PEER RE-ENGAGEMENT PROJECT

ENHANCED PEER INTERVENTION MANUAL

Teaming with Peers to Engage and Retain Hard-to-Reach Populations in Care

Miami New York San Juan

Health & Disability Working Group, Boston University School of Public Health

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More information about the Peer Re-Engagement Project can be found online at http://www.hdwg.org/prep

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PROJECT SUMMARY

This manual describes the process created and refined to link and re-engage people living with HIV/AIDS (PLWHA) of color in HIV primary care. It was funded by the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) as a Special Projects of National Significance Program and a Minority AIDS Initiative from 2011-2013. This initiative was implemented by three clinic sites located in Miami, FL; Brooklyn, NY; and San Juan, Puerto Rico. A multi-site evaluation and technical assistance center housed at the Boston University School of Public Health, in conjunction with the sites, developed an enhanced peer intervention to be implemented at all three sites and coordinated a multi-site program evaluation. The overall goal of the initiative was to engage and retain PLWHA of color with comorbidities of behavioral health issues into HIV primary care. The purpose of this manual is to document the enhanced peer intervention that was developed and implemented at the three sites and to provide a framework for future implementation of this model of an enhanced peer intervention.

The Peer Re-Engagement Project (PREP) was a multisite, randomized trial evaluating the efficacy of peer support and education in engaging and retaining people living with HIV in primary care. The enhanced peer intervention was one of two study arms tested in this study across three sites in Miami, New York City, and San Juan. The enhanced peer intervention included eight peer–patient educational sessions which were developed and trained on prior to program implementation. The intervention also included peer provision of ongoing emotional and practical support for their patients over a 12-month period. The study design used to evaluate this intervention was a longitudinal, randomized controlled study, in which participants were randomly assigned to standard of care (i.e., control group) or to standard of care plus the enhanced peer intervention (i.e., the treatment or experimental group). Data were collected at baseline and at 6-month and 12-month follow-up points through patient interviews, medical chart reviews, and peer contact forms. Participants of this study were limited to the following eligibility criteria:

- HIV-positive, and
- 18 years or older, and
- Out of medical care at clinic for 4 months or more, or
- Newly diagnosed or new patient to clinic and intake indicates a need for substance use, mental health, or housing services.

Participants were recruited by internal referrals and primary clinic records for those out of care. Patients identified as “out of care” were referred to a program/study coordinator through internal and external referrals. Participants referred were recruited to participate in the study, screened for eligibility, consented on the study, and enrolled into the study. Participants completed baseline interviews upon enrollment and were randomized immediately thereafter into the standard of care or enhanced peer intervention group.

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> *I feel the program has been an asset to our agency. It has afforded us the opportunity to provide additional peer support services to our minority male clients. And our evaluation team has been excellent and a pleasure to work with.*
>
> Carolyn McKAY
> Care Resource
> Miami, FL

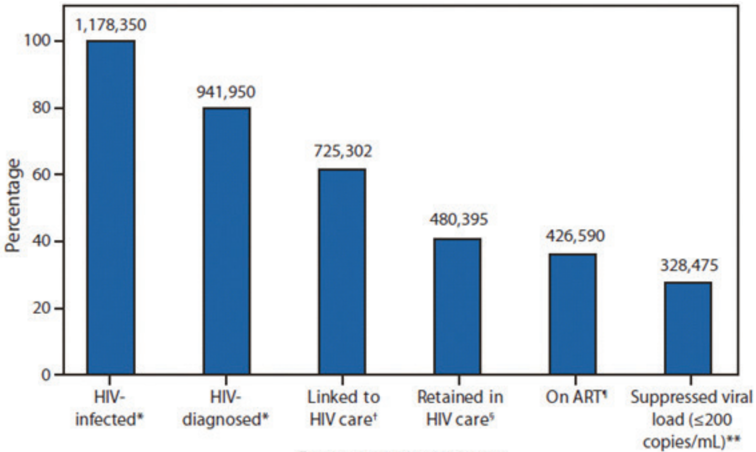
National HIV/AIDS Strategy

There are many points along the continuum of HIV care where people living with HIV/AIDS (PLWHA) can fall through the cracks, at great risk to their own health and potentially to the health of others. As shown in the diagram on the next page, of the estimated 1.1 million PLWHA, only about 65% of these individuals are linked to HIV care, 37% are retained in care, and only 25% are virally suppressed. This highlights the fact that there are critical gaps along the HIV care continuum that need to be addressed in order to reap the full benefits of treatment as prevention.

In 2010, the White House released the National HIV/AIDS Strategy (NHAS) for the United States, which served as the nation's first comprehensive and coordinated response to address curbing the HIV epidemic. The NHAS delineated clear and measurable goals and targets for 2015:

1. **Reduce new HIV infections** by 25%, lower transmission rate by 30%, and increase awareness of HIV+ serostatus to 90%.
2. **Increase access to care and improve health outcomes for PLWHA** by linking 85% of newly diagnosed PLWHA to care within 3 months of diagnosis, increasing Ryan White patients who are in continuous care to 80%, and increase the proportion of Ryan White patients with permanent housing to 86%.
3. **Reduce HIV-related disparities** by increasing the number of men who have sex with men, Blacks, and Latinos with undetectable viral load by 20%.[1]

In 2011, as part of a widespread effort to address these national objectives, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) announced a funding opportunity for the Minority AIDS Initiative (MAI) Retention and Re-Engagement in HIV Care Project.[2] Three clinical sites in San Juan, Brooklyn, and Miami were selected to implement and evaluate an enhanced peer intervention aimed at re-engaging hard-to-reach, racial/ethnic-minority patients who have fallen out of care and linking newly diagnosed racial/ethnic-minority patients at risk of falling out of care.



There are critical gaps along the HIV care continuum that need to be addressed in order to reap the full benefits of treatment as prevention.

Source: Cohen et al., Morbidity and Mortality Weekly Report (MMRW), 2011

Over 15 years ago, the HIV Cost and Services Utilization Study of a national probability sample of PLWHA who had at least one medical visit found that Blacks and Latinos were more likely to receive suboptimal care than Caucasians.[3] This trend continues today, despite many efforts to reduce disparities. Blacks and Latinos have higher rates of HIV infection, are likely to enter care at a later stage in the disease, and are less likely to be retained in care.[4-6] Compared to Caucasians, Blacks and Latinos also have lower knowledge about antiretroviral medications.[7] This has significant implications for long-term health.[8]

While the development of Highly Active Antiretroviral Therapy (ART) has extended the lives of those with HIV/AIDS, the complexity of some current HIV/AIDS regimens, the potential for HIV/AIDS to develop drug resistance, and the cost of drug therapy makes treatment a challenging prospect for many people living with the disease. Study after study has also documented that those most vulnerable to poor outcomes are people who are triply diagnosed with HIV, mental illness, and substance abuse disorders, many of whom are also homeless.[9, 10] A study of nearly 10,000 HIV-infected patients found that 25% had received a psychiatric diagnosis, 25% had been diagnosed with a substance abuse disorder, and 12% had received both diagnoses. Individuals with both diagnoses who did not receive any treatment for mental health or addiction had the highest risk of death.[11] A systematic review of the relationships between alcohol abuse and HIV outcomes found a consistent association between alcohol abuse and lack of adherence, as well as poor treatment outcomes.[12] Other studies have found a strong association between alcohol use, depression, and HIV disease progression.[13] The evidence suggests that people of color with mental health and/or substance abuse conditions are at very high risk of non-engagement in HIV care.

The Health & Disability Working Group (HDWG) at Boston University School of Public Health, in collaboration with Care Resource; Puerto Rico Community Network for Clinical Research on AIDS, Inc. (PR CoNCRA); and the Program for AIDS Treatment and Health (PATH) Center, was awarded funding to develop, implement, and evaluate innovative service delivery models for multiply diagnosed minority populations in New York, Miami, and San Juan. The enhanced peer intervention was designed to provide supportive and coordinated services for HIV, mental health, substance abuse, housing and other social services by an HIV-positive peer in order to engage and retain at-risk patients in care and to improve health outcomes.

The Affordable Care Act and Ryan White

The integration of peers into the "health home" model and interdisciplinary health care team is particularly relevant to the recent nationwide implementation of the Affordable Care Act (ACA). The ACA encourages the widespread adoption of Patient-Centered Medical Homes (PCMH) designated as "health homes" for Medicaid patients with chronic conditions, including HIV. Under the law, primary care provider sites have the option to increase reimbursement if they are recognized as PCMH. In this model, an interdisciplinary "primary care team (including physicians, nurse practitioners, and physician assistants) works collaboratively to provide comprehensive care management and coordination, health promotion, referral to community and social services, family and patient engagement, and use of information technology to link services."[14]

A major component of the Affordable Care Act is "Delivery Reform," which strives to reduce costs and improve delivery (shifting from a model focused on paying for volume to a model focused on paying for outcomes) by improving care coordination. In line with the goals of the ACA, there is the potential to integrate peers as part of the interdisciplinary primary care team to build a health home for patients. Peers can contribute by:

- Working with patients to ensure a smooth transition into primary care;
- Working closely with the rest of the primary care team to coordinate needed services and facilitate referrals to community and social services;
- Promoting health by meeting with patients to discuss health and care topics; and
- Supporting patient engagement by providing emotional and practical support.

Furthermore, peers can play a critical role in the support for outreach, benefits counseling, and enrollment activities across all Ryan White programs. The ACA will make more PLWHA eligible for Medicaid who previously were not. Currently, those individuals are generally covered by Ryan White funding, as it is considered a last resort funding for people living with HIV. Training peers to assist patients in the process of determining eligibility and through the enrollment process will be beneficial for the patients but may also reduce Ryan White costs by decreasing the number of uninsured and underinsured people living with HIV who are currently covered by Ryan White.

Demonstration Site Descriptions

Care Resource, Miami, FL

Rooted in the 1998 merger of Health Crisis Network (1983) and Community Research Initiative (1989), Care Resource is now South Florida's oldest and largest HIV/AIDS service organization and a true leader in the community. Care Resource became a Federally Qualified Health Center in 2009, with offices in Fort Lauderdale, Miami-Dade and Miami-Beach, offering general primary-care services to the whole South Florida community. Since its inception, the agency has expanded, and new services have been added in response to the needs of the epidemic. In 1999 primary medical care was implemented, creating a system to rapidly and effectively triage those identified as HIV positive into a comprehensive system for medical care and supportive services. Today, patients have access at a "one-stop" location to HIV counseling and testing, primary medical care, case management, dental care, nutritional counseling, mental-health and substance-abuse counseling, transportation vouchers, and wellness screenings.

Furthermore, the agency's many prevention and education programs go out into the community and engage populations at high risk, affected and/or infected by HIV/AIDS, by disseminating prevention information and connecting those in need to the health care system. Prevention programs target youth, men who have sex with men, the incarcerated, African-American, Haitian, and Hispanic men and women believed to be HIV positive or at risk of contracting the virus.

PR CoNCRA, San Juan, PR

Puerto Rico Community Network for Clinical Research on AIDS (PR CoNCRA) is a community organization which was founded in 1990. PR CoNCRA has aimed to promote the health and improved quality of life for people living with HIV/AIDS (PLWHA) and simultaneously reduce the rate of HIV transmission over the past 24 years. Initially, services provided by PR CoNCRA were targeted towards gay, bisexual, and men who have sex with men (MSM) populations, with the objective of improving access to health care services related to HIV/AIDS for these specific populations. Over the years, as the epidemic began to shift, the population accessing services at PR CoNCRA expanded and now includes: youth, women and injection-drug users, among others.

PR CoNCRA offers its patients a comprehensive array of services by using a "one-stop-shop" model, including: HIV testing and counseling, HIV medical care, primary care, medical case management, dental care, support groups, nutritional counseling and therapeutic massage. PR CoNCRA also has a variety of youth programs which provide a safe space for young people who are HIV positive or at risk of infection to support one another and engage their community.

