understand and manage the dynamics of difference when cultures intersect; and
e) are willing to examine components of cross-cultural interactions (communication, problem solving, etc.).

At the organizational level, this phase leads to an effort to hire unbiased employees, to seek advice from communities of color (and others), and to assess what can be provided to diverse clients.

6. Advanced Cultural Competence

Individuals at this phase:

a) move beyond accepting, appreciating, and accommodating cultural difference and begin actively to educate less informed individuals about cultural differences; and

b) seek out knowledge about diverse cultures, develop skills to interact in diverse environments, and become allies with and feel comfortable interacting with others in multicultural settings.

At the organizational level, this translates into conducting research on diversity, hiring staff who are specialists in cultural competence practices, and acting as an advocate for historically underrepresented groups and for multiculturalism.

In surveying different models of cultural competency, listed below are the basic set of common skills that individuals need to interact in a culturally competent manner: (Anand, 2000)

1. Being aware of one's own culture, values, and biases.
2. Being aware of and working at controlling own biases and how these may affect interactions with others.
3. Culture-specific knowledge.
4. Knowledge of institutional barriers that prevent some populations from accessing resources.
5. Ability to build strong cross-cultural relationships and to be at ease with difference.
6. Flexibility and ability to adapt to diverse environments.
7. Ability and willingness to be an ally to individuals who are different from oneself.
8. Effective communication skills across differences.
9. Able to mediate cross-cultural conflicts.

Remember that cultural competency is much less an outcome than it is a process that seeks to continually improve and adapt interactions, relationships, services, coalitions, and planning for a more equitable, caring and inclusive future.

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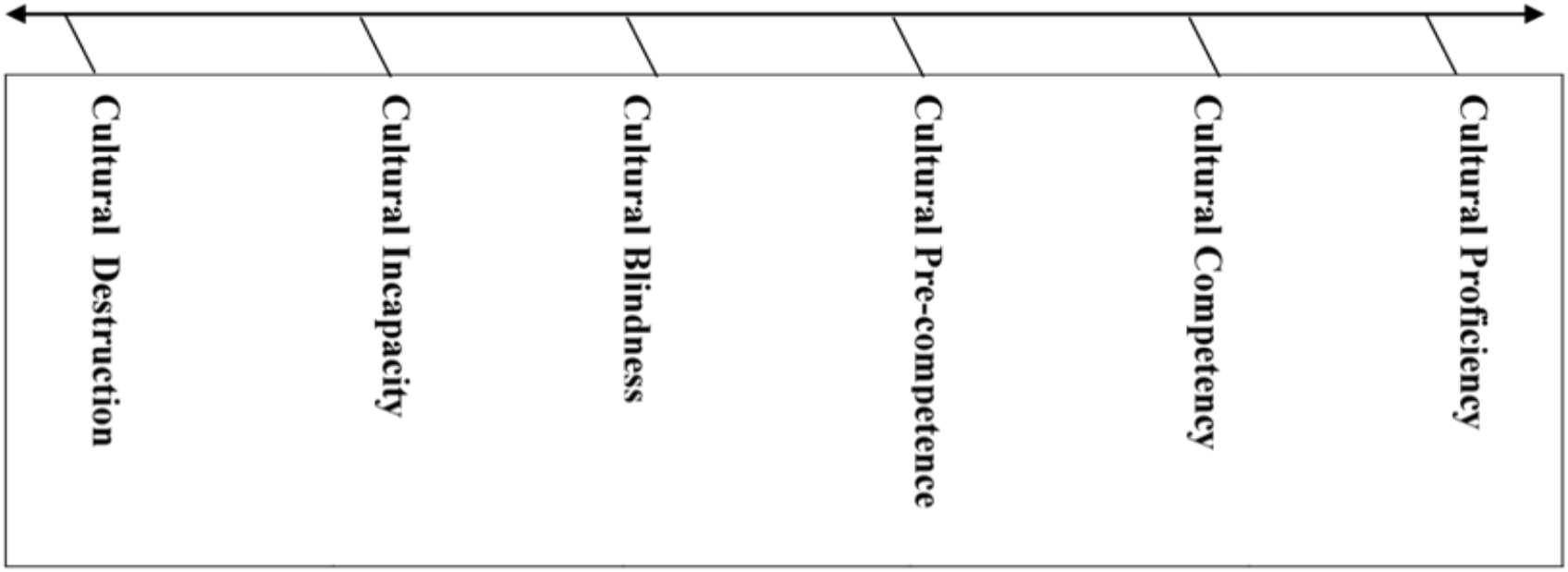
Terry Cross' Cultural Competence Model



Building Bridges to Cultural Competency – Module II,
Trainer Manual
NYSDOH – AIDS Institute

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Cultural Competence Model by Terry L. Cross[1]

1. **Cultural destructiveness is** at the far negative end of the spectrum while cultural proficiency represents the positive end of the continuum.
2. **Cultural Destructiveness:** It refers to the blatant attempts to destroy the culture of a given group. There is also an assumption that one group is superior to another." It acknowledges only one way of being and purposefully denies or outlaws any other cultural approaches.
3. **Cultural incapacity:** "An individual or organization lacks the capacity to be responsive to different groups, but this is not intentional. Ignorance and unfounded fear is often the underpinning of the problem." Incapacity might consist of the failure to recognize when mistreatment is due to cultural differences thereby perpetuating its occurrence.
4. **Cultural Blindness:** "People who are culturally blind are ignorant of cultural differences and often perceive themselves as "unbiased". This is due to the fact that they believe that "culture makes no difference" in relation to the way the group acts or reacts." Cultural blindness fosters the assumption that people are all basically alike, so what works with members of one culture should work with members of all other cultures.
5. **Cultural Pre-competence:** "This implies the movement towards cultural sensitivity. In this phase individuals actively pursue knowledge about differences and attempt to integrate this information into delivery of services. There is a recognition that cultural differences exist but those differences are acknowledged as "differences" and nothing more. Cultural pre-competence encourages learning and understanding of new ideas and solutions to improve performance or services.
6. **Cultural competence:** "In this phase the organization or individual has the capacity to function in an effective manner within the context of the targeted group. Acceptance and respect of differences, continual self-assessment, attention to dynamics of differences, and continual expansion of knowledge about the target group are important factors of competency." Cultural competency involves actively seeking advice and consultation and a commitment to incorporating new knowledge and experiences into a wider range of practice.
7. **Cultural Proficiency:** Cultural proficiency is at the positive end of the continuum. It is where health and human service providers should strive to be. It involves pro-actively regarding cultural differences and promotes improved cultural relations among diverse groups. "Individuals in this category hold culture in very high esteem and they are regarded as specialist in developing culturally sensitive practices."

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[1] SISTA Community Facilitator Manual. *What is Culture?* Marilyn Moering, Jo-Anne Hoye. June 2004.

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Cultural Competence Continuum: Agencies and Professionals

Cultural Destructiveness (is intentionally destructive)	**Cultural Incapacity** (is not intentionally destructive but lacks capacity to help people of color)	**Cultural Blindness** (expresses a philosophy of being unbiased)	**Cultural Pre-Competence**	**Basic Cultural Competence**	**Advanced Cultural Competence**
-- practices cultural genocide (e.g. Boarding schools for Native Americans)	--takes paternal posture toward "lesser" races	--believes that color or culture make no difference; we're all the same	--realizes its weaknesses in serving minorities and attempts to make specific improvements	--has acceptance and respect for differences	--holds culture in high esteem
--dehumanizes or subhumanizing clients of color	-disproportionately applies resources	--believes helping approaches used by dominant culture are universally acceptable and universally applicable	--tries experiments; hires minority staff, explores how to reach clients, trains staff on cultural sensitivity, recruits minorities for their boards and advisory committees	--engages in continuing self-assessment regarding culture	--adds to knowledge base by doing research, developing new approaches based on culture, publishing results of demonstration projects
--denies clients access to their natural helpers or healers	--discriminates based on whether clients "know their place" and believes in the supremacy of dominant culture helpers	--thinks all people should be served with equal effectiveness	--has commitment to civil rights	--makes adaptations to service models in order to meet client needs	--hires staff who are specialists in culturally competent practice
--removes children from their families on the basis of race	--may support segregation as a desirable policy	--ignores cultural strengths, encourages assimilation, and blames clients for their problems	--may feel a false sense of accomplishment that prevents further movement	--works to hire unbiased workers	--advocates for cultural competence throughout the system and improved relations between cultures throughout society
--risks client's well-being in social or medical experiments without their knowledge or consent	--enforces racist policies and maintains stereotypes --promotes ignorance and unrealistic fears of people of color --maintains discriminatory hiring practices --gives subtle "not welcome" messages --has lower expectations of minority clients	--follows cultural deprivation model (problems are the result of inadequate cultural resources) --practices institutionalized racism --sets ethnocentric eligibility for services	--may engage in tokenism	--seeks advice and consultation from minority community	

Source: Adapted with permission from Terry L. Cross, MSW, Director National Indian Child Welfare Association, Portland, Oregon

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Framework for Supportive Supervision Case Discussion

Supportive Supervisor: _____ Supervisee: _____

Narrative Description:

- Age, Gender, Race/Ethnicity, Identified Sexual Orientation and/or Risk Behavior, Presenting Complaint/Concern, History

Current Client Plan:

- What is the current plan in working with the client

Concerns/Issues:

- What concerns do you have in working with this client?

- What challenges will you face in working with this client?

Issues Discussed in Supervision:

-
-
-

Follow-up Plan with Client:

-
-
-

Other Issues that Impact this Supervisee:

- What impact does this work have on you?

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Justice Resource Institute

Resource tool: Framework for Clinical Case Consultation

Clinical Supervisor: _____ Supervisee: _____

Narrative Description:

- Age, Gender, Race/Ethnicity, Identified Sexual Orientation and/or Risk Behavior, Presenting Complaint/Concern, History

Current Counseling/Treatment Plan:

- What is the plan in treating/counseling the client

Concerns/Issues:

- What concerns do you have in counseling this client?
- What issues does this raise for you personally?
- What challenges will you face in counseling this client?

Issues Discussed in Supervision:

-
-
-

Follow-up Counseling/Treatment Plan:

-
-
-

Other Issues that Impact this Supervisee:

- What impact does this work have on you?

Administrative Supervision Scenarios

Group 1 – Status review meeting to discuss new, recent or established referrals.
As you are reviewing the Peer's caseload with her, you notice that she has not done some follow-up check-ins with several clients that you had discussed a few weeks prior. These are clients with multiple diagnoses who require a good deal of help at this time. She states that she has been very busy with some new clients who have needed her assistance. You have become aware recently of a pattern where this Peer seems to have difficulty establishing rapport and ongoing consistency with clients who have substance use issues. You have explained to her in the past that many of the clients served have these issues. It now appears that she is spending a lot of time with clients who seem to have life experiences that are closer to her own. You are worried because you have just received three new referrals with substance use history and all other Peer caseloads are full.

Group 2 – Peers professionalism including peer/client boundaries, presentation of self outside the site.
It has come to your attention that the Peer is under great financial hardship and is trying to find ways to supplement her income. She has begun selling copies of movies/DVDs, to staff at a clinic site. You ask her about this and she states that she is very discreet about this side business and does not directly solicit clients. She also shares that it will make it possible for her to avoid seeking a second job to pay her bills.

Group 3 – Client caseload issues including physical and emotional health of peer, time management and time off
The Peer lets you know that she has received four referrals in the past week from clinic social workers. The social workers mentioned that she is the "perfect Peer" for these referrals. She states that she would like to keep them on her caseload. You have noticed that she is showing some signs of being overwhelmed and you have heard that she missed a few meetings in the past few weeks due to assisting clients. She maintains that her caseload is fine and she just needs to get on top of a few things. When asked how her paperwork is going she states that she is behind but feels she can catch up next week. She mentions that she may want to reschedule an upcoming vacation to a later date so that she can catch up on her work.

Group 4 – Documentation of services, extra job duties and future training needs.
Your outside funder is getting ready to review case files for a quality improvement review that happens annually. You have reminded the Peers about the need to have all client files up to date by the end of the week. When you do a spot check on some files, you realize that one particular Peer has not kept notes on her client contacts. She is a star Peer in her rapport and assistance with clients, yet acknowledges that she dislikes paperwork. She assures you that she realizes the importance of getting files up to date and will dedicate a day this

week to catching up. You have heard this before and remember that she has a workshop at the end of the week that will take up much of her time before the deadline.

Group 5 – Collaboration with multidisciplinary team
The Peer comes to you and seems upset about an interaction she just had with a social worker. During a multidisciplinary team meeting at the clinic the social worker disclosed some information about the Peer's client that was not meant for the entire team to hear and seemed "gossipy" in nature. The social worker also put the Peer on the spot by insisting that the Peer be available in the next week to transport the client on some appointments an hour away from the office. She is panicked because her next week is very busy with meetings and appointments.

Administrative Supervision - Small Group Discussion Questions

In your small group, discuss how you would respond to the peer in your assigned scenario. Answer the following questions or others you identify.

1. What questions you would ask this peer?

2. What topics/areas would you cover with the peer on the issued identified?

3. What guidance, advice or training would you offer to the peer?

4. Anything else you as a supervisor could/should do?

5. What would be most challenging about discussing this issue with the peer?

6. Would the answers to these questions vary for paid versus volunteer peers?

Administrative Supervision for Peer Workers

While general approaches to administrative supervision are appropriate for peer workers, there are some additional monitoring duties that administrative supervisors will want to take on as a routine part of supervision. These duties are listed below. The list is not exhaustive, but provides a starting point. This list assumes that the administrative supervisor is already managing employees' work and vacation time, adherence to organization-wide policies, and meeting other basic requirements for supervising employees.

Administrative supervisors consistently monitor:

1. Status of peers' caseload, particularly new referrals
2. Peers' fitness for work (physical and emotional health)
3. Documentation and how peers' are managing time
4. Peer/client boundaries
5. Scope of work issues

Consistent monitoring may occur by holding a weekly or bi-monthly (e/o week) status review meeting with each peer worker. Below is a summary of items to cover during status review meetings. Conducting regular meetings will allow administrative supervisors to choose some items to focus on during one meeting, and reserve other items for the following meeting.

1. Status of peers' caseload, particularly new referrals

A. New referrals
- Does peer have a current or previous relationship to the person referred
- Determine with peer whether appropriate to take on the client
- Was new referrals successfully contacted
- Problem solve how to contact hard-to-reach clients
- Check on plan for follow up
- Assess client's needs for additional resources

Note to administrative supervisors: Many peers are hesitant to take an active stance with new clients. Often, peers report that they are afraid of being intrusive with clients who do not seem enthusiastic receiving support. There are a host of reasons why clients may not show enthusiasm for receiving help, and many of these reasons do not indicate clients' lack of need or desire for services. It is important for peers to have a supervisor who will encourage them to take an active stance while also respecting client boundaries and privacy.

B. Recent referrals (those that the peer has received in the last month)
- Has a plan for support been established (i.e. Is the peer providing weekly or monthly support? Is she conducting phone calls or home visits?)
- Has the peer established contact with other service providers

- Assess client's needs for additional resources

C. Established clients (During each meeting, peers or supervisors may want to choose one or two clients to focus upon on a rotating basis)
- How is the plan for support going for the client? The peer?
- Help peer problem solve if plan is off track or needs adjustment
- Check on peer's involvement with multi-disciplinary team
- Assess client's needs for additional resources

D. Peer workload
- Can peer take more clients at this time
- Assist peer in monitoring her need for time off
- Assess need for additional training or information on resources

2. Fitness to work
- Discuss health issues, concerns, and self-care.
- Be ready to offer time off or a flexible work schedule if possible.

3. Status of documentation
- Documentation is usually the first thing that gets put off when busy
- Is peer up-to-date on documentation
- Help peer create strategies to complete documentation

4. Peer/client boundaries
- Must be explicit and flexible for clients. (Peers ally themselves with their clients, and yet also maintain boundaries akin to a helping professional).
- Peers communicate the time and energy they can give to clients
- Peers should never give personal phone numbers, email or home addresses. Explicitly state and periodically remind peers that this is a program standard.
- Peers should be comfortable explaining to clients their role—its advantages to clients as well as its limitations.
- Peers should contain their client contact to their normal work hours as possible or should count any client time as paid time, and make scheduling adjustments as necessary.
- Supervisors stay aware of peers' tendencies to rigidly stay within normal working hours and/or offer excessive flexibility to clients.

5. Scope of work issues
- Success in managing regular job duties and extra projects
- Status of additional tasks or extra projects
- Balance of client duties with other tasks or projects

Supervisor's Checklist to Review Peers' Approach to New Clients

Administrative as well as supportive supervisors may find it useful to use the following tool to help peers assess the effectiveness of their approach when establishing a new client relationship. The check-list may be completed by the peer worker in advance of meeting with the supervisor, or it can be completed while reviewing cases together within the supervisory session.

	Yes	No	N/A
Did I establish rapport in my greeting and opening conversation?			
Did I ask open-ended questions?			
Did the client speak as much or more than I did?			
Did I *get* information about the client's perspective on his/her illness and treatment?			
Did I *give* information in response to goals, concerns, and problems that the client expressed?			
Did the client show that s/he understood the meaning of information provided?			
Did I provide *too much* information?			
Did I assess whether the client has adequate social support?			
Did I discuss referral needs and options with the client?			
Did we agree upon a plan of action for the immediate future?			
Did I deal with the client's and my own emotional reactions?			

Modified from:
Quality Assurance Measures for Voluntary Counseling and Testing Services
IMPACT/AIDSMARK June 2001

Peer Advocates' Group Meeting Guidelines

Case presentations during Peer Team Meetings allow peers to obtain support and feedback about cases as well as learn from others' case presentations. The format best works when it includes time for the peer to present her case (10-20 minutes) and time for discussion, questions and feedback (10-20 minutes) from peers and the supervisor. Peers should be coached to review this sheet BEFORE the meeting in order to prepare for the presentation.

Peers choose between providing a self-report (see below) and presenting a client. Generally, peers complete self-reports once in a while (every 3-6 months).

Questions A Peer Should Ask Herself To Prepare For Self-Report:

1. Generally, how is my work going? *(Consider yourself, your clients, HIV/AIDS, treatment issues, case managers, referrals, peer advocacy, health care providers, activities, client issues, the logistics of your job, home visits, etc.*)
2. The best thing that has happened lately? *(Your "high")*
3. The worst thing that has happened lately? *(Your "low")*
4. Anything puzzling me?
5. Am I feeling inspired? Burned out? Numbed out? Empowered? Confused? All of the above?
6. Current challenges needing feedback from colleagues?
7. Need a specific type of information from colleagues?
8. Helpful info for group?
9. Am I ready to receive listening, feedback and support?

If Presenting a Client's Case, Consider the Following Guidelines:

1. What you would most like to receive from the group (listening? Support? Feedback? Ideas? Information? Encouragement?)
2. How and why the client was referred
3. What other resources are being utilized by this client?
4. Description of the client (for example: age, ethnicity, health status, length of diagnosis, current issues, living situation, etc.)
5. Frequency of contact with client and type of contact
6. Care plan goal(s) if it has been set
7. What is working and what is not working
8. Client's strengths and weaknesses with which you are familiar
9. Your countertransference
10. Specific areas of concern regarding your work with client
11. Questions for the group

WORLD/Janie Riley, MFT

Justice Resource Institute

Peer Self Care Plan

For: _____ Start Date: _____

Choose at least one item to focus on from each category:

Body	Mind/Emotions	Spirit
Healthier Eating	**Time alone**	**Attending spiritual or religious services (church)**
Exercise	**Relaxing activity (i.e. bath)**	**Praying/meditating**
Walking	**Talking with trusted others**	**Reading spiritual books, sayings**
Breathing/stretching	**Journaling/writing**	**Being outdoors/in nature**
Water intake	**Positive affirmations**	**Remembering higher purpose/re-committing**
Sleep habits	**Attending a support group, church, 12-step meeting, therapy, etc.**	**Creative visualization**
Pampering	**Meditation/visualization**	**Practicing self-love**
Going to doctor	**Reviewing limits and boundaries**	**Doing a good deed**

Goal #1 (Primary Goal)

For myself I will…

How often…

Update…

Goal #2

For myself I will…

How often…

Update…

Goal #3

For myself I will…

How often…

Update…

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Sample Supervisory Strategies and Scenarios

Strategy: Identify and Build on What Works
Ironically, peers often do not readily notice how much they are actually helping. This is a common phenomenon for many in the helping professions. The tendency is for peers to focus on what is not working, and either ignore or discount what is working. This is why it is important to listen carefully when peers give narratives of their work with clients, and be ready to highlight the ways in which they are actually supporting the larger goals for the client. This serves the function of building peer's self-esteem as well as helping peers build on those personal strengths or actions that are actually supporting client outcomes.

Sherrie Scenario: In a frustrated tone, a peer reports to her supervisor that nothing seems to be working for her client Sherrie, because Sherrie is still missing doctor's appointments and may not be taking her medication at all. The supervisor asks her to describe what is happening (*a standard open-ended inquiry*). The peer states that Sherrie has missed her last appointment to get blood work, and that she is sharing in the support group that she hates taking her meds and has decided to stop taking them. She states that the other group members warn her that this could spell trouble, but she doesn't seem to listen.

Question:
After empathizing with the peer, and before troubleshooting, what might you focus on or ask more about in order to help peer feel a sense of efficacy as well as hope for this client?

Strategy: Support Realistic Expectations for Self and Clients
Exceedingly high expectations peers have for themselves or for clients is a major cause of job stress and burnout leading to low retention and diminished client outcomes. In the course of their work, it is easy for peers to slowly expand their role to the point that they are doing case management for clients. In many communities, under-funding creates situations in which clients do not have easy access to all the services they may need. Peers will often try to overcompensate for these gaps in service by taking on time consuming tasks. Peers also are vulnerable to feeling that they need to solve client problems especially those that include life and death themes such as faulty adherence practices and intimate partner violence.

Deborah Scenario: A peer reports to her supervisor that her client Deborah has been beaten up by her boyfriend again. The peer is visibly agitated by this and talks about the client as if she is responsible for getting the client to leave the boyfriend.

Question: What might the peer need from her supervisor?