PATH Center, Brooklyn, NY

The Program for AIDS Treatment and Health (PATH) Center is the acclaimed HIV/AIDS center of the Brooklyn Hospital Center. The primary objective of the PATH Center is to ensure the highest quality of care for HIV-positive patients in a welcoming and caring environment. PATH provides a one-stop location with state-of-the-art HIV medical and psychosocial care for adults, children, adolescents, and families. The services offered at PATH include HIV testing and counseling, HIV primary care, medical assessments and individualized care plans, case management, benefits counseling, nutritional guidance, dental care, support groups, and home visits.

Intervention Goals

The enhanced peer intervention is focused on integrating peers, individuals from the community living with HIV, into the health care team in order to lend patients emotional, practical, and social support; to provide patients with education on topics related to living with HIV and navigating the health care system; and to support patients and the health care team in coordinating services. This intervention was designed as such in order to achieve the following goals for racial and ethnic minorities living with HIV:

1. To increase retention in care of out-of-care patients
2. To link newly diagnosed patients into HIV medical care
3. To increase the percentage of patients with viral suppression
4. To increase patient knowledge of HIV treatment
5. To improve patient self-efficacy
6. To improve health-related quality of life

PART 2: SCALING UP THE ENHANCED PEER INTERVENTION

Work Plan to Design and Implement the Enhanced Peer Program

Designing and preparing to implement an Enhanced Peer Program requires the development of a work plan to identify and map out the necessary tasks. These activities include conducting a needs assessment, soliciting technical assistance and training for project staff and administrators, identifying target populations, and developing plans for outreach and program enrollment. See Appendix A for a sample work plan which outlines the steps necessary in designing and implementing an effective Enhanced Peer Program.can refer to the Enhanced Peer Program.

Identifying and Recruiting Peers

Who are peers? For the purposes of this program, peers are defined as HIV-positive individuals from the community who share characteristics and/or life experiences with the population that they serve, are engaged in medical care and adherent to treatment, and are willing to openly share life experiences related to their HIV status.

Identifying and recruiting an individual that is a good fit for the peer position is a task that requires many factors be taken into consideration. The process requires a collaborative effort among several members of the health care team and other staff at the organization. Communication between the peer program staff and other members of the health care team (e.g., case managers, providers, administrative staff, etc.) will be essential in identifying a new peer. The peer will be working very closely with all of these staff members, and effective integration of the peer into the health care team will require their buy-in from initial phases of program implementation. Scheduling meetings with case managers or providers to discuss potential candidates within their caseloads that meet the criteria to be a peer is a highly effective way to identify individuals for this position. In order to thoughtfully identify and recruit individuals that may be well suited for this position, it is critical to involve other members of

> *When we started to implement the project, the environment required training, guidance, and protocol revision. There was a lot of resistance and a lack of knowledge about the role of peers: why they were necessary, if they were going to invade my space and my work. Little by little, the peers started earning the trust of the case managers, the trust of the nurses.*
>
> Carmen M. Rivera
> Peer Program Manager
> Puerto Rico Community Network for Clinical Research on AIDS (PR CoNCRA) pictured on right with Nathania, a peer

the health care in the process of defining peer roles and responsibilities within the organization. If the peer program administrators decide to recruit peers from within their patient caseloads, some of the general traits to identify within existing HIV-positive patients include:

- Responsible health-related behavior (i.e., are adherent to their medication regimens, consistently attends medical appointments)
- Have knowledge about the community that is served and resources available in the community
- Desire to obtain employment
    - o Consider patients who may already work part-time and would like to transition to a full-time position.
- Have been able to maintain viral suppression
- Motivated to help others

For more information on peer recruitment, go to Section 5 of the *Building Blocks to Peer Program Success* toolkit at: http://peer.hdwg.org/sites/default/files/RecruitingHiringAndOrientingPeers.pdf

Assessing Peer Readiness

Once a pool of candidates has been identified for the peer position(s), there are several things to consider when evaluating an individual's readiness to serve as a peer. The following are questions to be discussed or assessed during initial meetings with potential candidates during the application and interview process:

1. Is this the individual's first job?
2. Is this individual ready to become fully (or partially) employed if he or she has not been for some time?
3. Is this job likely to bring negative consequences to the individual such as straying from treatment regimens, relapse (for those with a history of substance abuse), or mental health problems?
4. Does the individual feel comfortable disclosing his or her HIV status within the organization's professional network?
5. Does the individual feel comfortable sharing personal life experiences with patients?
6. Does the individual demonstrate empathy and compassion?
7. Does this individual seem motivated to serve as a role model to others living with HIV?
8. Will this individual's benefits package (insurance status) be affected?
9. Is this individual willing to do intensive outreach in the field (i.e., "feet in the street") in order to keep patients engaged?
10. If the individual is a patient, does he or she feel comfortable shifting back and forth between role of patient and role of colleague?

Peer Hiring Process

Organizational Challenges

It is imperative to work closely with other departments, particularly Human Resources (HR), to address organizational barriers that may arise. Working collaboratively with these departments will not only provide the opportunity to educate staff about the peer program internally, but will also provide insight about administrative procedures and protocols useful in preparing peers for the hiring process. Below are some of the organizational challenges that may emerge and what can be done to prevent or address them.

***Challenge 1:** HR or other departments do not understand the peer position as an equally valued member of the health care team and do not want to stray from standardized, traditional job titles and functions.*

- Gaining buy-in from HR and across the agency will help staff to see the value of including a peer as part of the health care team. In order to do this, collaborate with staff from HR and across the agency to develop a job description that clearly identifies roles and responsibilities of the peer to assist HR in creating the position. Be sure to emphasize that the peer will be augmenting and assisting the work of already created (and traditional) members of the health care team – not taking over their roles. See Appendix B for a sample job description.

***Challenge 2:** HR hiring clearances and background checks, including criminal record and drug testing, require candidate candor and transparency.*

- Work closely with HR to gain an understanding of specific requirements of the hiring process (e.g., are there specific convictions in a criminal record that will not be tolerated among personnel? is candidate disclosure of criminal history necessary? will there be drug tests, and if so, which drugs are tested for? etc.).
- Meet with candidates to clearly explain HR requirements and to assist in engaging in this process (e.g. – this will vary at each agency – encourage them to be candid about their past because criminal backgrounds will be checked but candor about past criminal activities will be regarded positively, explain what drug testing is required and how often, etc.).

***Challenge 3:** An extremely rigorous hiring process requires a great deal of time and persistent efforts.*

- Work with HR to gain an understanding of estimated and realistic timelines for hiring procedures and take these timeframes into account during the initial process of developing a program implementation timeline and work plan.
- Identify a point person (i.e., program coordinator, peer supervisor) who will be responsible for working with HR and other administrative departments.

***Challenge 4:** Identifying physical space for the newly hired team member. (Peers will require access to private meeting space to meet with patients.)*

Gaining agency-wide buy-in of the peer program is critical in addressing this. Once this happens, staff members become more flexible and accommodating with sharing space. Having clear and open communication across the agency allows for a collective effort to systematically make space available when patients need to meet with a peer privately.

Hiring Peers Who Are Patients

Identifying patients who may be qualified to work as a peer within your organization can be an effective strategy for recruitment of this position. However, several considerations need to be addressed during the recruitment and hiring process (some may need to be revisited continuously even after the peer is hired) in order to ensure that the patient's interests are protected, including:

- The effect of salaries and compensation on benefits or entitlements such as: nutritional assistance programs, housing program, health insurance benefits, etc. HR and program manager or supervisor should be informed about state benefit requirements and refer peers to a benefits counselor, as needed.

- The impact of human resources guidelines, personnel policies, and other institutional protocols within the organization on how the peer will operate and how these policies may impact his or her role as a patient, interactions with clinic personnel and other patients (e.g., continued comfort disclosing private health and other information with fellow staff members, maintaining confidentiality of fellow patients, etc.) Allow time for peer candidates to review the manuals, policies and procedures on their own before meeting to discuss the documents and responding to any comments, concerns or questions. These documents may need to be reviewed periodically to ensure that peers fully understand their content.
- Readiness of other members of the health care team to view the peer as a colleague. Emphasize the peer will be transitioning into the professional network of existing members, even if they decide to continue accessing services at the agency. Staff members may need to be reminded regularly in individual and team meetings that the peer's role is a professional one which must be regarded as such.

For more information on the peer hiring process, go to Section 5 of the *Building Blocks to Peer Program Success* toolkit at: http://peer.hdwg.org/sites/default/files/RecruitingHiringAndOrientingPeers.pdf

Intervention Staff Trainings

Peer Core Competency Training

In order to support HIV-positive peers who work to engage and retain PLWHA in health care, HDWG staff, in collaboration with colleagues from the Justice Resource Institute (JRI) and Kansas City CARE Clinic (KC CARE), developed a comprehensive five-day curriculum covering core topics and principles that a peer would need in order to support patients. A group of potential peers were trained at each site using trainers from JRI and KC CARE. In Puerto Rico, the training was conducted in Spanish. The topics covered in the Peer Competency Training Curriculum include:

- Peer Roles
- Peer Communication Skills
- HIV Basics
- The Immune System and the HIV Life Cycle
- HIV Medications
- Peer Disclosures
- Assessing Adherence
- Drug Resistance
- Understanding Labs
- HIV Stigma
- Motivational Interviewing
- Supporting Patients with Disclosure
- Depression and HIV
- Harm Reduction
- Sexual Health
- Documentation
- Confidentiality and Boundaries
- The Interdisciplinary Team

To view the complete PREParing Peers for Success Peer Core Competency Training Curriculum and a Sample Training Agenda go to:
http://www.hdwg.org/prep/curricula

Interdisciplinary Team Training

Integration of the peer into the health care delivery team is critical to the effective coordination of services for patients. As such, an Interdisciplinary Team Training will familiarize the health care team (e.g., case managers, nurses, physicians, etc.) with the roles and responsibilities the peers will take on, how the roles and responsibilities of other members of the health care team will be impacted, and provide a general opportunity for team building. HDWG staff, in collaboration with colleagues from the JRI and KC CARE, developed a half day-curriculum for peers, case managers, and other members of the health care team. This training took place on the last day of the five-day peer core competency training outlined above. The topics covered include:

- Interdisciplinary Approach to Care
- Role of Team Members
- Team Exercise
- Case Manager Q&A

The PREP Interdisciplinary Team Training Curriculum is included in Day 5, Section XX of the *PREParing Peers for Success* Peer Core Competency Training curriculum, which can be found at http://www.hdwg.org/prep/curricula

Peer Supervision Training

Peer supervision training is useful for preparing supervisors to provide a highly supportive and professional environment for the peers. The primary objectives of peer supervision are

1) to construct a supervision model that supports and sustains peer work, including administrative, supportive, and clinical systems,
2) to address the complexities of confidentiality and boundaries in peer programs, and
3) to support peers' integration as part of the health care team. HDWG staff, in collaboration with colleagues from the JRI and KC CARE, developed a one-day curriculum for peer supervisors to address these goals.

Topics covered:

- Peer Roles
- Integrating Peers as Part of Interdisciplinary Team
- Peer Supervision
- Confidentiality and Boundaries
- Transference and Counter-Transference
- Documentation

To view the complete *PREParing Peers for Success* Peer Supervision Training Curriculum go to: http://www.hdwg.org/prep/curricula

Peer Orientation

Once peers have completed the Peer Core Competency Training, going through a standard agency orientation will help newly hired peers become more competent and confident in their new role. One area of particular importance is how to manage issues of confidentiality. The plan that peer supervisors create to manage issues of confidentiality will depend on each peer's level of access to medical records, but at a minimum a new peer requires intense training on HIPAA and agency protocols as part of his or her orientation. One effective component of peer orientation is shadowing a variety of staff with whom the peers will be working closely, such as case managers, nurse practitioners, social workers and other members of the health care team. This kind of orientation allows the peers to clearly understand the roles and responsibilities of other staff as compared to their own and helps build relationships between the peer and these other staff.