Sample Responses to Help Peers Talk Through the Dilemma:

Sherrie Scenario

1. Sherrie must be feeling pretty safe with you and the group if she is disclosing her difficulties. Can you remind me how your relationship with her started?

2. You really know what is going on with this client, and it is so important that you are tracking her so well. I wonder if you already have some ideas about what might be going on for her?

3. Seems like she is realizing the impact HIV can have on her and having a really hard time with it. Often, this is a stage women go through before they make a more firm commitment to taking care of themselves. What might she need from you and the group in order to stick with the process?

4. I bet sometimes you don't feel you are doing enough—but it seems you are actually doing a lot.

Deborah Scenario

1. Would it be helpful to review your responsibilities/commitments to your client(s)?

2. Are you taking on the task of separating this client from her boyfriend?

3. What are your expectations of yourself as a peer?

4. What are your expectations of this client? What are your client's expectations?

5. You must be feeling an immense amount of stress. We all do when we take it upon ourselves to change someone before they are quite ready.

6. Are there ways we can think differently about how to support the safety of this client?

The KARMA of Boundaries…And Questions to Evaluate Boundary Dilemmas

Know yourself and your role(s)

-What is your role?
-What is not your role/responsibility?

Stress may be a sign that you need to remember your role.

Allow boundaries to support your work

-What kinds of boundaries support your best work?
-Are you making your boundaries clear to others?

If you are stressed out, you might want to do a boundaries inventory.

Remember others need boundaries, too

-What kinds of boundaries might someone else need?
-Are you respecting the autonomy of others?

People don't want everything you have;
they do want that which you can honestly give.

Maintain boundaries and adjust as needed

-Are you being consistent?
-How flexible are you? Too much/Too little?
-Would it be helpful to have a check-in with someone?

Not too tight, not too loose.

Acknowledge mistakes

-How do you know when you've made a mistake?
-How might you formerly acknowledge a mistake?

Remember to forgive yourself first.

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BALANCE Model for Supervisors

B	**Be Present**	Breathe, Focus, Relax
A	**Ask Open-Ended Questions**	What, How, Why
L	**Listen**	Stay open-minded.
A	**Affirm**	Make positive statements. Remember body language.
N	**Normalize Feelings**	Feelings can't be controlled, Actions can.
C	**Check Countertransference**	What does this remind you of?
	Challenge Assumptions	Are we sure we're right about this?
	Consider Alternatives	Is there any other way to approach this?
E	**Express Appreciation!**	You are doing such good work, Thank you!

BALANCE Model for Supervisors/Janie Riley, MFT

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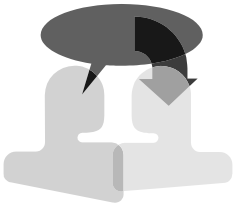
Countertransference: How Can You Recognize It?

You could be experiencing countertransference if one or more of the following is true:

1. You think you know exactly what a client needs to do.
2. You are making assumptions about a client without checking them out with her.
3. You are going out of your way for a client, even though she is not working very hard for herself.
4. You are avoiding a client(s).
5. You feel you are being manipulated.
6. You begin to ignore or forget your boundaries, or the boundaries of your organization.
7. You are spending too much time with one client for an extended period of time.
8. You worry about a client(s) excessively.
9. You begin to use your client for your own stress relief.
10. You are feeling confused about your role with a client(s).
11. You feel angry, sad or judgmental about a client(s) a lot of the time.
12. You find yourself being late consistently with a client.
13. While meeting with a client, an intense feeling suddenly arises—could be anger, sadness, or any other feeling, even a "positive" one. The feeling distracts you from your normal ability to listen well.



What can you do to address your countertransference?

1. Take some time to consider your feelings about the client(s) who are triggering you.
2. Check to see if you are over-identifying with your client (perhaps she and you have some similarities that trigger feelings for you). Remember that sometimes these similarities are hard to acknowledge.
3. Talk to a trusted colleague, supervisor, counselor, or other supportive person.
4. Engage in a stress reduction technique of any sort.
5. Re-assess your boundaries with a client(s). Do you need to spend more or less energy on this person(s)?
6. Question your assumptions.
7. Remember your limits.
8. Remember that you do not have to be perfect.
9. Remember that your job is not to fix people—people are ultimately responsible for themselves.
10. Remember to get help if you need it.
11. Get feedback from someone who will remind you of your strengths.
12. Remember that one of your most important jobs is to role model self-care.

Supervision: A Balancing Act!

4 Components of Supportive Supervision include:

1. A Supportive Space

- Provide a regular time and place for peers to get support and explore work.
- Maintain a stance of **positive regard** toward peers.
- Support peers in talking about the challenges inherent in peer advocacy. Peers may experience a range of feelings about clients and the medical system. This is normal for anyone working in a helping capacity. Since peers have often had experiences similar to some clients, personal feelings may arise. A supervisor does not need to counsel peers. Rather, a supervisor can **listen**, provide empathy, and link a peer's experience back to her work as a peer, and/or encourage a peer's self care.

2. Client Care

- Review and assess client care. Supervisor and peer do this together. It is particularly important to **monitor follow-up** with clients.
- Assess for **client and peer safety** and provide direction when necessary.
- Support peers in maintaining consistency and/or setting boundaries with clients.

3. Professional Development

- If applicable, mentor peers in areas such as counseling and treatment education.
- Support peers in maintaining balance in their professional role and practice **self care.**
- Support peers in maintaining professional boundaries in the workplace and with other service providers.
- Develop a sense of how peers would like to expand job and career, and support and provide ideas and opportunities for growth.

4. Stance of the Supportive Supervisor

- Learn from peers while also providing structure and direction when needed. Especially if a supervisor is HIV-negative, the supervisor has a lot to learn from a peer and a peer's clients.
- **Maintain curiosity**, ask questions and listen carefully to peers, asking clarification questions when necessary. This often has the side effect of helping the peer articulate her own wisdom and evaluate her own work.

Sample Job Qualifications for Peer Supervisory Positions

Administrative Supervisor

1) High school diploma or equivalent. Bachelor's degree or some college work preferred.
2) Good oral and written communication skills.
3) Good organizational and time management skills.
4) Some knowledge about the provision of direct service and fieldwork.
5) Previous experience in a leadership role and/or providing support or mentorship to others on a consistent basis.
6) Demonstrated experience or strong interest in supervising others (e.g. Training).
7) Firsthand experience living with HIV and/or demonstrated interest in the field.
8) Knowledge of HIV/AIDS disease and treatment spectrum.
9) Experience using basic counseling skills.
10) Experience responding to and/or triaging crisis situations.
11) Understanding of client confidentiality.
12) Experience and/or interest in working in a multi-cultural setting.
13) Experience attending and/or facilitating support or other groups.
14) Ability to support and supervise a broad range of individuals with diverse professional development needs.

Supportive Supervisor

1) Bachelors or masters degree in social work, psychology or related field.
2) Experience providing direct service to clients; fieldwork preferred.
3) Previous supervision experience strongly preferred.
4) Firsthand experience living with HIV and/or demonstrated interest in the field.
5) Knowledge of HIV/AIDS disease and treatment spectrum.
6) Knowledge of mental health issues including substance abuse, domestic violence, trauma, grief and loss.
7) Experience using basic counseling skills.
8) Experience responding to crisis situations.
9) Understanding of client confidentiality.
10) Experience and training in multi-cultural awareness.
11) Experience facilitating groups/understanding of group dynamics.

Clinical Supervisor/Consultant

1) Masters level degree in social work, psychology or counseling. License required.
2) Two or more years of experience providing direct service to clients; fieldwork preferred.
3) Previous supervision experience strongly preferred.
4) Firsthand experience living with HIV and/or demonstrated interest in the field.
5) Knowledge of HIV/AIDS disease and treatment spectrum.
6) Knowledge of clinical concepts such as transference/countertransference.
7) Knowledge of mental health issues including substance abuse, domestic violence, trauma, grief and loss.
8) Experience responding to crisis situations.
9) Understanding of client confidentiality.
10) Experience and training in multi-cultural awareness.
11) Experience facilitating groups/understanding of group dynamics.

*Women of color & women living with HIV/AIDS strongly encouraged to apply.

The Lotus Project
Women's HIV/AIDS Peer Education Training

PACT Supervisor's Overview

(To be filled out by PACT staff member/supervisor, in order to clarify parameters and priorities of peer's responsibilities.)

The purpose of this document is to help define the specific qualifications and roles of peer workers in your program.

Peer Qualifications

Unlike their professional colleagues, peers bring unconventional assets to the work place. It is important that supervisors and peers have the same understanding of the essential qualifications of peer workers. These qualifications may include:

- Share diagnosis and/or treatment with clients (e.g. HIV positive; on ART)
- Local resident or familiar with community
- Experience dealing with some of the difficulties faced by the client population (e.g., past experience with substance dependency; caring for HIV+ children)
- Non-judgmental; able to accept alternative perspectives and lifestyles
- Able to reflect on and apply life experience
- Able to relate easily to clients and program staff alike
- Good communication skills
- Able to participate as team member; voice opinions and share information with others
- Able to work independently

Peer Roles

Peer workers undertake a wide range of roles, as this list compiled by the recent National Community Health Advisor Study illustrates:

- **Bridge gaps between communities and the health and social service systems. This includes:**
    - *Educate community members about how to use the health care and social service systems*

    - *Gather information for medical providers*
    - *Educate medical and social service providers about community needs*
    - *Translate, including making medical language understandable for patients*
- **Provide culturally appropriate health education and Information**
    - *Teach concepts of health promotion and disease prevention*
    - *Help to manage chronic illness*
- **Assure that people get the services they need**
    - *Case finding/outreach*
    - *Make referrals*
    - *Provide follow up*
- **Provide informal counseling and social support**
    - *Provide individual support and informal counseling*
    - *Lead support groups*
- **Advocate for individual and community needs**
    - *Advocate for clients, translating, navigating, trouble shooting*
    - *Advocate for community needs specific to health care*
- **Provide clinical services and help meet basic needs**
    - *Provide clinical services, e.g. first aid in migrant labor camps*
    - *Help clients secure the basics: food, shelter, or employment, as a precursor to providing health related services. (may be done through referrals)*

The following are examples of peer roles within a multidisciplinary HIV adherence support program:

- **Facilitate communication with health professionals**

Peer workers encourage clients to build an open and trustful relationship with their healthcare providers, helping to overcome communication barriers. Peer workers encourage clients to empower themselves by asking questions of doctors in an open and honest way and initiating discussion about any issue of importance to the client.

- **Assist with adherence techniques**

Under the guidance of their supervisor, peer workers promote client self-efficacy through behavior change counseling and goal-setting. Peers also help the clients dynamically adapt their treatment adherence plans, taking into consideration individual barriers that might affect their adherence to medication. Peers can provide

practical advice about medication-taking cues, reminders, or organizational tools that have worked for them.

- **Counsel on medication adherence**

Peer workers provide informal counseling related to HIV treatment, medication, and the importance of adherence. Peers actively listen to their clients and help them to understand their diagnosis, medical regimens, and the effects of treatment. Peers promote an interactive, problem-solving approach to HIV treatment adherence.

- **Provide social support**

Part of their work with the client is to find opportunities in which to applaud and support their client. Even if the support is not directly about adherence, positive feedback and approval of the client's problem-solving or coping ability will help the client build self-efficacy and confidence.

- **Reach out**

The peer worker is able to meet the client at home or at some other location at a time that is convenient for the client. Peer workers' familiarity with the context of clients' lives enables them to access clients more easily that most healthcare providers. In the context of an ART adherence support program, peer outreach efforts are geared towards eliminating barriers that prevent clients from receiving HIV care and medication adherence support. Peer workers help improve client attendance at scheduled appointments and participation in support group and other program activities.

- **Record activities**

It is critically important that peer workers consistently document all client contact. Programs should devise an appropriate format and dedicate time and resources to review, test, and modify formats to ensure they are easy to understand and appropriate to the peers' work. Minimally, peer workers should record a client identifier code, nature/type of contact, information discussed, adherence issues addressed, actions taken, and referrals made. Forms should be kept in a central client file

- **Collaborate with adherence team members**

Peer workers refer clients to social workers, case managers, and health educators, or facilitate other referrals, as appropriate. Peers are responsible for attending all

program-sponsored educational workshops, discussion groups, and support groups. Peers are expected to provide on-going feedback to all levels of program staff and to share ideas for improved client service.

- **Advocate and educate**

Peer workers help increase referral options by connecting the program with community-based organizations and other resources. Peers take an active role in promoting and supporting participation in TB screenings, health fairs, and other related community events.

Once the team has defined roles and activities, a brief list can be generated for peers and their supervisors to refer to when discussing strategies for approaching clients.

Program-Specific Qualifications and Roles

Key Peer Qualifications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Peer Roles:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date:_____

Initials: _____/_____

Peer Encounter Checklist

Complete this checklist as soon as possible after each encounter with a client. Responses on this checklist may be used in supervision.

PEER INITIALS/CODE: _____ **CLIENT CODE: _____**

DATE: _____

	Yes	No	N/A
Did I establish rapport in my greeting and opening conversation?			
Did I ask open-ended questions?			
Did the client speak as much or more than I did?			
Did I *get* information about the client's perspective on his/her illness and treatment?			
Did I *give* information in response to goals, concerns, and problems that the client expressed?			
Did the client show that s/he understood the meaning of information provided?			
Did I provide *too much* information?			
Did I assess whether the client has adequate social support?			
Did I discuss referral needs and options with the client?			
Did we agree upon a plan of action for the immediate future?			
Did I deal with the client's and my own emotional reactions?			
Modified from: *Quality Assurance Measures for Voluntary Counseling and Testing Services* IMPACT/AIDSMARK June 2001			

PACT Peer Educator Self-Assessment

Date _____

This self-assessment is not a test! It is intended to help you see the strengths and weaknesses that you bring to your work with clients.

PART ONE: For the following questions, think about times you were able to perform these skills well and times when you performed them less well than you would like. Write down a few words about your strengths and weaknesses.

***How well can I*:**

Listen?

_____
_____
_____
_____
_____
_____

Communicate clearly and in language that is appropriate for the situation with my clients? Co-workers? Supervisors?

_____
_____
_____
_____
_____
_____

Recognize and control how my body language affects my working relationships (clients, co-workers, supervisor)?

_____
_____
_____
_____
_____
_____

Work with team members toward collective goals?

Take initiative on the job?

Problem solve effectively with my clients? Co-workers? Supervisor?

Judge my own strengths and weaknesses?

Handle stressful situations with my supervisor? Co-workers? Clients?

Understand and follow rules and procedures of my program?

Get to work and related activities on time, consistently day after day?

Manage my time?

PART TWO: Listed below are a number of behaviors that are essential to relating to others.
To be completed with the peer at an early meeting, to facilitate self awareness about skills and behaviors needed to work with clients

How do you rate yourself on these behaviors? Use the following scale:

1	*2*	*3*	*4*	*5*
Very Weak	*Moderately weak*	*Adequate*	*Moderately strong*	*Very strong*

1. **Feelings:** I am not afraid to deal directly with emotion, whether it is my own or others'. I allow myself to feel and give expression to what I feel.

1	2	3	4	5
Very Weak	Moderately weak	Adequate	Moderately strong	Very strong

2. **Initiative:** In my relationships I act rather than react by going out and contacting others without waiting to be contacted.

1	2	3	4	5
Very	Moderately	Adequate	Moderately	Very

Weak	weak		strong	strong

3. **Respect:** I express that I am there for others even if I do not necessarily approve of what they do.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

4. **Concreteness:** I am not vague when I speak to others. I do not beat around the bush in that I deal with concrete experience and behavior.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

5. **Immediacy:** I deal openly and directly with others. I know where I stand with others and they know where they stand with me.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

6. **Empathy:** I can see the world through the eyes of others by listening to cues, both verbal and non-verbal, and I respond to these cues.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

7. **Confrontation:** I am able to challenge others responsibly and with care. I do not use confrontation to punish.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

8. **Self-disclosure:** I let others know the person inside, but I am not exhibitionistic. I am open without being a secret-reveler or a secret-searcher.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

9. **Self-exploration:** I examine my life style and behavior and want others to help me to do so. I am open to change.

1	2	3	4	5
Very Weak	Moderately Weak	Adequate	Moderately Strong	Very Strong

Modified from Donald Clark, 'Big Dog Little Dog (2004)
http://www.nwlink.com/~donclark/leader/leadtrn.html

Date ___/___/___

Adherence Support: Individual Client Review

To guide the peer in reviewing clients during supervision

1. What are this client's long and short-term goals?

2. How does the client feel about his/her diagnosis?

3. What are the client's beliefs about medication-taking in general?

4. What does the client know about his/her medication and treatment plan?

5. Has the client successfully faced difficult challenges in the past? What coping skills or strategies did s/he use *(support from family? seeking out service agencies)*?

6. Has your client had to make difficult treatment decisions (including decisions about being adherent) before? What were they? What barriers did the client face, and how did the client respond?

7. Where does adherence fit into the client's life goals?

Peer Weekly Staffing Report

The peers at Project Ark in St. Louis, MO, use the below peer weekly staffing report to document their contacts with clients on a weekly basis. The peers fill out the form during the week and turn the document in, together with any client chart notes, to their supervisor on Fridays. The supervisor uses this information to prepare for supervisory meetings with the peers and to track the number of minutes peers are in contact with clients, a requirement for the grant that funds the peer program. Using this tracking system, the staff was able to document that the program had met its goal for time peers spent with clients for the year.

Peer Weekly Staffing Report

Peer Name: ____________________ Date: ____________________

Date	Client Name	New or Existing Client	Program Site	Phone Contact	Mail/Email	Educational Meeting	Intake	Support Group	Clinic Visit	Total Time In Minutes	Total Units (1 Unit = 15 min)
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								

Challenges of the Week: ____

____

Highlights of the Week: ____

____

Please photocopy your progress notes for this week and attach them to this report.
Please turn this report into Stacey by FRIDAY of each week. Thank you!!!

WORLD
Peer Advocacy Record of Community Service

Your Name: _____ **Today's Date**: _____

Date of Service: _____ **Location:** _____

Check all that apply: ____ Outreach ____ Prevention ____ Education ____ Support

Type of Service (Check all that apply):

- ☐ Public Speaking Engagement
- ☐ Conference Presentation or co-Presentation
- ☐ Panel Participant
- ☐ Facilitate or Co-Facilitate HIV/AIDS Educational Seminar
- ☐ Provide Information or Education to Public Health Facility
- ☐ Provide Information or Education to Health Care or Health Care Providers
- ☐ Provide Information or Education to Mental Health or Social Workers
- ☐ Guest Speaker at Community Service Project or Program
- ☐ Guest Speaker at Community Support Group
- ☐ Interfacing with Media (e.g. news or magazine interview and/or photo shots)
- ☐ Other _____

Estimated total time spent on project: _____
(Please include preparation, phone calls/email, meetings, actual time spent in the community, follow-up)

Please briefly explain your understanding of why your services were requested:

Please briefly explain the outcome (How many people were there, quality of event):

Please briefly explain how the provision of this service relates to the objectives of your position at WORLD:

Peer Educator Contact Form

Date of Contact __ __/__ __/__ __ __ __ Date

Peer ID _____

Client ID: _____

Partner agency/organization_____

Type of Contact (check one)

Face-to-face (Individual)	1
Group	2
Telephone	3
Letter	4
Email/internet	5
Other (specify): _____	6

Duration of Contact (In Hours)

Less than 5 minutes__
More than 5 minutes less than 1 hour__
More than 1 hour__

Appointment reminders/coordination	
Provide general HIV education	
Provide information about HIV medications	
Provide information about the program	
Provide harm reduction supplies (condoms, bleach)	
Accompany to medical visit	
Accompany to social services	
Refer to medical services	
Provide specific HIV risk reduction/counseling	
Refer to or make appointment for health care	
Refer to or make appt. for housing services	
Refer to substance abuse treatment	
Refer to needle exchange	
Refer to or make appt. for mental health care	
Refer to or make appt. for other services	
Relationship-building	
Provide mental health counseling	
Provide other counseling	
Other 1: (specify)_____	
Other 2: (specify)_____	

For Local Site Use-Notes about client contact

PEER Center
Peer Education & Evaluation Resource Center

The Lotus Project
Women's HIV/AIDS Peer Education Training

people to people

PACT
Peers in action

In a multidisciplinary, clinic-based ART adherence support program, peers actively reach out to their caseload of about 15 clients each in order to engage clients in care, help them identify and resolve barriers to becoming adherent, and help them build long-term adherence skills. Peers work collaboratively with the program case manager and health educator. The peer contact form, below allows peers to document all aspects of their work with clients in a user-friendly format. Peers complete the form as soon as possible following each contact. The program coordinator reviews the contact forms weekly for completeness and discusses issues documented in the 'notes' section in bi-weekly individual peer supervision sessions.

Peer Contact Form
HATS (Harlem Adherence to Treatment Study)
Client Code: _____Peer Code: _____Date of Contact ___/___/___

Description of the contact: Please circle the appropriate item:

<table>
<tr>
<td>Who Initiated Contact?

❑ Client
❑ Peer
❑ Other Staff
❑ Other individual</td>
<td>Who was Contacted?

❑ Client
❑ Family/Friends
❑ Case Worker
❑ Medical
❑ Other
❑ Not Applicable</td>
<td>Type of Contact

❑ Face to face
❑ Phone
❑ Mail
❑ Left message only
❑ Phone; no answer
❑ Other</td>
<td rowspan="2">Adherence Questions

Did you talk about adherence?
❑ Yes
❑ No

Is the client say she or he is adherent?
❑ Yes
❑ No

Did you discuss T-cells or viral load?
❑ Yes
❑ No

Did the client mention missed days or medication holidays?
❑ Yes
❑ No

If the client has missed meds, about how many days?