Simultaneously, the peer supervisor and/or project manager must communicate the roles and responsibilities of the peers with all staff so that the rest of the team is prepared to facilitate the integration of the new peer position into the team. One key to success of the program is for project managers to schedule meetings with specific personnel, such as case managers and supervisors, to help them understand which tasks are appropriate (or inappropriate) for peers to be carrying out. For example, at PATH Center, the program manager met with staff members individually several times to clarify that the primary role of the peer – even though they may be able to assist with some administrative tasks which help to support patients and providers – is not to serve as an administrative support for the rest of the staff.

Additional Trainings

Refresher trainings on the topics covered in the Peer Core Competency Training will be necessary for the peers over the course of their work. One way to identify training needs is for a supervisor or program administrator to ask peers regularly to identify topics to review formally. For example, PREP staff provided surveys for peers across all three sites to complete in order to select topics to review or be trained on. These topics were then reviewed as part of the Project's monthly peer conference calls (discussed in further detail in Part 2, Section F4 on Peer Supervision and Support). Staff turnover may also require new core competency trainings, in which case it may be more effective to conduct new trainings on site. This was the case for Care Resource, which requested this training when they hired a new peer. In this case it is also helpful for the trainers to involve existing staff who previously completed the core competency training to help plan, coordinate, and conduct the training.

Project management staff can leverage existing training resources by including peers in staff trainings available at their own agencies during staff meetings or scheduled events. Additionally, by consistently evaluating new topics that may facilitate implementation, effectiveness, or sustainability of the program, they can increase the effectiveness of the entire team. For example, the Program Manager at PR CoNCRA requested training for all members of the health care team on cultural competency specific to homelessness. The Program Manager recognized that many of the peer caseloads consisted of individuals struggling with unstable housing conditions and in order for the peers to effectively assist their patients in accessing housing services, the rest of the health care team needed more education and sensitivity regarding the topic.

Integrating the Peer into the Health Care Team

Simply hiring a peer as an employee at an agency is not enough to reap the full benefits of a peer program. Fully integrating the peer as a member of the health care team is critical in order to enable the peer to effectively and efficiently coordinate care and services, assist the other team members in providing services, and provide emotional and practical support to the patient.

Integrating peers into the health care team can be challenging due to potential resistance from team members. First, it can be a challenge for staff to readjust the way they regard the peer, who role has shifted from patient to coworker. Second, clinicians may be concerned initially that the peers might overstep their boundaries and attempt to provide medical advice that they are not necessarily qualified to give, and ultimately interfere with clinician treatment plans and overall health care delivery. Case managers, on the other hand, may fear that peers will encroach on their roles and responsibilities and undermine the relationships that they have with their patients. The steps outlined below will help to successfully assuage concerns and simultaneously integrate the peer into the interdisciplinary health care team as a valued member.

Internal Promotion of the Peer Program

The success of the peer program at any agency will depend heavily on one person: a peer program champion. Before implementing the peer program, identify a peer program champion who will be primarily committed to implementation of the peer program and invested in increasing credibility for

> I have seen clients who were previously withdrawn gradually going to their appointments. It has significantly improved treatment adherence. I would advise any organization that is considering integrating a peer program into their institution to do it as soon as possible because it really helps the clients. My advice would be: Don't wait, do it right away.
>
> Dr. Roberto Calderón Santiago
> (shown here with a patient and peer)
> PR CoNCRA
> San Juan, PR

the program across the organization (e.g., Program Director, Project Manager, Program Coordinator, Peer Supervisor etc.). The role of this champion is to involve a variety of staff members throughout the program design, implementation, and planning processes to gain buy-in across the staff. He or she can do this by sharing all key documents related to the design and implementation of the program, such as work plans, goals, objectives, protocols, and peer job description, with key staff—particularly members of the interdisciplinary health care team—and incorporating their feedback. During the initial planning and implementation stages, one strategy to increase agency-wide buy-in and support for the peer program used by PREP program managers was to build upon the common commitment and passion of all the interdisciplinary team by dedicating time at as many staff and team meetings as possible to demonstrate how peer work will help achieve common goals and support fellow staff members.

Throughout the duration of the program, the program champion will be responsible for coordinating and/or attending interdisciplinary meetings in order to continuously update colleagues on the status of the program and elicit feedback. Once implemented, provide peers with regular opportunities to present to the interdisciplinary team about their work and how it fits in with the overarching goals of the health care team and the organization. Similarly, the program champion should utilize all modes of communication available to keep the interdisciplinary team informed of program progress, including internal memos, emails, signage, meetings, etc. Meeting personally with staff, such as case managers or case manager supervisor, to address their individual concerns, was also an effective strategy used by PREP program managers in gaining support for the PREP program.

Another key strategy in lessening resistance from other members of the health care team is to carefully professionalize the peer program, without compromising the essence of the peer role. Some strategies used to help professionalize the peer program include ensuring that peers are well acquainted with the agency's policies and procedures, respect boundaries with colleagues and patients, and maintain a professional role and environment. At the same time, peers are a unique member of the team in that they offer personal experience and emotional support to their patients. While it is important to abide by agency policies and procedures, it is equally important to stress that peers are available to meet with patients where they are and to share their own experiences and life lessons, which will help to gain patient trust. Focusing on the professional aspect of the peer program and the role peers play with patients will help staff and peers to come to a shared understanding that the peer role is unique in that it draws from personal experience and provides a supportive relationship with patients in a way that other team members are not able to.

Defining Peer Roles and Responsibilities as Required by Intervention

The establishment of well-defined roles and responsibilities of peers and other staff is key to a successful peer program. The more inclusive the process of defining these roles is, the more buy-in there will be for the peer program across the agency. Peers serve many roles as part of the medical care team and within the social support systems needed by participants. These roles and functions are aimed at improving and enhancing the lives of those living with HIV. Defining peer roles is critical in order to establish boundaries between the peer roles versus the role of other staff members (including other members of the health care delivery team or administrative staff), which will largely determine the program's level of success. This means explicitly stating how other staff members (e.g., physician, nurse, case manager, etc.) will be expected to work with the peer; this includes clearly identifying the ways the roles and responsibilities of other staff members may change. Processes or procedures that may be affected by integrating peers into the health care team may include outreach protocols, recruitment procedures, documentation of services, and patient reminder systems. Ultimately, defining roles and responsibilities for peers and their coworkers will:

- Ensure that peers (and other staff) are responsible for completing tasks that they are qualified to do.
- Avoid overlapping or duplication of responsibilities with other members of the clinic (particularly case managers).
- Prevent team tension by clearly delineating what each person is responsible for.

To gain wide acceptance of the program, develop job descriptions and share them with members of the management team, external consultants, and representatives from funding sources. During the recruitment process (and again once hired) review this job description closely with. The peer job description can be used to clarify expectations, as a tool to provide feedback at regular supervision meetings, and as an evaluation tool for job performance. For example, supervisors can refer to this job description and other agreed upon roles and responsibilities on a regular basis to assess how the peer is doing in terms of role shifting. Based on this assessment, the peer may work to match his or her behaviors to the job description, or the staff may refer to the agreed upon job descriptions to be refreshed on roles, responsibilities, and boundaries within the health care team. See Appendix B for sample job descriptions.

For more information on establishing peer roles and responsibilities, go to Section 4 of the *Building Blocks to Peer Program Success* toolkit at: http://peer.hdwg.org/sites/default/files/4_PeerRolesAndResponsibilitesComplete.pdf

Adapting Communication and Coordination Systems

The level of communication among all team members, including the peers, will determine how efficiently and effectively the team is able to coordinate and deliver quality care. The more information the team has on each patient, the better. Creating systems of communication and coordination among team members will ensure that the team reaps the full benefit of the unique relationship each staff person, in particular the peer, has with each patient.

The task of assessing the communication and coordination systems during the program design phase falls to the program champion. This assessment provides an opportunity to review standard operations, protocols, and procedures of the team and of the agency. Having done this, the program champion is able to identify the areas where the peer can contribute most and make appropriate revisions to the standard operating procedures. Because of the potential overlap in roles and responsibilities between peers and case managers, it is important that the program champion or the peer supervisor (it may be the same person) work closely with the existing case managers and the case manager supervisor to adapt existing protocols or developing new ones. Adapting communication systems will be particularly useful for keeping the entire team up to date on the status of each patient. Granting peers access to electronic medical record (EMR) systems and other documentation data systems, such as CareWare, is critical as it is more efficient and streamlined than informal lines of communication and will reduce loss of information.

The program champion, peer supervisor, and case manager supervisor also coordinates and facilitates regular case conferencing meetings between peers, case managers, psychologists, doctors and nurses to discuss how to address the needs of patients. If case conferencing already takes place within the agency, make sure that peers attend these meetings, as they will provide a most effective venue for information sharing that will benefit patients, peers, and the rest of the team alike. In addition to facilitating communication among the health care team and care coordination staff, peer inclusion in case conferencing will continue to highlight the distinction between roles and responsibilities of peers versus case managers and the advantages of having both on the interdisciplinary team. Similarly, ensure that peers regularly participate and report on progress of the program at all relevant staff and team meetings (particularly health care team meetings) or team huddles.

Peer Supervision and Support

Effective peer supervision calls for a highly supportive supervisory style that borrows from mental health counseling, social work, and supervision. Pioneer peer programs across the nation have witnessed a high turnover rate among peers. In order to address this, peer programs have found that implementing three types of coordinated supervision can positively affect retention rates among peers: administrative, supportive, and clinical. Administrative supervision is offered to all employees as part of good program management. Administrative supervision for peers should include:

- Goal setting with the peer
- Working with the peer to review goals and progress on these goals
- Professional development, including training that will help the peer in his or her role
- Troubleshooting any administrative barriers as the peer works with each client
- Managing logistics
- Checking in with the peer about job satisfaction

Supportive supervision provides an opportunity for the peer and supervisor to talk about issues that emerge as a result of the peer's own life experiences in working with patients in similar life situations. These issues are redirected toward helping the peer both maintain boundaries and manage within the scope of his or her work. Sometimes, overwhelming feelings emerge for a peer as a result of working so closely with patients, which may interfere with boundaries in the workplace and with patients, and potentially lead to burnout. Supportive supervision enables the peer to look for ways in which he or she can continue to support patients in working towards their goals, yet feel supported in maintaining his or her own boundaries with colleagues and patients.

Regularly providing supportive supervision to the peer provides both a safe and uninterrupted time and space to discuss issues important to the peer.

With clinical supervision, the peer has the opportunity to explore more deeply feelings of transference and countertransference that emerge with patients. Unlike supportive supervision, clinical supervision allows the peer to develop a deeper understanding into how his or her reactions can be triggered by the client and through this understanding and exploration can maintain a relationship with the client that will be productive.

For more information on how to build organizational capacity to effectively supervise peers, go to Section 6 of the *Building Blocks to Peer Program Success* toolkit at: http://peer.hdwg.org/sites/default/files/6._SupervisingPeersComplete.pdf

Peer Conference Calls

If possible, working with a network of peers from different agencies is very useful in providing an additional layer of support. If there is access to such a network, holding monthly conference calls for peers from across agencies and facilitated by an experienced Peer Supervisor who is not affiliated with any of the agencies at which peers provide services can help peers to grow personally and professionally. During these calls peers may be encouraged to case conference, share experiences, exchange ideas, ask for advice, and offer feedback to one another. These calls offer a space for peers to cooperatively problem solve with others that may be facing similar issues, and allows them to build a community that can also be a consistent, albeit distant, source of social support. They may also serve as a venue for continuing education; and peers should be encouraged to communicate topics of interest (including refreshers on previously covered topics) that can be presented upon by consultant experts or the facilitator of the call via webinar. Some of the topics that were requested as refresher presentations by the PREP peers were:

- Boundaries with Patients
- Depression and HIV
- Harm Reduction
- Communication Skills
- Understanding Labs

PART 3: IMPLEMENTING THE ENHANCED PEER INTERVENTION

> *The peer educator helps us to inform, educate, get in touch with lost cases, plan, and manage the integration of the client into the social reality.*
>
> Agustín Ruiz
> Case Manager
> Puerto Rico Community Network
> for Clinical Research on AIDS
> (PR CoNCRA)

Identifying and Recruiting Patients for Enhanced Peer Intervention

Strategies for Patient Identification and Outreach

Using data to identify out-of-care patients.

Effective strategies of identification for out-of-care patients will vary from organization to organization. One strategy that may be used to determine which patients have fallen out of care is to use data systems to generate lists of patient who have not been in for a primary care visit within a certain timeframe.   This may be a challenge if the data system is part of a system-wide monitoring and documentation system, identifying subgroups or running these kinds of queries may not be useful (i.e., the lists are too long and include patients from other agencies; the lists include patients who are not necessarily eligible because the characteristics cannot be refined to a useful level). Therefore, data systems that are not designed to carry out such tasks may generate inaccurate lists. Another issue that may pose a challenge in generating out-of-care lists through data systems is general data-entry errors or time lags. If agencies are still in the process of moving from hard-copy medical records, or from one data-entry system to another, it will use inaccurate or incomplete information to generate lists that will not be useful. There also may be multiple data systems such as EMRs, scheduling systems, case management or other Ryan White reporting systems, from which information is needed. Effectiveness of this strategy will largely depend on the data systems that are used within the organization, the capacity of these systems to perform particular queries, and the ability to merge data from multiple data systems into a single report. Before deciding on this strategy as a means to identify patients, meetings should be convened with IT or relevant staff members who are well acquainted with the agency's electronic data systems.

Developing a process to identify out-of-care patients within the organization.

For those cases in which generating accurate out-of-care lists is not possible, the most effective way to identify out-of-care patients is to develop a system within the health care team in which providers, case managers, or other staff look through their own caseloads and determine which of their patients have not been in within the past four months or longer. The peer can play an integral role in this process, as he or she can be the point person for all team members to report to regarding patients who have not been in care. For example, peers can develop lists manually by going through patient medical records to identify patients that are out of care and meet criteria to enroll in the program. This strategy is more time intensive, but can be used as a last resort or at smaller organizations with fewer patients.

Identifying at-risk newly diagnosed for the PREP program.

Identifying newly diagnosed patients who are at risk of falling out of care (i.e. need mental health, substance use, and/or housing services) may involve one or both of the following: 1) creation of a referral system within the organization (e.g., if the agency provides HIV testing and counseling) so that newly diagnosed patients who are at risk for falling out of care are referred, and 2) establishment of formalized partnerships with external agencies that refer newly diagnosed patient at risk for falling out of care to the organization for peer services. A common component of each of the above strategies is education and communication between the project directors and other agency departments and outside partners. At Care Resource in Miami, for example, the project director met regularly with each department within the agency to discuss the program, including eligibility criteria, so that referrals could be made from across the agency.

Using outreach to engage out-of-care and at-risk newly diagnosed in care, and to get them enrolled into the peer program.

Once out-of-care and at-risk newly diagnosed patients have been identified, the next step is intensive outreach to link patients to care immediately. Outreach for this population requires regular communication with case managers; knowledge of the community, resources, and partner agencies; and the time and commitment to have "feet in the street."

Peer Role in Patient Identification and Outreach Processes

Identification of and outreach to out-of-care patients and newly diagnosed patients at risk of falling out of care is a collaborative effort that requires cooperation among many staff members including:

- Outreach supervisor and specialists who receive referrals
- Medical case managers and other providers who identify and refer patients who have not been in care and provide contact information during the outreach process
- Data managers who generate lists

Peers, too, play an integral role in the process of identifying out-of-care patients. First and foremost, they serve as a central keeper of information regarding out-of-care and new at-risk patients. Peers work closely with staff across the agency to identify patients who are truly out of care. Constant communication and meetings with the following personnel can facilitate this process:

- Reception/Registration staff
- Medical case managers
- Medical providers (e.g., nurses, physicians)
- Outreach specialists

Depending on the identification strategy, peers may also be responsible for looking through automatically generated lists and comparing those to Electronic Medical Records (EMRs) or other kinds of data systems used by the agency to verify which patients are truly out of care.

The level of peer involvement required for outreach will also depend on the existing resources within the agency. Some agencies may already have an outreach department employing full time outreach specialists; such was the case at Care Resource. Here, the peers were responsible for making referrals to the outreach department for those patients who have been determined to be out of care and following up with the outreach staff to ensure that the patient was referred to the peer program. If the agency does not have an outreach department, peers may be responsible for doing intensive outreach to patients via phone calls, text messages, emails, and other kinds of correspondence; fieldwork at partner organizations (e.g., residential treatment agencies, homeless shelters); and home visits. This also requires working closely with case managers to obtain contact information, other information regarding the patient that may shed light upon his or her whereabouts (e.g., homeless shelter where patient regularly stays). Because many patients struggle with housing instability, contact information in medical charts can often be outdated. Peers strategize ways of locating patients through other means, such as calling case managers at other agencies or using social media.

Peers responsible for conducting outreach require training to track and document their patient-contact attempts and the results of these contact attempts during outreach. This is a critical component of the identification and outreach process because

1) it makes the outreach process more efficient so as not to duplicate work; and
2) it informs other members of the health care team about the current life circumstances of patients who are found.

The PREP program developed an outreach form which was used by peers who conducted outreach. Each peer printed a copy of the form each week and entered date and type of contact attempts made and the respective results for any patient. At the end of each week the form was submitted to the peer supervisor who updated and maintained a master electronic version for all contact attempts made by all peers. See Appendix C for the outreach log used by peers in the PREP program.

Engaging and Retaining Patients in Care and Adherence to Treatment

The PREP Intervention Protocol (see Appendix D) delineates the specific tasks that peers conduct with their patients. The protocol covers three general areas that fall within the purview of the peer in order to engage and retain patients in care:

Developing Rapport and Providing Support to Patients

Peers offer a great deal of practical and emotional support to their patients that other members of the health care team may not have the tools, resources, experience or time to provide. Patients, however, must first feel comfortable with the peers before they are willing to accept this support. A primary responsibility of peers is to establish a level of trust and comfort with patients. This can be a major challenge for this particular population, who are dealing with complex life circumstances and may have had negative experiences in the health care system in the past. By disclosing their HIV status and sharing personal experiences, peers create a safe and comfortable environment in which patients feel they can be candid about their own experiences and life circumstances. Peers are trained in communication and motivational interviewing skills which enable them to elicit important information from patients that is critical to evaluating their needs and readiness to take certain actions. They also work closely with patients to set goals and consistently follow up on these goals. Peers are expected to communicate consistently with their patients. The PREP Intervention Protocol (see Appendix D) specifies that peers conduct (at least) weekly check-ins with their patients by phone or in-person for the first three to four months of the intervention. The level of communication may be greater depending on the needs of the patient. Peers learn very quickly that being flexible with their patients (e.g., unscheduled calls, walk-ins) is of critical importance to how regularly they communicate with them. After the initial three to four months meeting with a patient, peers can reduce the level of communication by reaching out on a bi-weekly basis, unless the patient continues to require intensive services.

Peers who have gained the trust of their patients are more likely to maintain constant communication with them. This enables the peers to provide practical support such as meeting with the patient to learn of upcoming appointments outside of the agency, making appointment reminder calls or texts for medical or other visits (including their own scheduled visits with the patients), and providing transportation assistance or coordination in order to ensure that the patient attends his or her appointments.

Coordination of Services

The trust and candor established within the peer–patient relationship is crucial due to the important and sometimes sensitive information elicited by the peer. While peers offer emotional and practical support to their patients by listening and offering assistance, they also gain insight into the life circumstances that their patients are facing and that need to be addressed concurrently with their HIV care needs. Peers are able to communicate important and relevant information to the rest of the health care team and other colleagues in order to efficiently coordinate and provide delivery of appropriate health care and social services. As part of the health care delivery team, peers across the PREP sites were granted access to shared data systems and EMRs so that information gathered in their encounters with patients could be added to the record and viewed by the rest of the health care team. The peers also had access to information collected by their colleagues regarding their patients. Furthermore, peers were fully integrated into regular team meetings in which they and their colleagues discuss cases and exchange information.

Peers also play an integral role in care and service coordination for their patients by developing strong partnerships and regularly communicating with providers at partner organizations that provide substance abuse and mental health services. The majority of patients not engaged in HIV care struggle with mental illness, substance abuse, and /or housing issues. While engaging these patients in HIV primary care is a priority, these patients may also require other medical and social services which should be coordinated along with their HIV care. A major responsibility of peers is to follow up on patient referrals, including those for substance abuse and mental health treatment, as well as housing and other social services – both within their agencies and with external partner agencies. As peers consistently follow up with outside providers, they are building important relationships and networks that can improve delivery and coordination of care for patients.

Similarly, a majority of patients at risk for falling out of care face extremely challenging life circumstances. These circumstances often are of the highest priority for patients and, if not addressed, can interfere with patient engagement in HIV care. Just as peers have the resources and ability to build strong relationships with mental health and substance abuse providers outside of their agencies, they are also able to do so with agencies that provide social services that are regularly needed by their patients. Homelessness and housing instability are challenging issues that peers address with many of their patients. When peers build strong relationships with providers at housing agencies, it benefits their patients. It also allows for peers to communicate to the health care team important information regarding housing status that may have an impact on patient engagement in care or adherence to treatment.

Documenting Peer Work

As described in the Section on Adapting Communication and Coordination Systems, peer documentation of their encounters with patients is critical to keeping the rest of the health care team informed about pertinent patient information. This enables the team to reduce duplication of work, adapt treatment and care plans with patients, and adapt communication methods (i.e., outreach strategies, interpersonal provider-patient communications) based on patients' current life circumstances. PREP program staff developed contact forms that included activities integral to the peer roles and responsibilities. These forms were used by peers each day that they have an attempted or successful encounter with a given patient. Any information documented in these forms that may be pertinent to the other members of the health care team was entered by the peer into the respective data system (e.g., case management database, electronic medical record, etc.). Program staff collected these forms and stored them in participant files (separate from the medical files). These records proved useful when the health care team later needed to review in-depth information regarding a particular patient, as well as for supervision and evaluation purposes. See Appendix E for the PREP Peer Contact Form.

Implementing Peer–Patient Sessions

As part of the Peer Enhanced Intervention, peers were trained to conduct a series of one-on-one educational sessions with their patients. The Intervention peer–patient sessions are 30-60 minute face-to-face meetings that are scheduled on a generally bi-weekly basis. The purpose of these educational sessions is to educate patients about a variety of issues that they may face as individuals living with HIV; these topics span a wide range including, but not limited to: how to interpret laboratory values, improving understanding of why drug resistance occurs, how to disclose your HIV status, or how to improve communication with your health care provider. Peers are trained during the peer core competency training in all of the topics covered in the educational peer–patient sessions. The following is a complete list of the topics covered by the peer with their patients.