_____ days</td>
</tr>
<tr>
<td>Where?

❑ Unsuccessful contact
❑ Phone contact
❑ Program office
❑ ID clinic
❑ Other clinic
❑ Street
❑ Hospital wards
❑ Drug Program
❑ Other Location
❑ Client's Home</td>
<td>Life Stressors Addressed

❑ None
❑ Health
❑ Anxious/depressed/ lonely
❑ Benefits/insurance
❑ Problems with partner/kids
❑ Money
❑ Housing
❑ Family's health
❑ Death of family/friend
❑ Legal problems
❑ Any accident
❑ Other (Explain)</td>
<td>Referrals Made

❑ None
❑ Program Case Mng
❑ Health Educator
❑ Medical Provider
❑ Outside referral
❑ Program support group

Incentive Provided

❑ Yes
❑ No</td>
</tr>
<tr>
<td colspan="4">NOTES: Share with us anything you want about the contact</td>
</tr>
</table>

The program's funding source requires that it report numbers of peer-client contacts each month, along with other patient indicators such as HIV primary care and case management appointments kept, most recent CD4 and HIV RNA measures, and any new diagnoses. Peer-client contacts are abstracted from peer contact forms each month by a

clinic data form and entered into the clinic's electronic information reporting system. Monthly reports of patient-level program data are generated through the electronic system.

In addition to required reporting, the program's evaluation team has determined to answer several evaluation questions and has proposed corresponding indicators that the program will track, collected from the peer contact form. The evaluation questions and indicators are:

Evaluation Questions	Evaluation Indictors
Do peers successfully reach program clients?	Ratio of successful contacts to attempted contacts
Do peer services address potential barriers to adherence?	Life stressors addressed
Do peers contribute to comprehensive service provision?	Referrals to program, hospital, and outside service providers
Do peers address adherence behavior in their interactions with clients?	Adherence questions

The program case manager and health educator responsible for entering evaluation indicators into a program evaluation database every week. The program coordinator generates reports summarizing the indicators every month and presents them to the evaluation team at monthly evaluation meetings

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		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								
		N/E	☐ Washington University ☐ New Hope Clinic ☐ Other ________								

Challenges of the Week: ____

____

Highlights of the Week: ____

____

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Logic Model—Brainstorm Notes

Draft an overall problem or goal and then list possible answers/ideas for resources/inputs, activities, outputs, outcomes, and impacts.

- ***Goals***—overall project purposes

- ***Inputs***—resources available to a program as well as "object" (e.g. clients) of program activities

- ***Activities/Interventions***—planned tasks that define the program or service

- ***Outputs***—level of activities actually implemented or initial results of services

- ***Outcomes***—short or intermediate indicators of progress toward a goal

- ***Impacts***—long-term progress toward a goal

Logic Model

RESOURCES or INPUTS	ACTIVITIES	OUTPUTS	SHORT & LONG-TERM OUTCOMES	IMPACT
In order to accomplish our set of activities we will need or already have the following:	*In order to address our problem or issue we plan to do the following:*	*What we actually did. The initial results were:*	*We expect that if accomplished these activities will lead to the following progress toward our goal:* *Time frame TBD*	*We expect that if accomplished these activities will lead to the following major changes:* *Time frame TBD*

Problem/Goal:

Kansas City Free Health Clinic
HIV Primary Care Department
Quality Assurance Program Summary

Program	Quality Management Components in place
HIV Primary Care	**Chart Audits** Completed monthly and quarterly per plan. In addition to outcomes monitored under Ryan White Part C/Part A plan, the following are monitored on Clinic patients only: **Indicators** 1. % of patients with an adherence assessment at last visit Definition: An adherence assessment will be considered completed if patient or any member of the health care team documents number of missed doses, percent of missed doses, number of refills since last visit, or number of missed refills since last visit. Goal: 80% 2. % of patients on ARV with at least an annual lipid profile Definition: An annual lipid profile will be considered completed if a fasting lipid profile lab report done in the previous 12 months from date of audit is noted in the chart Goal: 80% 3. % of patients with at least an annual RPR Definition: An annual RPR will be considered completed if an RPR lab result done in the previous 12 months from date of audit is noted in the chart. Goal: 80% 4. % of female patients with a PAP smear in the previous 12 months. Definition: An annual PAP smear will be considered completed if there is a PAP smear lab report done in the previous 12 months from date of audit is noted in the chart. Goal: 80% 5. % of patients with a primary care visit at least every 4 months Definition: A primary care visit will be considered completed if a Physician, Nurse Practitioner, Physician Assistant or Registered Nurse documents a face to face visit in the medical chart. Goal: 80%

HIV Primary Care Department
Quality Assurance Program Summary

Program	Quality Management Components in place
HIV Primary Care	6. % of patients on ARV with a viral load every 4 months Definition: A viral load will be considered completed if a lab report done in the previous 4 months is noted in the chart. Goal: 80% 7. % of patients on ARV with a CD4 count every 4 months. Definition: A CD4 count will be considered completed if a lab report done in the previous 4 months is noted in the chart. Goal: 80% **Process Audits** • Appropriate implementation of standing orders Audit 2 charts per week. 13 weeks per quarter. 26 charts per quarter. 80% compliance. **Reports** Monthly activity report to Executive Director 6 month progress report for Part C Annual RDR for Part C and Part A Quarterly administrative and quality management reports to Health Department **Patient Satisfaction Survey** – Done annually. Mailed to 25% of active patients. **Informal Review of Voice Mail log** – Log is reviewed to determine timeliness of response, reason for call, action taken. Those with medication refills are compared with chart to determine adherence to standing orders and nursing practice **Multidisciplinary Team Meetings: Case Conferencing Tool –** Weekly all clients who receive primary care and case management services at the Clinic, who are scheduled for an appointment during the upcoming week, are clinically reviewed. Able to observe Primary Care staff's knowledge of their patients, plans for care, integration of other services into the care plan and general communication and collaboration with other

HIV Primary Care Department
Quality Assurance Program Summary

Program	Quality Management Components in place
HIV Primary Care	departments. Monitor referrals of new positives into primary care. On the spot problems identification and resolution occurs. **Ridgemark Statistics** – Monthly reports of patient encounters, demographics of new and all patients. Shared with all of Primary Care staff. **Bi Weekly Staff Meetings--** Information sharing, problem identification and resolution, review of qm audits and results, development of new services, policies and procedures.
Program	Quality Management Components in place
Peer to Peer Treatment Adherence	• Process: Demographics, number of peer contacts, number of primary care visit, viral load, CD4 counts **Phone Log Audits—**80% of patients with a scheduled appointment and who have given us permission to call will be given an appointment reminder phone call the day before their appointment **Did Not Keep Appointment Log Audits-** 75% of patients who did not keep their medical appointment and who have given us permission to call will be given phone call prompting them to reschedule their missed appointment **Chart Audits** 25% client charts audited quarterly to assess client directed goals developed and achieved. **Referrals for Just in Time Individual Encounters—**80% of patients referred through Multidisciplinary Team Meeting for a peer individual encounter will be contacted. **Referrals for Just in Time Group Encounters---**80% of patients referred through Multidisciplinary Team Meeting for a peer group encounter will be contacted. **Patient Program Evaluation Survey** –Completely quarterly. Mailed to 25% of active patients. **Reports** Monthly activity report 6 month and 12 month CAP/DIFFA report

HIV Primary Care Department
Quality Assurance Program Summary

Program	Quality Management Components in place
Peer to Peer Treatment Adherence	**B-Weekly Supervision** – Treatment Adherence Specialist meets with each peer counselor on a bi- weekly basis. Reviews progress notes and verbal reports of interactions with clients. Offers coaching, mentoring and support.
Program	Quality Management Components in place
Peer Education Training Site (PETS)	**Reports** Quarterly activity reports Organizational Capacity Building Activity Log completed monthly
Program	Quality Management Components in place
Part C	**Quarterly Chart Audit** At each site Kansas City Free Health Clinic staff or site staff will audit 10% of the patients supported by Part C for the same indicators as noted in HIV Primary Care. Per Part A contract, 80% compliance is expected.: Kansas City Free Health Clinic staff will complete at least 1 administrative, clinical and fiscal site visit per year at each site. **Annual Site Visit** – Site visit to assess fiscal, clinical and administrative compliance with legislative mandate, program requirements and contract. **Registration/Billing** – Systems are in place to assure that patients are registered as a Part C patient by each site prior to payment of any submitted bill. Systems are in place to assure that only outpatient care is reimbursed. **Informal Assessment of sites** – Done on an ad hoc basis through contact with sites at meetings and on phone. Problem identification and resolution. **Reports** 6 month progress report Annual RDR Bi-Monthly call with Project Officer

Process Evaluation
Peer Education Training Site Grant
Missouri AIDS Alliance

Goals	Data Collection Strategies	Data Source	Data Collection Schedule	Data Themes	Data Analysis Technique
1. Staff feedback is used as a means to identify success and barriers to program implementation.	Interview Alliance staff	Program staff	Quarterly	Communication Use of program and evaluation protocols	Content Analysis
2. Work Plan reviewed quarterly to determine gaps in tasks and timeline.	Review Work Plan	Work Plan Quarterly meeting minutes Curriculum materials Organizational Action Plans	Quarterly	Quantity & quality of products	Discrepancy Analysis
3. Participants are satisfied with program.	Collecting surveys	Participant feedback forms Overall participant program satisfaction surveys	Quarterly	Quality of program service delivery	Number & Percentages Crosstabs

Kansas City Free Health Clinic

HIV Patient Satisfaction Survey

Personal Information

1. Today's Date:	5. Ethnicity: (Check all that apply)
2. Your Age:	☐ White/Caucasian
3. Your Zip Code:	☐ Black/African American
4. Your Gender:	☐ Hispanic/ Latino
☐ Male ☐ Female	☐ Other (Please write in) _____
Transgender ☐ Male to Female ☐ Female to Male	

	All of the time	Most of the time	Sometime	Rarely	Never	Does not Apply
6. While I checked in & waited for my visit, staff was unfriendly to me.						
7. When I leave a message someone calls me back within 24 hours.						
8. I know how to contact the physician after hours.						
9. When I asked my providers questions about my HIV care, it was hard to understand their answers.						
10. I found my providers to be accepting & nonjudgmental of my life and healthcare choices.						
11. My providers explained the side effects of my HIV medications & ways to help me remember to take my medication.						
12. My providers talked to me about how to avoid passing HIV to other people & how to protect myself from getting Hep C & other STDs.						
13. My providers asked me about my physical & emotional needs & made sure I got a referral (to my case manager or directly to mental health, substance abuse counseling, dental or support groups)						
14. The staff and providers kept my HIV status confidential						

Overall Quality of HIV Care

15. I am satisfied with the services I receive at KCFree.

☐ Definitely Yes ☐ Maybe ☐ Definitely Not ☐ Not Sure

16. At any point, did you feel treated poorly at the Kansas City Free Health Clinic? ☐ Yes ☐ No

If Yes, to question 16 please check all the reasons you felt you were treated poorly. If no, skip to question 17.

My Race/Ethnicity ☐ Yes ☐ No	My Age ☐ Yes ☐ No	My Gender/Sex ☐ Yes ☐ No
My Sexual Orientation ☐ Yes ☐ No	My Appearance ☐ Yes ☐ No	My Difficulty Speaking English ☐ Yes ☐ No
My Alcohol/Drug Use ☐ Yes ☐ No ☐ I am not using alcohol/drugs		

☐ Other (Please write in)_____

17. Additional Comments

_____
_____
_____
_____
_____
_____

Thank you for completing this survey.