Session 1 – Introduction and Assessment

Session 2 – HIV Transmission and the Viral Life Cycle

Session 3 – Effective Communication and Self-Advocacy (on-going)

Session 4 – Understanding Lab Values

Session 5 – HIV Medications

Session 6 – Drug Resistance and Adherence; Understanding and Managing Side Effects

Session 7 – Disclosure and Stigma

Session 8 – Harm and Risk Reduction

During the initial visit (Session 1) peers assess the needs of their patient by asking a variety of open-ended questions designed to elicit descriptive responses regarding the patient's history and current life circumstances (see Appendix F for the PREP Peer–Patient Educational Conversation Guide used by peers of the PREP program). Depending on needs and knowledge levels of each patient, the peer is enabled to adapt a curriculum for that particular patient using the eight sessions outlined above. Peers are able to determine which sessions to cover more in-depth, which topics to review regularly, which topics can be combined, and which topics the patient doesn't need to spend as much time on. During each session, peers reassess the needs of the patient and can adapt this curriculum according to patient health, circumstances, or emotional well-being in order to strategically determine which topics might be most useful at that time. However, each peer was required to address these eight topics at least briefly.

The sessions are meant to be flexible in a few ways. As described above, the content of the curriculum can be adapted to suit the needs of the particular patient.

At times, peers may have to accept that life events can sometimes interfere with educational sessions. Part of the peer role is to provide emotional and practical support as needed, and if this is the case it will often cut into the time of the more structured educational sessions. Peers will need to be flexible in determining whether to provide this support or to conduct an educational session during their scheduled time with each patient.

Peers are also flexible in terms of the frequency of these sessions. Although the protocol for this program states that sessions should be completed with patients on a bi-weekly basis, the length of time between sessions may vary from patient to patient in order to schedule around existing co-located medical (or other) visits, which reduces the likelihood of having to reschedule the session. In fact, the PREP peers also developed systems with the receptionists and other providers to let peers know if one of their patients came in for a walk-in visit so that the peer could try to make contact with the patient on his or her way out, or while waiting for an appointment. This process also gave peers the opportunity to accompany patients to visits. Peers often do this in order to review health information with their patient and the clinician, support their patients in improving their communication skills with their clinician, or provide additional emotional support, for example.

The location of their meetings can also vary to improve the likelihood that the patient will engage in these sessions. Peers may do home visits, meet patients at residential treatment centers, visit them in the hospital, or meet them at other locations depending on what the patient prefers or the particular circumstance. This is particularly helpful if there is a lack of private space at the agency at any given time.

Peers often ask patients if they are having any particular issues in terms of their health, health care, or emotional well-being during these sessions in order to strategically determine which topic might be most useful for that individual in that moment. Sessions can also be combined if the peer feels that the patient will benefit from this. For example, PREP peers found that certain sessions are likely to be combined often (such as sessions five and six, and sessions seven and eight) or repeated more often than others (such as sessions three, five, and six). In general, even after the entire curriculum has been completed, it is helpful for patients to do some refreshers if the topic is relevant at the time or to help patients absorb the information better.

These sessions also create an initial environment for peers to learn more about the particular needs of the patient and for the patients to get to know more about their peers, their experiences, and the resources that they have to offer. Ultimately, these meetings enable the peers and their patients to build rapport. Once these sessions are completed, peers continue their emotional and practical support by continuing their weekly or bi-weekly check-ins with patients (by phone or in-person). This support continues for at least one full year, at which point the patient is assessed to determine whether he or she can be transitioned into the standard of care at the agency. This transition process is described in more detail in the following section.

See Appendix F for the PREP Peer–Patient Educational Conversation Guide used by peers of the PREP program.

Transitioning Patients to Standard of Care

Developing a Transition Protocol

The enhanced peer intervention is intended as a temporary intensive service that is provided for particularly at-risk patients to help them become more involved in their own health care and improve certain life circumstances that will help them adhere to their HIV treatment. Ultimately the aim is to provide patients with the information, support, and skills to remain in care on their own. In order to provide the Enhanced Peer Intervention to all the patients that need it, it is critical to maintain smaller caseloads by transitioning patients that are ready to move on to standard-of-care services. This has important implications for sustainability of the program, as it unlikely that an agency can hire as many peers as is necessary so that all patients of the agency are assigned a peer at one time. To ensure that patients who are ready move into standard of care and that the transition process is smooth for both the patient and the interdisciplinary team, the PREP program recommends developed a Transition Protocol and Policy that includes the following:

- Guidelines for how and when to utilize level-of-need assessment tools which will measure patient readiness to move onto standard-of-care services. Introduce these guidelines to peers as part of his or her orientation and training; prior to him or her taking on a caseload. More detail is provided on patient assessment in the following section.
- Guidelines for how to discuss the transition plan with the patient once he or she is ready to "graduate" from the peer program.
- Guidelines and procedures for team members to follow in preparation and throughout the process of transitioning the patient (e.g., required meetings between the case manager and peer to discuss whether patient is ready to be transitioned, meeting between case manager, patient and peer to develop a care plan, etc.).
- A list of local support services and resources that staff can refer patients to once they have graduated from the peer program (in addition to standard-of-care case management at their own agency).

See Appendix G for the PREP Completion and Transition Policy and Procedure.

Developing an Assessment Tool

The transition protocol and policies will include guidelines on how to determine whether a patient is ready to transition into standard of care services by indicating how and when to use the project's level of need assessment tool. In developing an assessment tool, consider the goals of the program and the resources available. The goals of the peer program link directly to the outcomes which will be regularly assessed by the peers. For example, the PREP program peers used a tool which assessed patient level of need with respect to mental health, substance abuse, housing status, and transportation – all of which are associated with the primary objective of the project (engagement and retention in care) and are areas that the peers had the capacity to impact directly or indirectly. Requiring that patients complete certain milestones is also useful in ensuring that certain project objectives are achieved with each patient. For example, the PREP transition plan required that patients complete all eight educational sessions and be in the peer program for 12 months before they are assessed and considered for completion of the peer program.

See Appendix H for the PREP Level of Need Assessment Tool.

Sample Work Plan for Implementing an Enhanced Peer Intervention

Goal: Design and implement culturally competent coordination of services by integrating peer into the interdisciplinary health care team

Objective 1.1. Conduct needs and assets assessment at provider organization

- Action Step 1.1.1. Develop needs and assets assessment instrument to assess structural, programmatic and clinical characteristics of provider interventions. Identify target population Deliverable: Assessment conducted and results written up.
- Action Step 1.1.2. Solidify intervention plans and identify training needs. Deliverable: Intervention protocol, training needs assessment results written up.

Objective 1.2. Solicit technical assistance and identify resources for intervention planning, implementation, and collaborations

- Action Step 1.2.1 Build partnerships with other providers that have or are currently implementing a peer program. Conduct monthly conference calls to exchange experiences in planning interventions. Deliverable: Calls convened, minutes distributed.
- Action Step 1.2.2 Participate on technical assistance (TA) webinars and meetings on linkage to care, peer models, consumer involvement, service linkages, interdisciplinary care, harm reduction, and/or staff training, interagency collaboration, strengths-based case management, peer interventions and other topics as identified. Deliverable: Webinars disseminated to team. Audio and PowerPoint presentations uploaded to a resource website accessible to primary care team.
- Action Step 1.2.3 Identify session topics and develop or adapt session materials and guide. Deliverables: Session manual.
- Action Step 1.2.4 Determine roles and responsibilities of peers. Deliverables: Protocols for how peers will communicate and work with other primary care team members; describe roles and responsibilities in writing; develop job description.
- Action Step 1.2.5 Identify and hire peers. Deliverables: Peers hired as employees of the agency.
- Action Step 1.2.6 Identify qualified training staff. Identify and adapt training curriculum based on population clinical needs assessment and training needs assessment. Deliverable: Relationship established with training staff, memoranda of understanding (MOUs) signed. Training curriculum developed.
- Action Step 1.2.7 Train staff (including peers, peer supervisors, case managers, clinicians that are part of primary care team) on culturally competent interventions - patient navigation/peer programming/strengths-based case management/web/mobile interventions, etc. Deliverables: Trainings convened.

- Action Step 1.2.8 Form collaborative relationships and linkages with mental health and substance abuse treatment and housing providers. Deliverable: Relationships established, MOUs signed.
- Action Step 1.2.9 Solicit and participate in available TA around clinical quality and quality improvement, as needed. Deliverable: TA provided and evaluated

Objective 1.3. Develop plan to enroll patients into the Enhanced Peer Program.

- Action Step 1.3.1 Develop plan to identify and locate target population in the community (out-of-care individuals and newly diagnosed or new patients to clinic at high risk of falling out of care). Deliverable: Identification systems developed and described in writing.
- Action Step 1.3.2 Develop plan for outreach and recruitment of target population. Deliverables: Protocol for recruitment developed and described in writing.
- Action Step 1.3.3 Develop referral and enrollment process for eligible patients. Deliverables: Flow chart demonstrating processes in which patients will enroll in the Enhanced Peer Program. Protocol of referral and enrollment processes.
- Action Step 1.3.4 Form collaborative relationships with agencies serving the target population who can refer to the Enhanced Peer Program. Deliverables: Relationships established, MOUs signed.
- Action Step 1.3.5 Develop marketing strategy to promote the program and encourage referrals to the Enhanced Peer Program. Deliverables: Marketing tools developed and disseminated within community.

CARE Resource Peer Support Job Description

Job Title: Peer Support	**Status:** Part Time
Department: Information & Quality Services	**Revised:** March 20XX
Reports To: Intervention and Evaluation Coordinator	

JOB SUMMARY: The Peer Support is responsible for providing emotional and educational support for clients who are HIV positive and have mental health, substance abuse and homelessness issues. S/he is responsible to engage, inform, support and empower those who are eligible for services and would like to receive services from Care Resource. He/She also is responsible for assisting in the intake process by gathering documentation and by providing administrative support in order to expedite service delivery.

ESSENTIAL JOB RESPONSIBILITIES:

Outreach and Social Networking

- Assists in identifying male patients (age of 18 or older and men of color) who have been lost to care for four months or more, or newly diagnosed with HIV and have a mental health, substance abuse treatment or a housing need for program participation.
- Welcomes clients into the agency and provides orientation/education regarding the agency and its services.
- Accompanies clients to medical, mental health, substance abuse treatment or social service appointments in order to improve attendance.
- Helps clients to schedule medical appointments and follows up with providers to ensure clients attend appointments.
- Contacts clients to verify and/or remind them of appointments with other departments or other agencies.
- Communicates with clients one to three days before a foreseen hurricane/natural disaster according to emergency plan procedure.

Health Education and Promotion

- Provide emotional support to patients around topics such as disclosure options and dealing with stigma.
- Provide emotional and educational support to patients who have mental health, substance abuse and homelessness issues.
- Serves as mentor regarding interaction with medical providers, helping patients prepare for visits and then debriefing what happened, depending on patient need.
- Provides educational support to clients to enhance their knowledge and understanding of medication protocols, side effects and adherence.
- Walks clients through initial appointments for medical care or other social services in order to ensure that clients have a clear understanding of initial steps that need to be taken to obtain appropriate services.
- Monitors clients adherence as required.
- Educates new clients on the process and what to expect from the HIV service delivery system.

CARE Resource Peer Support Job Description (cont.)

- Participates in staff training sessions and other meetings as required by the agency and/or the funding sources.

Documentation, Compliance and Quality Assurance
- Maintains Timely, Accurate, Legible and Clear chart documentation according to agency requirements.
- Maintains record keeping requirements and assists with chart reviews for Q/A purposes as requested.

Other
- Participates in agency developmental activities as requested.
- Other duties as assigned.

Safety
- Ensures proper hand washing according to Centers for Disease Control and Prevention guidelines.
- Understands and appropriately acts upon assigned role in Emergency Code System.
- Understands and performs assigned role in agency's Continuity of Operations Plan (COOP).

JOB SPECIFICATIONS

Education: High school diploma required.
Training and Experience: One year of related experience working in programs with at risk populations and performing outreach is required. Knowledge and trainings in HIV/AIDS are required.
Licenses and/or certifications: N/A
Job Knowledge: Bilingual (English-Spanish/English Creole) highly preferred. Computer knowledge should include Microsoft Word and Excel. Good communication, problem solving, team work and organizational skills are required in order to engage participants. Ability to work with multicultural and diverse population is required. Must be self-motivated, detail oriented, able to travel locally and work flexible hours.
Contact Responsibility: The responsibility for external contacts is frequent and important.
Other: Own transportation is required.