Kansas City Free Health Clinic

Encuesta de satisfacción a pacientes VIH positivos

Información Personal

1. Fecha de hoy:	5. Grupo étnico: (Check todas las que apliquen)
2. edad:	☐ Blanco/Caucásico (a)
3. Código Postal:	☐ Negro/ Afro-Americano (a)
4. Genero:	☐ Hispano/ Latino (a)
☐ Masculino ☐ Femenino	
Transgenero ☐ Hombre a Mujer ☐ Mujer a Hombre	☐ Otro (Por favor escríbalo) _____

	Todo el tiempo	La mayoría del tiempo	Algunas veces	Raramente	Nunca	No aplica
6. Mientras checaba con recepción y esperaba por mi cita, el personal de recepción fue poco amistoso.						
7. Cuando dejo un mensaje alguien me regresa la llamada dentro de 24 horas.						
8. Yo se como contactar al doctor después de horas de oficina.						
9. Cuando le pregunto a mis proveedores acerca de mis cuidados del VIH, fue difícil entender sus respuestas.						
10. Me di cuenta que mis proveedores aceptan y no juzgan mi estilo de vida ni mis decisiones acerca de mis cuidados de salud.						
11. Mis proveedores me explicaron acerca de efectos secundarios de medicinas del VIH y maneras que me ayudaran a recordar tomar mis medicinas.						
12. Mis proveedores me hablaron acerca de como evitar pasar el VIH a otras personas y como protegerme de contraer hepatitis C y otras Enfermedades Transmitidas Sexualmente (ETS).						
13. Mis proveedores me preguntaron acerca de mis necesidades físicas y emocionales y se aseguraron que fui referido (a) (con mi manejadora de casos o directamente con un profesional de salud mental, consejería de abuso de sustancias, dental, o grupos de apoyo).						
14. El personal y los proveedores mantuvieron mi estatus de VIH confidencial.						

En General la Calidad de Cuidados del VIH

15. Estoy satisfecho (a) con los servicios que recibo en la clínica KCFree.

☐ Definitivamente Si ☐ Quiza ☐ Definitivamente No ☐ No estoy seguro (a)

16. En algún momento, se sintió tratado (a) de mala manera en la Clínica Kansas City Free Health? ☐ Si ☐ No

Si su respuesta fue si a la pregunta 16, por favor cheque todas las razones que usted sintió fue tratado (a) mal. Si no, pasé a la pregunta 17.

Mi Raza/etnicidad ☐ Si ☐ No	Mi Edad ☐ Si ☐ No	Mi Genero/sexo ☐ Si ☐ No
Mi Orientación Sexual ☐ Si ☐ No	Mi apariencia ☐ Si ☐ No	Mi dificultad hablando Ingles ☐ Si ☐ No
Mi Uso de drogas/alcohol ☐ Si ☐ No ☐ porque no estoy usando drogas/alcohol		
☐ Other (Please write in)_____		

17. Comentarios adicionales

_____

_____

_____

_____

_____

_____

Gracias por completar esta encuesta.

HIV Treatment Adherence Survey

I. Please answer true or false to each question.

		True	False
1.	You can tell if a person has HIV because they look sick.		
2.	It is not harmful for an HIV positive person to have unprotected anal or vaginal sex with another HIV positive person because they are both already HIV positive.		
3.	Viral load is a measure of how many copies of HIV were detected in your blood test.		
4.	I feel that everyone should start taking HIV medications as soon as they are diagnosed so they can live a long healthy life.		
5.	Moderate exercise may help lessen some of the side effects associated with HIV and HIV treatments.		
6.	Good nutrition plays a vital role in the ability of the immune system to fight HIV and prevent AIDS related infections.		
7.	Using tobacco, caffeine, recreational drugs, and alcohol does not have an impact on the immune system.		
8.	If you have problems with your appetite or digesting your food, you should talk to your health care provider about it.		
9.	I take more than half of my HIV medications (ART) which I think is better than taking none at all.		
10.	If I have side effects from my anti-HIV medications, I stop taking them until my next doctor's visit.		
11.	If I lived with or took care of a person with HIV, I would definitely avoid using the same eating utensils as precaution against catching HIV.		
12.	I will not become resistant to my anti-HIV (ARV) medications when I adhere to medications at least 95% of the time.		
13.	I eat a variety of foods from the food pyramid because I believe that good nutrition plays a vital role in fighting HIV/AIDS related infections.		
14.	When I take my HIV medications as scheduled/prescribed I feel in control of my HIV.		

II. Please circle the most appropriate response to each question below.

1. When I have a busy or changing schedule, it is OK to take doses a few hours early or late.
   a. Strongly Agree
   b. Agree
   c. Disagree
   d. Strongly Disagree

2. I believe my medications for HIV will have a positive effect on my health.
   a. Strongly Agree
   b. Agree
   c. Disagree
   d. Strongly Disagree

3. Disclosure is a very personal and private decision; therefore, I disclose only when I feel comfortable enough with the person(s) in my life.
   a. Strongly Agree
   b. Agree
   c. Disagree
   d. Strongly Disagree

4. People who have AIDS get opportunistic infections because:
   a. When HIV enters the body, the virus replicates itself and causes infections
   b. The drugs used to treat HIV cause infections
   c. HIV weakens the immune system and makes it difficult to fight disease
   d. All of the above

5. Health care workers use universal precautions when caring for:
   a. Patients known to have AIDS
   b. Patients who may have HIV
   c. Patients with any diagnosed infectious disease
   d. All patients

6. HIV is more likely to be transmitted during oral sex:
   a. To the person receiving semen or vaginal fluids in his or her mouth.
   b. To the person having oral sex performed on him or her.
   c. On in man-to-man oral sex.
   d. Only in woman-to-man oral sex.

7. Most women with HIV/AIDS became infected by:
    a. Their fetuses during pregnancy
    b. Sharing needles or having sex with someone who has HIV
    c. Taking care of people with AIDS
    d. No one really knows for sure how women become infected

8. People who are infected with HIV can infect others:
    a. Only after they have had a positive HIV test result.
    b. If they have symptoms of AIDS
    c. After they become infected, even if they look and feel healthy
    d. If they develop an opportunistic infection

9. The risk of HIV infection from blood donated by a family member or friend:
    a. Is much lower than the risk from blood donated by the general public.
    b. Is about the same as the risk of getting HIV from a transfusion of blood from the general public.
    c. Is so low that testing of the blood is not required.
    d. Is not an issue because this type of donation is no longer an option in the United States.

10. Blood from a person with HIV may test negative for signs of HIV if the person:
    a. Was recently infected
    b. Currently has a sexually transmitted disease (STD).
    c. Has not yet developed opportunistic infections.
    d. Is in good physical health.

11. HIV+ mothers may transmit the virus to their infants:
    a. Before birth
    b. During the birth process
    c. Through breastfeeding
    d. All of the above

12. For many people with HIV, combination therapy can:
    a. Extend and improve the quality of life
    b. Block the ability of HIV to multiply
    c. Protect the immune system for some time
    d. All of the above

13. How many doses of medications have you missed in the last three days?
    a. None
    b. One
    c. Two
    d. Three
    e. More than three
    f. I am not taking any medications

14. I clean my "works" (drug-injecting equipment) correctly with water and chlorine bleach several times, each time.
    a. I do not use "works"
    b. Most of the time
    c. Never
    d. Every time

15. How often did you use condoms or dental dams when you had sex with other people in the past month?
    a. I did not have sex with anyone in the past month
    b. Every time
    c. More than half the time
    d. Less than half the time
    e. Never
    f. Cannot remember/don't know

Thank you for completing this questionnaire!

Communicating and Reporting Plan

Step 1: *List single audience below: (individual or group).*	**2. Audience Characteristics**							
	How Accessible?	**Reading Ability?**	**Familiarity with program or evaluation?**	**Attittude toward/interest level in program?**	**Role in decision making about program or evaluation?**	**Familiarity with research and evaluation in general?**	**Attitude toward/interest level in this evaluation?**	**Experience using evaluation findings?**
1	Easily	High Level	Very Familiar	Positive/High	Crucial	Very Familiar	Positive/High	Substantial
	With some effort	Mid Level	Somewhat Familiar	Neutral	Important	Somewhat Familiar	Neutral	Some
	With substantial effort	Low Level	Not Familiar	Negative/Low	Minor	Not Familiar	Negative/Low	None
		Non-Reader			No Role			
Step2: *For each charateristic to the right, mark the response that best describes this audience.*	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know	Don't Know

		3. Communicating/Reporting Purpose	**4. Priority**	**5. Implications for Content**	**6. Formats to Use**	**7. Dates**	**8. Resources Needed**
Step 3: *check the purpsoes for communicating with this audience.* **Step 4:** *Considering the audience and the purpose, prioritize each communicating and reporting task.* **Step 5:** *Note Implications that thecharacteristics of this audience may havefor the contents of communications reports.* **Step 6***: Indicate the appropriate formats to use.* **Step 7***:Indicate date for for communiation/report.* **Step 8:** *Indicate resources needed*	***During the Evaluation***	☐ Include in Decision Making about Evaluation Design and Implementation.	HI MED LO				
		☐ Inform About Specific Upcoming Evaluation Activities.	HI MED LO				
		☐ Keep Informed About Overall Progress of the Evaluation.	HI MED LO				
		☐ Communicate Interm Findings	HI MED LO				
	After the Evaluation	☐ Inform About Program and Evaluation to Build Awareness and/or Support	HI MED LO				
		☐ Communicate Final Findings to Support Change and Improvement	HI MED LO				
		☐ Communicate Final Findings to Show	HI MED LO				
		☐ Other	HI MED LO				

Rosalie T. Torres, Hallie Preskill, Mary E. Piontek. Evaluation Strategies for Communicating, Reporting, Enhancing and Learning in Organizations. 2nd Edition. Sage Publications Inc. Thousand Oaks CA 2005, pg. 34.

FOCUS GROUP INTERVIEW GUIDELINES

Role of Interviewer

- Ask enough questions or probes to be sure question is answered
- Make questions specific; not abstract or philosophical
- Offers reinforcement to keep a discussion going
- Be directive by administering a structured or partially structured question format

Important Reminders

- Quality and sequence of questions is important
- 10 to 12 questions are adequate for 2hr session or 5 to 6 for one-hour session
- Honor the participants. Be cautious of assumptions you make about their experiences and views. Do not exhibit a condescending attitude

Follow these steps

1. Have a copy of questions in hand, a pen for writing participants' name and a watch to end session on time.
2. Pre-arrange room so that participants and moderator have eye contact with one-another
3. Explain to participants the purpose of the focus group, what you will do with the results and the rules

   Rules include:

   - Everyone's opinion is valuable
   - Speak one at a time
   - Everyone must participate (will call on people if they don't speak up)
   - If tape recorder is involved, ask permission to use it
   - Explain that the discussion is confidential; Use only first names throughout session

4. Ask if there are any questions about the purpose and rules then begin discussion by having participants and moderator (& note-taker, if there is one) introduce self. If there is time to "break the ice" do a short ice-breaker such as during the introductions have participants say their favorite TV show as a kid.