PHYSICAL REQUIREMENTS

This work requires the following physical activities: constant talking in person, talking on the phone, hearing/ visual acuity. Frequent driving, walking, sitting and bending. Occasional standing and climbing are required. Work is performed in an office or community settings.

STATEMENT OF ACCEPTANCE OF RESPONSIBILITIES

I, ____ verify that I meet the qualifications specified above for the position of Peer Support. I have read my job description and accept my stated responsibilities.

Signature: _____________________________________ Date: ______________

Pr CoNCRA Descripción del Puesto Educador Par

Descripción General del Puesto: Las y los Educadores Pares facilitaran el acceso a servicios de prevención, cuidado y tratamiento de VIH/SIDA. Serán responsables de ofrecer apoyo a las y los participantes de la clínica con una serie de estrategias, dirigidas a lograr la retención o re-integración a los servicios clínicos y a fortalecer la adherencia al tratamiento de estas personas. Se recomienda que la persona sea VIH positivo y que sea adherente a su tratamiento para servir como Par. A continuación se desglosan las funciones y tareas con las cuales deben cumplir las y los Pares.

Cualificaciones del Puesto

A. **Educación:** Diploma de Escuela Superior, o en su lugar cursos que le capaciten para ejercer sus funciones, adiestramientos relacionados al VIH
B. **Experiencia:** Requiere un mínimo de 2 años de experiencia en área relacionada
C. **Conocimiento y Destrezas Necesarias:**
  - Conocimiento y experiencia sobre aspectos de educación, prevención y tratamiento del VIH/SIDA
  - Orientado al servicio al cliente y las relaciones publicas
  - Capacidades y destrezas de comunicación oral y escrita
  - Destrezas en uso de computadora con sistemas de Word

Funciones Esenciales

1. Garantizar y cumplir con todas las políticas, protocolos y procedimientos establecidos por PR CONCRA, muy en particular, asegurar la confidencialidad y la seguridad de la información de las personas que reciben servicios de la clínica.
2. Servir de enlace entre las y los pacientes y las y los proveedores de servicios de salud de PR CONCRA.
3. Coordinar y ofrecer actividades educativas para los participantes a nivel individual, sobre la educación de la prevención, cuidado y tratamiento de VIH.
4. Diseñar e implementar sistema de recordatorio de citas, para que las y los pacientes en la clínica de adultos de PR CONCRA cumplan con sus citas.
5. Revisar en coordinación con las y los manejadores de caso, el sistema de referido de PR CONCRA para fortalecer el mismo y aumentar el nivel de participación y adherencia al tratamiento de las y los pacientes.
6. Facilitar la comunicación y citas de las y los pacientes con el sistema de referidos de PR CONCRA.
7. Ayudar a las y los pacientes a navegar el sistema de cuidado de salud resolviendo dificultades, para que estos puedan acceder a los servicios internos y externos.
8. Acompañar a las y los pacientes a sus citas tanto a las clínicas, así como a las del sistema de apoyo para mejorar su calidad de vida, según sea necesario o requerido.
9. Ser pro activo, anticipar los retos e identificar posibles soluciones a las situaciones imprevistas o problemas que puede enfrentar un o una paciente al acceder a servicios clínicos o de apoyo.
10. Abogar por servicios de apoyo para las personas pares y ser su voz, cuando sea necesario.

PR CoNCRA Descripción del Puesto Educador Par (cont.)

11. Servir de mentor y con su modelaje inspirar a sus pares a mantenerse integrados a los servicios relacionados al cuidado de su salud.
12. Ofrecer apoyo emocional en cualquier fase de la intervención, refiriendo al participante a la o el Manejador de Caso asignado.
13. Proveer apoyo social a las y los participantes para fortalecer su sistema de apoyo familiar y social y a su vez evitar el aislamiento.
14. Realizar actividades de alcance comunitario de participantes de PR CONCRA para atraer a estas personas a servicios de cuidado de su salud. (Estas actividades incluyen visitas al hogar, a la comunidad y a lugares donde puedan ser contactados las y los participantes del Proyecto, entre otros).
15. Colaborar en actividades de alcance comunitario, proveyendo información de prevención y tratamiento de HIV y promover la prueba rápida y otros servicios de laboratorio.
16. Según requerido, participar en reuniones con el equipo de Manejo de Caso y proveedores de salud para asegurar la provisión de servicios de cuidado de su salud y referidos apropiados de sus pares..
17. Colaborar con las y los Manejadores de Caso de PR CONCRA, para darle seguimiento al plan médico para autorizar pruebas y laboratorios requeridos.
18. Documentar y archivar a diario, hojas de referidos y todas las intervenciones en el expediente médico de la persona que está sirviendo, asegurando la calidad de los servicios.
19. Preparar informes de labor realizada, según le sea requerido.
20. Representar a la Organización en reuniones, charlas y/o talleres, según se le solicite
21. Cumplir con otras tareas según requeridas.

Relaciones Interpersonales
A. **Internas** - Deberá comunicarse efectivamente con el personal de la Agencia.
B. **Externas**-Capacidad para interactuar con los participantes, familiares y con todo el personal de la Agencia.

Supervisión
A. **Ejercida:** No ejerce funciones de supervisión
B. **Recibida:** Recibe supervisión directa de la Coordinadora del Proyecto Acércate e indirecta de la Directora Ejecutiva y de la Directora Auxiliar de la Organización.

La información arriba detallada pretende describir de forma general la naturaleza y nivel de trabajo a ser realizado en la posición. Esta descripción no pretende ser interpretada como una lista completa de todas las tareas, deberes, responsabilidades o requisitos de la posición.

Revisado y conforme por:

Empleado: ____________________ ____________________
Firma Fecha

Directora Ejecutiva: ____________________ ____________________
Firma Fecha

Rev. Diciembre 2011

The PATH Center Table of Organization Position Review: Outreach and Testing Positions

Position Title: Peer Outreach Worker (RREP)
Reports to: Program Manager, Special Projects

- Working under the direction of the Program Manager for Special Projects, the Peer Outreach Worker works to encourage engagement into care, and support adherence to treatment by providing education, resources, and mentorship within the guidelines of the Retention and Re-Engagement Project (RREP). This includes adhering to study protocol, involvement in preparing and implementing patient treatment education programs, participation in the selection of patient education materials, and appointment accompaniment when necessary.
- Conduct outreach on street, in parks, at community-based agencies, and other places where HIV-positive people of color may be found, engaging them and helping them to engage in care.
- Reaches out to new patients entering PATH clinic, helps them to become oriented, understand clinic flow, and get comfortable in the PATH clinic setting.
- Conduct HIV rapid testing as needed, working closely with HIV Counselor/Tester.
- Conduct “in-reach” within The Brooklyn Hospital Center to identify at-risk people of color, encourage testing, and help those diagnosed as HIV-positive to enter care with PATH (the hospital’s HIV service) or elsewhere if the patient prefers.
- Help to select new patient education materials, develop fact sheets and other resources materials to help patients manage their care.
- Conduct home visits and/or make reminder calls and send reminder letters to help HIV-positive patients keep their appointments. Follow-up with patients who miss their appointments according to study protocol – by phone, by letter and/or in person – to keep them in care.
- Escort patients to appointments as needed.
- Develop and maintain relationships with key referring agencies. Stimulate growth of referrals from outside agencies by serving as resource person. Conduct agency visits, meeting with patients and staff to share information and promote the use of PATH services. Help put written linkage agreements into place.
- Maintain data and prepare required data and written reports both internally and for the funding agency.
- Participate in trainings and meetings with Boston University and other study sites as requested. Participate in Performance Improvement Committee meetings, at the request of the Executive Director.

The PATH Center Table of Organization Position Review: Outreach and Testing Positions (cont.)

- Participate in PATH staff and outreach team meetings, including active participation in PATH Center Advisory Board meetings. Attend additional staff and TBHC meetings at the request of the Executive Director or Program Manager of Special Projects.
- Provide other assistance to PATH clinic operation, as requested by the Executive Director or Program Manager of Special Projects, including: setting up food cart for patients, mailing of reminder letters to patients, assembling materials for clinicians use.

Requirements: Experience, volunteer or paid, working with patients in HIV medical setting. Experience in conducting outreach preferred. HS Diploma or GED preferred. HIV counseling and testing certification.

Peer Outreach Log

Week: Peer educator/ Outreach Worker:

Out-of-Care Patient PR CoNCRA ID #	Case Manager	Contact Attempt # 1		Contact Attempt #2		Contact Attempt #3		Contact Attempt #4		Contact Attempt #5		Result
		Date	Type	Date	Type	Date	Type	Date	Type	Date	Type	

Type of contact:

Home visit	1
Telephone:	2
Shelter or institutional visit:	3
Email	4
Text message:	5
Other:	6

Results:

Patient was re-engaged into medical care and supportive services	1
After fifth attempt to contact, pt. was not re-engaged into medical care	2
Patient in care elsewhere	3

PREP Intervention Protocol

A. Intervention goals

- Increase retention in care of out-of-care people living with HIV/AIDS (PLWHA) (measured as an increase in the number/percentage of HIV-infected patients who had a medical visit with a provider with prescribing privileges, e.g., MD, PA, NP, in an HIV-care setting two or more times at least 3 months apart during the measurement year)
- Link newly diagnosed PLWHA into HIV medical care
- Increase the percentage of patients with viral load suppression
- Increase patient knowledge of HIV treatment
- Improve self-efficacy
- Improve health-related quality of life

B. Peer roles

- Link newly diagnosed PLWHA to HIV medical care and support services
- Outreach and re-engage PLWHA patients who have fallen out of care (not seen by MD for 4 months or longer) into HIV medical care and social support services
- Coordinate with and support other clinical staff such as case managers in achieving the patient service plan
- Assist with health systems navigation
- Coaching and mentoring patients on communicating with health care providers
- Educate and support PLWHA in adhering to care and treatment
- Adhere to activities as outlined in the study protocol

See Appendix C for specific job descriptions from each local site.

C. Office space for peers

- Peers should be given access to computers, a telephone, and desk. This could be a shared space with other peers or case managers.

D. Length of time

- The total time that a participant will participate in the study is 12 months; the intervention starts AFTER the participant signs the consent form, baseline data collection is completed, and the site receives notification that the person has been randomized to the peer intervention group.
- At the end of the 12 months (after completion of the 12 month follow-up interview), the agency may discharge the person from the program to the standard of care at the agency, continue to provide the peer service, or refer the person to other external agencies for peer services according to the agency's protocol.

PREP Intervention Protocol (cont.)

E. Training sessions

- Peers are expected to complete the training program offered by Boston University . This includes the 4.5 days of training for peers and .5 day session for case managers. (To view the complete PREParing Peers for Success Peer Core Competency Training Curriculum and a Sample Training Agenda go to: http://www.hdwg.org/prep/curricula)
- Peers are expected to attend the full workshop. Supervisors should monitor if any sessions are missed and work with BU staff to make up the sessions.
- In the event of staff turnover, the local site will coordinate with BU on a plan for training and mentoring new peer staff.

Refresher trainings

- BU will work with local sites to assess the need for additional peer training sessions during the course of the intervention.
- Local sites can send peers to local trainings sponsored by other entities (e.g., local departments of health, Centers for Disease Control). If peers do attend the sessions, study coordinators/ supervisors are asked to document the title, content of the training and amount of hours to the BU program manager.