5. Begin discussion.

Massachusetts Department of Public Health
Peer Support Service Evaluation
Focus Group Guide
Service Coordination & Collaboration Groups (SCCs) & Consumer Advisory Board (CAB)

Confidentiality Statement

The purpose of this evaluation is to learn more about the benefits, challenges and perceived outcomes of peer support services for people living with HIV/AIDS. We plan to assess the various models of peer support identifying effective models as well as exploring ways in which peer support services in Massachusetts can be improved. Information that you provide during the focus group will be kept completely private and used solely for the purpose of this evaluation. Your name will not appear on any of the data collected. The information will not be reported in a way that anyone can tell who you are without your written permission. All the information from this group will be combined with the data from other focus groups with SCCs and the CAB in the state of Massachusetts. Once all the focus groups have been completed evaluators from Boston University will summarize the information obtained and write a final report to be submitted to the Massachusetts Department of Public Health.

Focus Group questions

1) What types of activities do you do prefer to work with a peer as opposed to other professionals? What activities do are you not comfortable working with a peer ?
2) What types of activities are you comfortable sharing in group in settings? Are there times you prefer to work individually with a peer? Can you give examples?
3) What are the challenges/reasons to peer led activities in their area?
4) What are examples of how peer led activities have helped them personally or their community?
5) What do peer leaders accomplish in your agency, in the lives of PLWHA and in their community? What do peer leaders bring that other professionals (case managers) do not?
6) What are areas for improving peer support activities?

PETS Qualitative Study

Background

Most peer intervention studies in the HIV literature examine changes in clients' knowledge, risk reduction behaviors, and emotional coping strategies. (Broadhead, 2002, Kalichman, 2001, 2005, Purcell, 2004) These studies examined interventions using peer support groups and one-one interventions usually of a relatively short duration of six months or less. Yet few published studies describe from the client's perspective the role and impact of the peer relationship on client use of HIV services and adherence to appropriate treatment. Furthermore, most published studies of peer-based interventions for HIV care and prevention have not described in detail the peer support provided through these interventions.

The purpose of the PETS qualitative study is to examine in-depth the impact of peer support on client's use of health care services, as well on their HIV knowledge, attitudes & beliefs, self-care, and overall quality of life. The study will also result in a detailed description of HIV peer support provided by a sample of trained HIV peer educators. The results will be used to develop a series of products (publications, instructional materials, etc) for policy makers and program planners to integrate effective peer educator/advocate programs in HIV service delivery.

Multisite questions

1. Does client interaction with peers impact a client's access to care, health care utilization, self-care practices, quality of life, HIV knowledge, attitudes/beliefs, unmet needs, experience of HIV stigma, self-efficacy and empowerment?
2. How do trained peer educators apply their skills and knowledge in their work with clients and in their community?

Study Design

- Longitudinal design for clients—Year 3 baseline interviews; repeat Year 4 (6-9 months);
- Cross-sectional for peers

Methods:

- In-depth interviews: conducted face-to-face or telephone by local staff request tape recording for transcription; study guide to developed by study team
- Purposeful sampling frame-
  - (Region, gender, race/ethnicity, length of time in program)
- 5-8 clients per site;
- 5-8 peers/site

Description of sample

1. HIV-positive Clients.
   a. Time since living with HIV:
      - Newly diagnosed clients (living with HIV $\leq$ 12 months)
      - Non-newly diagnosed clients (living with HIV more than 12 months)
   b. Level of retention in care
      - Clients living with HIV with history of inconsistent health care

(having a gap of 6 months or more in the past 2 years)
- Clients at-risk for dropping out of care

c. Length of time working with a peer
- New clients: minimum of 5 contacts
- Experienced clients: at least 6-12 contacts

Recruitment:
PETS will work with partner program staff to identify clients of PETS-trained peers who have been working together for a minimum of 5 contacts. A client participant is a person living with HIV who has a relationship with a PETS-trained peer either through the peer's employment, volunteer position, *or* may be associated with the PETS trained peer in the community (i.e. with or without an organization). Client participants may be recruited through community or clinic settings depending on the local PETS partner organizations. There is no requirement for the number of hours that a client works with a peer.

PETS Qualitative Study
1st Interview Guide
Clients

[INTRODUCTORY SCRIPT]
Thank you for agreeing to be interviewed today. We (Name of site) are working with HRSA on a national program to train people living with HIV/AIDS to become peers to work with others in managing their life with HIV. HRSA is interested in understanding how peers impact the lives of people living with HIV. I'm going to ask you questions about your experience living with HIV and then about your experience in working with a peer.

The information you share with us today is completely confidential. You will be assigned (or you can give us one!) a pseudonym and your responses will not have any identifying information. Your responses will only be shared with members of the study team and will be compiled with other participants across the country. The information we gather here today will be used to develop materials for other peer programs across the country.

To ensure that we are able to capture accurate and complete responses, we would like to record this interview. As I mentioned, the recording will be transcribed and all names and places will be removed so as to protect your identity. Recordings will be destroyed after transcription.

Do we have permission to tape record?

_____

1) In what year did you test HIV positive?

2) Let's go back to the time before you started working with [peer].
   What were your feelings about HIV and being HIV positive?
   In the long term, what were your expectations about living with HIV?
   What kinds of things did you do to take care of yourself?

3) Now I'd like to ask you about the HIV-related health care you have used since you have tested positive.
   a. Think about your experiences in gaining *access to* HIV healthcare services. Tell me about your good experiences in getting HIV healthcare. Tell me about the challenges you have faced in getting HIV healthcare.
   b. Now think about your experiences with your healthcare treatment providers. What challenges have you had in *sticking to* the HIV treatment and care plan recommended/prescribed to you by your provider(s)? (By HIV treatment and care plan I mean your visits to the doctor, HIV treatment adherence, medication, visits to the dentist for oral related care)

Probes: How has your relationship with your health care provider influenced you in sticking to your HIV treatment and care plan?

4) How is your health affecting your daily life right now?

Probe: Have you had to change your routines?
Probe: Have you stopped doing things you used to do?

5) Who do you turn to for support (for example, emotional, moral or practical support) during difficult times?

Have there been any recent changes in your support system?

When and how often do you turn to [peer] for any type of support?

Now I would like to ask you a few questions about your relationship with [peer].

6) When did you start working with [Name of peer]? Did you ask to work with a peer advocate/worker, or were you referred/assigned to work with [peer]? Who referred/assigned you? Why did you decide to start working with the [peer]?

What are your goals for working with [peer]? *Probe:* What do you expect to get out of the relationship with [peer]?

7) How often do you see [peer]? What is working with [peer] like?
Probe: Where do you usually see or talk to [peer]?
Probe: What are your meetings/talks like?
Probe: How does meeting with [peer] compare to meeting with your other providers (i.e., doctor, social worker)?
Probe: How does your cultural identity (your gender, race/ethnicity) influence your relationship?

8) What is your relationship with [peer] like now, as compared to when you first met?

9) Please provide examples of skills or knowledge about HIV that you have learned from working with [peer]?

(*Interviewer note*: use suggestions from list of peer core competencies, modified as appropriate for clients receiving peer support. Suggestions include the following: coping with HIV; HIV lifecycle; sticking or adhering to HIV treatment plans; self-care, etc.)

What else have you learned from working with [peer]?
Probe: Life skills like getting other services? Finding a job? Getting an education, etc. Connecting to support groups?

10) Please provide examples of how [peer] has influenced you with the following:

- Your use of HIV health care services, your HIV treatment and taking medications
- Relationship with providers such as doctors, case managers and dentist
- Self-worth (how you feel about yourself)
- Your ability to act in helping yourself and others
- Finally, in what way has the relationship with [peer] influenced you the most?

11) What future treatment and healthcare goals do you have?
Probe: Could you imagine working with [peer] to reach these goals? What might be helpful?

The most helpful?

Interviewer note: Thank participant and notify that he/she will be contacted in approximately 6 months (give an approximate month e.g. June) to get an update on his/her experience with the program.

PETS Qualitative Study
Follow-up Interview Guide
Clients

[INTRODUCTORY SCRIPT]
Thank you for agreeing to be interviewed today. We (Name of site) are working with HRSA on a national program to train people living with HIV/AIDS to become peers to work with others in managing their life with HIV. HRSA is interested in understanding how peers impact the lives of people living with HIV. My questions today will focus on your experience with the peer program since our last visit.

The information you share with us today is completely confidential. You will be assigned a pseudonym and your responses will not have any identifying information. Your responses will only be shared with members of the study team and will be compiled with other participants across the country. The information we gather here today will be used to develop materials for other peer programs across the country.

To ensure that we are able to capture accurate and complete responses, we would like to tape record this interview. As I mentioned, the tape recording will be transcribed and all names and places will be removed so as to protect your identity. Tape recordings will be destroyed after transcription.

Do we have permission to tape record?

---

1. How has your health been since the last time we talked?

   Probes: Have you been seeing a doctor for your HIV? Taking medications? Experienced any challenges with your health as it relates to HIV? How has [peer] helped you to meet your HIV health care needs?

2. In terms of support, who do you turn to now during difficult times? *Probe*: Can you give me an example of how [peer] has given support to you since we last talked?

a. How often do you see [peer]? What is your relationship like now, as compared to when you first met? Is your relationship what you hoped for or imagined it would be? To what extent does your cultural background (race/ethnicity, gender, age) affect your relationship with [peer]?

3. Since we last talked, can you give examples of skills or knowledge about HIV that you have learned from working with your [peer]? (*Interviewer note*: use suggestions from list of peer core competencies, modified as appropriate for clients receiving peer support. Suggestions include the following: coping with HIV; HIV lifecycle; sticking or adhering to HIV treatment plans; self-care, etc.)

4. What else have you learned from working with [peer]?
Probes: Life skills like getting other services? Finding a job? Getting an education, etc. Connecting to support groups?

5. Please provide examples of how [peer] has influenced you with:
   - Your use of HIV health care services, your HIV treatment and taking medications
   - Relationship with providers such as doctors, case managers, and dentist
   - Self-worth (how you feel about yourself)
   - Your ability to act in helping yourself and others
   - Finally, in what way has the relationship with [peer] influenced you the most?

6. Since we last talked, can you give me an example of a goal or something that you wanted to get done that [peer] helped you to do?

7. Is there anything you want to say that I haven't asked about?

Additional Evaluation Resources and Websites

Publications

Qualitative Research & Evaluation Methods by Michael Quinn Patton (3rd Edition, 2002)

Designing and Conducting Mixed Methods Research by John W. Creswell and Vicki L Plano Clark (2007)

Real World Evaluation; Working Under Budget, Time, Data, and Political Constraints by Michael Bamberger, Jim Rugh, and Linda Mabry (2006)

Evaluation Strategies for Communicating, Reporting, Enhancing and Learning in Organizations by Rosalie T. Torres, Hallie Preskill and Mary E. Piontek. (2nd Edition. 2005)

Websites

http://www.careacttarget.org/

The Target Center which stands for Technical Assistance Resources, Guidance, Education & Training offers technical assistance to the Ryan White Community. There is a full array of technical assistance and training resources funded by the HRSA HIV/AIDS Bureau.