F. Peer–Patient Sessions (for supervisors to review with peers)

Location for sessions:

Each site should make available private space for peers to meet individually with patients. This could be a conference room or office at the local host organization. It is strongly recommended that peer–patient sessions take place at the local host organization. However, peers could meet patients in an agreed upon place outside the local site's offices, as long as it is in compliance with agency policy and their IRB.

Frequency of sessions:

- Every 2 weeks.
- In-person
- 30-60 minute sessions.

Topics

- Session 1- Introduction and Assessment
    - o Should be held within one week (max) of patient enrollment.
- Session 2 – HIV transmission and the viral life cycle
    - o Option to do HIV 101 during Session 1 (after Introduction and Assessment).
    - o Materials: HIV Life cycle: Big picture

PREP Intervention Protocol (cont.)

  - o Viral life cycle DVD
  - o Routes of HIV transmission
- Session 3 – Effective Communication and Self-Advocacy (ongoing)
  - o Talking with your doctor
  - o Materials: "How to prepare for a visit with your doctor"
  - o Navigating the system - Local list of resources: pharmacy contacts; mental health services, substance abuse treatment programs, AA/NA, housing search services
- Session 4– Understanding Lab Values
  - o Reading and understanding CD4, Viral load and other clinical indicators
  - o Materials: Common Monitoring Tests for PLWHA (need in Spanish)
  - o Laboratory records
- Session 5 – HIV Medications
  - o Review medication chart
  - o Pill boxes
  - o Materials: Medications at work in the viral life cycle
  - o Lab and medication care
- Session 6 – Drug Resistance & Adherence; Understanding & Managing Side Effects
  - o Questions to assess adherence
  - o Symptom log
  - o DVD on resistance
- Session 7 – Disclosure and Stigma
  - o Some considerations before you disclose
- Session 8 – Harm & Risk Reduction
  - o How to talk with the patient…Conversation starters.

G. Patient Check-Ins

Peers are expected to make regular check-ins with the patient.

- Regularity of check-ins:
- Weekly for patients who are newly enrolled in the peer intervention.

PREP Intervention Protocol (cont.)

- Once Peer–Patient sessions are complete may transition to bi-weekly for patients who are ready (use acuity tool to assess level of need).
- Method of communication:
- By phone.
- In-person meetings may also occur if requested by a patient or case manager, or based on discretion of the peer.
- Text message, email, social media or other method of communication that is preferable for the patient.
- Questions/Tasks:
- Are any services needed? In particular:
    - o Mental health?
    - o Housing?
    - o Substance abuse?
- Have any referrals or appointments been made?
- Does patient need accompaniment to a medical or social services visit?
- Get patient in touch with people/services as needed.
- Appointment reminders.
- How are things going for you in general?
- Schedule next peer visit.

H. Documentation of Peer–Patient Contact

- Peer Contact Forms are completed anytime peer makes contact with a patient.
    - o One Peer Contact Form per day (i.e., multiple contacts made in one day are recorded on one Peer Contact form).

I. Peer Supervision & Support

- Designated supervisor: Sites are strongly recommended to set up a supervision system that includes weekly contact with a designated supervisor to review progress with patients, administrative tasks such as completing contact forms and assistance with supportive referrals.

PREP Intervention Protocol (cont.)

- Access to a clinical supervisor: Sites are strongly recommended to arrange for regular (monthly) clinical supervision with a licensed professional to provide clinical support to peers in managing their personal and professional work with patients." Supervision could be conducted in groups or individually, and may be provided in-house or by a consulting clinician. BU will work with local sites to adjust budget resources as necessary.
- It is recommended that supervisors hold regular (such as biweekly) meetings or group supervision.

J. Caseloads for Peers

- Estimated caseloads for each peer shall be 25-30 per peer FTE when the program is fully operational
- These may be increased with consent of the supervisor

K. Fidelity to intervention

- Only patients randomized to the peer group will receive these services for 12 months. At the end of the 12 months other patients will become eligible for services according to the local agencies protocol and resources.
- Sites will develop a protocol to coordinate peers and case managers in their work with patients.

44290

PEER CONTACT FORM

Peer Re-Engagement Project (PREP)

Participant ID: ☐☐☐☐

Date of Contact: ☐☐ / ☐☐ / ☐☐

Peer ID: ☐☐☐☐

Site: 1☐ NY 2☐ FL 3☐ PR

1☐ Check here if attempted to locate but unable to contact.

Total duration of all encounters on this date (minutes): ☐☐☐

Please mark all encounters for the entire day.

"X" each encounter that occurred.

"X" the type of contact. →

	Face-to-face	Telephone	Email / text msg / voicemail	Other *
1☐ Find client/Outreach	1☐	2☐	3☐	4☐
1☐ Take client to a medical appointment/visit	1☐			
1☐ Take client to a mental health appointment/visit	1☐			
1☐ Take client to a substance use treatment appointment/visit	1☐			
1☐ Take client to other social service appointment/visit	1☐			
1☐ Remind client about a medical or social service appointment/visit	1☐	2☐	3☐	4☐
1☐ Provide education on the HIV viral life cycle	1☐	2☐	3☐	4☐
1☐ Discuss HIV medications/treatment readiness	1☐	2☐	3☐	4☐
1☐ Discuss lab values	1☐	2☐	3☐	4☐
1☐ Discuss drug resistance and adherence	1☐	2☐	3☐	4☐
1☐ Discuss safer sex	1☐	2☐	3☐	4☐
1☐ Discuss drug use/harm reduction	1☐	2☐	3☐	4☐
1☐ Talk with client about disclosure	1☐	2☐	3☐	4☐
1☐ Mentoring/coaching on provider interactions	1☐	2☐	3☐	4☐
1☐ Provide emotional support/counseling	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for other health care	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for mental health care	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for substance abuse treatment	1☐	2☐	3☐	4☐
1☐ Assist with housing services	1☐	2☐	3☐	4☐
1☐ Assist with making appointment/visit for other support services	1☐	2☐	3☐	4☐
1☐ Follow up with client about a service or referral	1☐	2☐	3☐	4☐
1☐ Other (specify):				

* If "Type of Contact" = "Other", specify: ____________________

*****Please Write Progress Notes on Other Side of This Form*****

PREP Peer Contact Page 1 of 1 Version 05/16/2013

PREP PEER–PATIENT EDUCATIONAL CONVERSATION GUIDE

This curriculum was developed and used to train peers as part of the Peer Re-Engagement Project (PREP), a three-year study evaluating a program that brings HIV-positive peers—individuals from the community who are living with HIV—into the HIV care team to support patients who have fallen out of care or who are newly diagnosed with HIV and at risk of falling out of care. In this study, peers were trained to interact with patients in a series of eight interactive sessions, 30-60 minute face-to-face meetings that were scheduled roughly on a bi-weekly basis. The purpose of these educational sessions was to inform patients about a variety of issues that they may face as individuals living with HIV. Below is a conversation guide that outlines the education sessions that were used in this study. Your organization may wish to make adjustments to the content, number or length of sessions or frequency of meetings with patients, depending on the goals of the peer program within the organization.

These sessions are meant to be flexible. The content of the curriculum can be adapted to suit the needs of the particular patient. Additionally, peers recognize that life events can sometimes interfere with educational sessions. Part of the peer role is to provide emotional support as needed, and if this is the case, it will often cut into the time of the more structured educational sessions. The peers use their time with patients to provide this kind of support and provide education and are always flexible depending on the current situation of their patients.

Tips for Preparing for a Peer–Patient Session

- Check notes from previous encounters
- Check progress notes from other providers (if have access to these)
- Check latest labs
- If possible, meet with team to discuss progress of particular patients (during team huddles) for patients that are having difficulty engaging in care or are dealing with particularly difficult issues at the time.

Peer–Patient Session Materials

(page numbers refer to the *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula)

- Educational Session 2: *HIV Life Cycle—the Big Picture* (pg. 70); *Stages of HIV Infection* (pg. 57); *Routes of Transmission Risk* (pg. 54)
- Educational Session 3: *How to Prepare for a Visit with your Doctor* (pg. 120); Symptoms Log (pg. 121); *HIV Patient Bill of Rights* (pg. 124); *HIV Patient Bill of Responsibilities* (pg. 125)
- Educational Session 4: *Monitoring Tests for People with HIV* (http://www.thebody.com/content/art2599.html)
- Educational Session 5: *Medications at Work in the HIV Life Cycle* (pg. 78); *Medications in the HIV Life Cycle (pg. 79)*
- Educational Session 6: *Assessing Adherence* (pg. 108); *Symptoms Log* (pg. 121)
- Educational Session 7: *Some Considerations Before You Disclose* (pg. 173)
- Educational Session 8: *Substance Use and Harm Reduction* (pg. 187)

Educational Session 1 - Introduction and Assessment

Conversation starter: Introductions

- Hi, my name is _____ and I am a peer. A peer is someone who is living with HIV and has learned to manage and control it.
- I've been positive since ______ and have overcome many obstacles because I got the support that I needed to take control of HIV.
- One of the things that helped me the most was learning about the disease and how to control it, and hearing how others were coping with their diagnosis and the things they did to overcome the stress, fear, and anxiety associated with being HIV-positive.
- My role is to give you health information and be someone you can turn to for support.
- Tell me about yourself. When did you receive your diagnosis and how have you been coping with the disease (medically, home life)? Do you have family or any other support?
- For patients that are new to the clinic or been out of care; not newly diagnosed:
  - o How did you find out you have HIV? How long have you been positive?
  - o When were you last seen by a doctor? Where were you receiving care in the last year? What has been getting in your way of coming into the clinic?
  - o Are you taking medications? If yes, how is it going?
  - o Who is your doctor/medical provider? What is it that you like about the way your doctor/medical provider manages your care? Is there anything that you would like to talk about with your doctor/medical provider? Is there anything that you wanted to say to your doctor but didn't dare to? Is there anything that you dislike in the way he/she manages your medical care?
  - o Where are you living now/what is your living situation?
  - o Do you have anyone in your life that provides social support? Who else knows you have HIV?
  - o Have you made any medical appointments? Other appointments? How can I help you get to your appointments?
- For patients that are newly diagnosed with HIV:
  - o How did you find out you have HIV?
  - o Where are you living now/what is your living situation?
  - o Do you have social supports? Who else knows you have HIV?
  - o Have you made any medical appointments? Other appointments? How can I help you get to your appointments?
  - o How do you feel about your diagnosis? (PEER may want to share their feelings about first learning about their diagnosis, how long he/she has been positive, and what the experience was like for them)
- What do you know about HIV? Where did you get this information?
- Your participation with me in this program will allow us to work together on your learning about HIV transmission/viral life cycle, meds, and resistance etc. over the next several weeks.
- These are some of the things we'll be going over in our meetings – how does this sound? Is there anything else you'd like to discuss?
- What particular questions do you have about HIV?
- Thanks for taking the time to meet with me today. Let's plan to meet again on_______________

Session 2 – HIV Transmission and The Viral Life Cycle

Conversation starter: Transmission

- Today I'd like to discuss how HIV is transmitted and the different stages it goes through once it enters your blood. This includes the body fluids that transmit HIV and the ones that don't, the pathways that allow HIV to enter the body, HIV symptoms and AIDS symptoms.
- We'll also discuss the immune system, the stages of HIV infection, and how HIV invades CD4 cells to multiply and then destroy those cells. This is called the viral life cycle.
- Knowing how the virus works gives you the power to control it.
- In a couple of weeks, we will learn where/how medications work in reducing replication of HIV that allows the viral load to be low and your immune system strong.
- Let's plan to meet again on ____________________

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *HIV Life Cycle—the Big Picture* (pg. 70); *Stages of HIV Infection* (pg. 57); *Routes of Transmission Risk* (pg. 54)