> http://www.careacttarget.org/librarysearch.php
>
> If you go to the Technical Assistance Library on the Target Center and choose "Evaluation" as a resource topic, you will find many helpful resources including the below guides.
>
> Some helpful guides include:
>
> A Practical guide to Evaluation and Evaluation Terms for Ryan White CARE Act Grantees
>
> Outcomes Evaluation TA Guide: Primary Medical Care Outcomes Titles I and II of the Ryan White CARE Act
>
> The Outcomes Evaluation TA Guide: Case Management Outcomes Titles I and II of the Ryan White CARE Act

http://www.nationalqualitycenter.org/index.cfm/316

The National Quality Center in conjunction with HRSA HIV/AIDS Bureau, provides no-cost, state-of the-art technical assistance for all Ryan White HIV/AIDS Treatment Modernization Act of 2006 funded grantees to improve the quality of HIV care nationwide.
There is a tab for QI Resources (Quality Improvement resources) where you can find helpful tools to assist in your quality improvement efforts

http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm#top

CDC Report: Framework for Program Evaluation in Public Health
The Centers for Disease Control and Prevention (CDC) developed and published this framework for program evaluation "to ensure that amidst the complex transition in public health, we will remain accountable and committed to achieving measurable health outcomes."

http://dir.unitedway.org/outcomes/library/pgmomres1.cfm

The United Way Outcome Measurement Resource Network provides resources for evaluation. One example of an excellent resource if you are new to the concept of Program Evaluation is Measuring Program Outcomes: A Practical Approach .

http://www.ojp.usdoj.gov/BJA/evaluation/links/WK-Kellogg-Foundation.pdf

The Kellogg Foundation Evaluation Handbook provides principles for principles to help guide evaluation work and a blueprint for planning, designing and implementing effective program evaluations.

http://communityhealth.ku.edu/ctb/about_the_ctb.shtml

KU Work Group Community Toolbox is a free, capacity-building website available to communities. It includes an evaluation section which contains information on developing a plan for evaluation, methods for evaluation, and using evaluation to understand and improve the initiative.

PEER Center
Peer Education & Evaluation Resource Center

Validated Evaluation Instruments

These instruments have gone through rigorous testing/research to ensure that they have high validity and reliability. A validated tool has been shown to measure what it purports to measure, for example, showing that people with high scores on a questionnaire about risk-taking actually do take more risks than people with low scores. Reliability is another important factor when giving surveys and inter-rater and intra-rater reliability must be high. For example, if one evaluator gives a depression survey to 10 patients, is there a high level of agreement if a 2nd evaluator gives the same depression survey to the same 10 patients? If not, there may be bias in the way the evaluator is administering the survey or the survey may not be a very good tool for measuring depression. The following list provides tools that may be helpful in your HIV program evaluation.

The Berger HIV Stigma Scale is an instrument to measure the stigma perceived by people with HIV which was developed based on the literature on stigma and psychosocial aspects of having HIV. In this document, we have provided the actual tool, documentation on scoring the tool, and a journal article that describes its development. Please be sure use the appropriate citation if you use the tool – the citation is included with the scoring instructions.

The Risk Assessment Battery (RAB) is a self-administered, multiple choice questionnaire, It was developed to offer a quick and confidential assessment of both needle sharing practices and sexual activity associated with HIV transmission. The following link from the University of Pennsylvania will give you details on the RAB and the actual instrument: http://www.med.upenn.edu/hiv/rab_download.html

The Center for AIDS Prevention Studies out of the University of California, San Francisco has compiled a comprehensive list of survey instruments that are in the public domain. For example The HIV Treatment Adherence Self Efficacy Scale (HIV-ASES) can be downloaded from this site.

http://www.caps.ucsf.edu/tools/surveys/#105

Rand Health is another excellent resource for survey instruments. All of the surveys from RAND Health are public documents, available without charge (for non-commercial purposes).

Please provide an appropriate citation when using these products. In some cases, the materials themselves include specific instructions for citation.

Some materials listed are not available from RAND Health. Those links will take you to other websites, where you will find instructions for use.

The Medical Outcomes Study, Social Support Survey can be found here as well as other quality of life instruments.

http://www.rand.org/health/surveys_tools.html

Berger HIV Stigma Scale ©

This study asks about some of the social and emotional aspects of having HIV. For most of the questions, just circle the letters or numbers that go with your answer. There are no right or wrong answers. Feel free to write in comments as you go through the questions.

This first set of questions asks about some of your experiences, feelings, and opinions as to how people with HIV feel and how they are treated. Please do your best to answer each question.

For each item, circle your answer: Strongly disagree (SD), disagree (D), agree (A), or strongly agree (SA).

		Strongly Disagree (SD)	Disagree (D)	Agree (A)	Strongly Agree (SA)	
1.	In many areas of my life, no one knows that I have HIV	SD	D	A	SA	2
2.	I feel guilty because I have HIV	SD	D	A	SA	3
3.	People's attitudes about HIV make me feel worse about myself	SD	D	A	SA	3
4.	Telling someone I have HIV is risky	SD	D	A	SA	2, 4

5.	People with HIV lose their jobs when their employers find out.....	SD	D	A	SA	4
6.	I work hard to keep my HIV a secret.....	SD	D	A	SA	2, 3
7.	I feel I am not as good a person as others because I have HIV	SD	D	A	SA	3
8.	I never feel ashamed of having HIV.....	SD	D	A	SA	3
9.	People with HIV are treated like outcasts	SD	D	A	SA	4
10.	Most people believe that a person who has HIV is dirty.....	SD	D	A	SA	4
11.	It is easier to avoid new friendships than worry about telling someone that I have HIV	SD	D	A	SA	2, 3, 4
12.	Having HIV makes me feel unclean.....	SD	D	A	SA	3

13.	Since learning I have HIV, I feel set apart and isolated from the rest of the world	SD	D	A	SA	1, 3, 4
14.	Most people think that a person with HIV is disgusting	SD	D	A	SA	4
15.	Having HIV makes me feel that I'm a bad person.....	SD	D	A	SA	3
16.	Most people with HIV are rejected when others find out	SD	D	A	SA	1, 4
17.	I am very careful who I tell that I have HIV	SD	D	A	SA	2
18.	Some people who know I have HIV have grown more distant.....	SD	D	A	SA	1
19.	Since learning I have HIV, I worry about people discriminating against me	SD	D	A	SA	2, 4
20.	Most people are uncomfortable around someone with HIV	SD	D	A	SA	4
21.	I never feel the need to hide the fact that I have HIV	SD	D	A	SA	2
22.	I worry that people may judge me when they learn I have HIV.....	SD	D	A	SA	2, 4

23.	Having HIV in my body is disgusting to me.....	SD	D	A	SA	3

Many of the items in this next section assume that you have told other people that you have HIV, or that others know. This may not be true for you. If the item refers to something that has not actually happened to you, please imagine yourself in that situation. Then give your answer ("strongly disagree," "disagree," "agree," "strongly agree") based on how you think you would feel or how you think others would react to you.

		Strongly Disagree (SD)	Disagree (D)	Agree (A)	Strongly Agree (SA)	
24.	I have been hurt by how people reacted to learning I have HIV.....	SD	D	A	SA	1
25.	I worry that people who know I have HIV will tell others.....	SD	D	A	SA	2
26.	I regret having told some people that I have HIV	SD	D	A	SA	1

27.	As a rule, telling others that I have HIV has been a mistake	SD	D	A	SA	1, 3, 4
28.	Some people avoid touching me once they know I have HIV	SD	D	A	SA	1, 4
29.	People I care about stopped calling after learning I have HIV	SD	D	A	SA	1
30.	People have told me that getting HIV is what I deserve for how I lived my life	SD	D	A	SA	1, 4
31.	Some people close to me are afraid others will reject them if it becomes known that I have HIV	SD	D	A	SA	1
32.	People don't want me around their children once they know I have HIV	SD	D	A	SA	1, 4
33.	People have physically backed away from me when they learn I have HIV	SD	D	A	SA	1, 4
34.	Some people act as though it's my fault I have HIV	SD	D	A	SA	1, 4
35.	I have stopped socializing with some people because of their reactions to my having HIV.....	SD	D	A	SA	1

36.	I have lost friends by telling them I have HIV.....	SD	D	A	SA	1
37.	I have told people close to me to keep the fact that I have HIV a secret.....	SD	D	A	SA	2
38.	People who know I have HIV tend to ignore my good points.....	SD	D	A	SA	1, 3, 4
39.	People seem afraid of me once they learn I have HIV	SD	D	A	SA	1, 3, 4
40.	When people learn you have HIV, they look for flaws in your character.....	SD	D	A	SA	1, 4

SCORING for the Berger HIV Stigma Scale and Subscales

1) Items are scored as follows: strongly disagree = 1

disagree = 2

agree = 3

strongly agree = 4.

If a subject selects a response in between two options (e.g.: between SD and D), a numerical value midway between the two options would be used (e.g.: 1.5).

2) Two items are reverse-scored: items 8 and 21.

3) After reversing these two items, each scale or subscale's score is calculated by simply adding up the raw values of the items belonging to that scale or subscale. Subscale designations appear in small print in the far right margin of the instrument; it may be desirable to cover or delete those numbers before reproducing the instrument for administration to subjects. Sixteen items belong to more than one subscale, reflecting the intercorrelations of the factors on which the subscales are based.

4) The range of possible scores depends on the number of items in the scale. For the total HIV Stigma Scale, scores can range from 40 to 160 [1 x 40 items to 4 x 40 items]. For the personalized stigma subscale, scores can range from 18 to 72. For the disclosure subscale, scores can range from 10 to 40. For the negative self-image subscale, scores can range from 13 to 52. For the public attitudes subscale, scores can range from 20 to 80.

Please include the below citation if you use this tool:

Citation: Berger, B, Ferrans, CE, & Lashley, FR. (2001). Measuring stigma in people with HIV: Psychometric assessment of the HIV stigma scale. Research in Nursing and Health, 24, 518-529.

Lotus Project: Grant Websites & Resources

The Foundation Center is available online, but it's also really worthwhile to go to the physical library—they are located in a number of cities across the country—and do their basic training in searching for opportunities. It's a great investment.	www. foundationcenter.org
The Foundation Center Online offers monthly and annual memberships. One way to use this is to subscribe for one month to find a pool of funders (remember to unsubscribe when you are finished!)	www.fconline.fdncenter.org
GrantSpy.com is a terrific e-newsletter that comes everyday. It costs a little to subscribe (about $20/month), but they send a newsletter everyday with a variety of opportunities, federal, private, and some states.	www.grantspy.com
Grants.gov sends a daily email of federal opportunities. Most of these are included in the Grantspy newsletter.	www.grants.gov
Chronicle of Philanthropy lists grant opportunities as well as what organizations have received grants and gifts.	www.philanthropy.com/giving.com
TechSoup offers nonprofits a one-stop resource for their technology needs. *TechSoup by the Cup* is TechSoup's free email newsletter for nonprofits and technology. Each week it delivers the best of TechSoup articles, events, message-board discussions, donated software alerts, and more (http://ga0.org/ct/Z7zcPU610E6w/).	www.techsoup.org
Charity Channel has "Don Griesmann's Grant Opportunities" and a number of related list serves (http://charitychannel.com/enewsletters/).	http://charitychannel.com/enewsletters/dggo/
Egrants.net is a searchable Internet database of grants, contracts and fellowships in health care and medicine and a daily e-mail notification service that informs users of new grants and contracts in their specialized areas of interest – as soon as they are announced.	www.egrants.net