Educational Session 3 - Effective Communication and Self-Advocacy

Conversation starter: Effective communication and self-advocacy

- Let's review the importance of communicating effectively with your providers and how that impacts your health, as well as the importance of advocating for yourself.
- Having a partnership with your health provider is important because you want to have equal ownership about health decisions. Usually as a patient we follow whatever the doctor/nurse tells us to do; however research has shown that patients who ask questions increase their knowledge of their health/disease and have better health outcomes when fully involved in making health decisions.
- Suggestions to communicate more effectively are to come prepared with a list of questions for your medical appointments and/or I can help you prepare the list before your appointment, writing down any symptoms you experience between medical appointments is helpful – it's called a "symptom log," letting your provider know if you have missed appointments, honestly telling your doctor that you are uncomfortable with changes they may be recommending, and being truthful with your providers are ways to increase communication; yet advocate for yourself.
- Sometimes it may take a while to gain a trusting relationship, but know that I can attend your appointments with you, or if there is a supportive person in your life, you can ask them to attend the appointments with you.
- Let's plan to meet again on ____________________

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *How to Prepare for a Visit with your Doctor* (pg. 120); Symptoms Log (pg. 121); *Questions for Your Doctor about Medications* (pg. 123); *HIV Patient Bill of Rights* (pg. 124); *HIV Patient Bill of Responsibilities* (pg. 125)

Educational Session 4 - Understanding Lab Values

Conversation starter: Understanding lab values

- Your doctor will order blood tests on a regular basis to check HIV progression, see if your medications are working (if you're on meds), and determine the effects of HIV and meds on your organ function. This is why it's so important to come in to get your blood drawn every 3-4 months; if you don't, it will be very hard to take control of HIV and understand how the medications impact the virus.
- We're not going to cover every single blood test in this session, just the most common ones including: CD4 count, CD4 percent, viral load count, complete blood-cell count, liver function, kidney function, lipid profile, blood pressure, glucose levels, cholesterol, etc. These tests tell a story about your health and what needs to be done to keep you healthy.
- We'll also discuss healthy heart and the effects of HIV disease.
- Another reason to get your labs done regularly and understand what the numbers mean is that you and your doctor can do certain things to change the lab values whenever they're not normal. For example, if your cholesterol is too high, you and your doctor can intervene to lower it. If your CD4 is too low, you and your doctor can intervene to increase it.
- It's kind of like checking the oil in your car engine or taking your car in for a tune-up. If you don't do these things, what will happen to your car eventually? [Responses: Your car will need costly repairs or you may need a new car.]
- Routine screenings for preventive care are very important such as: eye exams, mammograms, PAPS, prostate, STD screenings. In addition, preventive care vaccines like flu, pneumonia and hepatitis are essential to maintaining good health.
- Have you had labs done, and what were the results?
- Let's review them to ensure that you understand the different labs that are monitored. We can also track your results on a spreadsheet. That way you can monitor independently and increase understanding of labs and your health. Always ask for a copy of your labs and keep them in one place so that if you move or change physicians, your new physician has a history of your care and treatment.
- Let's plan to meet again on ____________________

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *Monitoring Tests for People with HIV* (http://www.thebody.com/content/art2599.html)

Educational Session 5 - HIV Medications

Conversation starter: HIV medications

- HIV medications are beneficial for you. Because of HIV meds, many people are living longer, fuller lives. I don't think many of us would be alive today if it weren't for HIV meds. Many people are living longer – 10, 20, 30 years and beyond – because of HIV meds. You can do it too!
- Taking meds is one of the most important things you can do to take control of HIV.
- Each individual responds differently to meds: some people get intense side effects, while others get mild or no side effects; some people have side effects in the first 30 days and then they disappear. Because of this, it is important not to judge how your body will respond to meds by other people's experiences but from your own experience.
- Remember: the benefits of taking meds outweigh any difficulty taking them. Remember, too, that if they don't work for you, your doctor can put you on different meds until you find the ones that are just right for you.
- We're fortunate that today there are many meds to choose from, and newer meds have fewer side effects than the older ones.
- Taking meds can be complicated at first, but once you develop a daily routine, it gets easier.
- I can give you ideas about how to remember to take meds on time, how to take them correctly, and I will be here for you whenever you need to talk about them.
- It's a big commitment, but one that eventually becomes second nature for most, and one that could bring you good, stable health and longevity.
- Together we – you, me, the doctor, case manager and anyone else involved in your care – can minimize any negative experiences that may (or may not) develop.
- Now, let's take a look at the goals of HIV meds and how they work to stop HIV from multiplying in order to give your immune system a fighting chance.
- Let's look at the different combination of medications that are available and where they work in the viral life cycle to reduce the virus.
- Let's plan to meet again on ____________________

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *Medications at Work in the HIV Life Cycle* (pg. 78); *Medications at Work in the HIV Life Cycle* (pg. 79)

Educational Session 6 - Drug Resistance & Adherence; Understanding & Managing Side Effects

Conversation starter: Drug resistance & adherence

- Today's session builds on the last session we had on HIV meds: adherence, resistance and managing side effects.
- Adherence means "sticking to your medication schedule" at least 95% of the time. It means taking your meds correctly and on time every day. It also means managing side effects so that you're not discouraged from continuing to take your meds.
- Most people who stop taking meds do so because of side effects. Perhaps they didn't have information about how to manage side effects, or no one helped them learn how to manage them. But you have a team of people supporting you in sticking to your meds and identifying possible barriers to adherence, including me. In addition, there are many methods and tools (pillboxes, calendars, alarm watches etc…) available to help.
- We'll also talk about medication resistance; there are different types, and some are the direct result of non-adherence.
- Resistance means that the meds no longer work in blocking HIV from multiplying. HIV usually becomes resistant when it is not totally controlled by medications. Now, let's get started.

Conversation starter: Managing side effects

- Many side effects are related to your digestive system, e.g., nausea, diarrhea, bloating, gas, etc. Many people manage these with other medications or certain foods:
  - Apples and apple products like apple juice and apple sauce (Possible concern about arsenic levels in the current apple supply.)
  - Black or green decaf tea
  - Boiled white rice
  - White toast
  - Ginger and ginger products like ginger tea, candied ginger, ginger ale, ginger snaps, etc.
  - Yogurt
  - Soda crackers
  - Fiber-rich foods or supplements
  - Medication: Imodium AD (loperamide)
- It's always important to contact your provider immediately to let them know if you're experiencing side effects.
- Never stop taking your medications without getting guidance from your providers.
- Let's plan to meet again on ____________________

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *Assessing Adherence* (pg. 108); *Symptoms Log* (pg. 121)

Educational Session 7 - Disclosure and Stigma

Conversation starter: Disclosure and stigma

- To tell or not to tell. To whom should I tell, everyone or a few? Whether you've been positive for a while or newly diagnosed, disclosing your status is different for each of us and sometimes can be complicated. There is no exact way of knowing when the right time is or the right way.
- Is there anyone you feel that you **must** tell, like a spouse, a partner, or perhaps someone whom you've been dating? It takes time to adjust to being HIV-positive, but keep in mind that there are HIV laws and statues in each state that are different. In some states, it is unlawful for a person living with HIV to engage in sexual activity with another person, donate organs or blood, or share needles. Condoms are not always a defense, despite the fact that condoms have been proven to reduce the risk of HIV infection, so know the laws in your state. With that in mind, it's a good idea not to rush into disclosing your status without first giving it some thought.
- There are some general tips:
  - Consider the five "Ws"-who, what, when, where and why.
    Who do you need to tell?
    What do you want to tell them about your HIV infection, and what are you expecting from the person you are disclosing your status to?
    When should you tell them?
    Where is the best place to have this conversation?
    What are you telling them?
  - ***Keep it simple. You don't have to tell your life story.***
- Let's plan to meet again on ____________________

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *Some Considerations Before You Disclose* (pg. 173)

Educational Session 8 - Harm & Risk Reduction

Conversation starter: Prevention messages – sexual health

- Today we are going to discuss sexual health. My goal is not to pry into your sex life, but to give you information about how to prevent HIV and sexually transmitted infections.
- This is an important topic, because your sexual health is related to your overall health and well-being.
- As sexual beings, sex is an important aspect of our lives, and there's no reason why we couldn't have a gratifying and fulfilling sex life just because we have HIV.

(cont. next page)

Educational Session 8 - Harm & Risk Reduction (cont.)

- For the longest time, health care and other service providers refrained from discussing the sexual lives of their HIV patients. They often felt that having that conversation could further stigmatize people with HIV, as it could trigger judgment on the part of the provider, and also because they themselves were uncomfortable having that kind of conversation. But people with HIV were clamoring for information about safer sex because, by and large, they didn't want to infect their sexual partners and also wanted to protect themselves from STI/STD, HCV and drug resistance. Now we are taking the time to have this conversation with all of our patients.
- Please remember that whatever information you share about your sex life is strictly confidential.
- Let's go over HIV transmission first, then STIs.

Risk hierarchy of sexual HIV transmission for HIV+ people:

High risk:
- Unprotected anal sex
- Unprotected vaginal sex
- MSM only: having unprotected anal sex as a bottom

Note: risk-reducing methods in high-risk sexual encounters: using lube, pulling out before ejaculating, having fewer exposures, having fewer partners, having an undetectable viral load, having regular STI screening (at least twice a year), being vaccinated against hep A&B, avoiding vaginal sex during menstruation, avoiding alcohol and drugs before or during sex (impairs decision making)

Low risk:
- Receiving oral sex
- Anal sex with condom
- Vaginal sex with condom

Note: risk-reducing methods in low-risk sexual encounters: not brushing or flossing before giving oral sex, not having oral sex when oral infection is present (bleeding gums), using condoms correctly, using water- or silicone-based lubricant

No risk:
- Giving oral sex
- Mutual masturbation
- French kissing
- Golden showers
- Sex toys (must be washed after each partner's use)
- Massage
- Ejaculating on partner's body (where there's no cavity or portal into blood stream)
- Abstinence

(cont. next page)

Educational Session 8 - Harm & Risk Reduction (cont.)

Conversation starter: Prevention messages - drug use (for patients who use alcohol and/or drugs)

- This portion of the harm reduction session focuses on recreational drug use including alcohol.
- It is important to know that alcohol and other drugs can suppress your immune system. They also reduce your inhibitions and may cause you to take risks you wouldn't normally take.
- Because all drugs are processed through your liver, it is important to know that too many drugs being processed at the same time can increase liver function and make you feel sick; it can cause liver failure or permanent liver damage.
- If you take HIV meds and then recreational drugs, the recreational drug has to "wait in line" to get into the liver and be processed. This can lead to a situation called "inhibition" which can cause an overdose of the recreational drug.
- If you take recreational drugs and then HIV meds, this could lead to a situation called "inducing" which means that your HIV meds would get processed too quickly and not get fully absorbed by your body. It could also lead to harmful drug interactions.
- If you inject drugs, make sure you use a new needle every time to avoid abscesses.
- Do not share your needle with anyone else, as this is the easiest way to transmit HIV.
- If you use a needle that someone else has used, you may acquire hepatitis C (this is the easiest way to acquire hepatitis C).
- If you do share needles and works, make sure you clean your needle and works with bleach and water (add cleaning instructions here).

Suggested materials from *PREParing Peers for Success* peer core competency training curriculum found at http://www.hdwg.org/prep/curricula : *Substance Use and Harm Reduction* (pg. 187)

PREP Completion and Transition Policy and Procedure

Policy

Patient completion of the PREP Peer Program (a.k.a. PREP Intervention) is a patient-driven process. The decision will be made collaboratively between the patient and peer, unless the patient is unresponsive to attempts made by peers to engage in the project. All patients from whom we have received permission will receive a letter of completion. Peers will meet with patients who have completed the PREP Intervention to explain that he/she has completed the individual-level intervention with a PREP peer (i.e., educational sessions and consistent outreach and communication) and that he/she will be transitioned to the standard-of-care case management and will receive referrals to support services that may be needed as a result of discontinued peer services (e.g., peer support groups). The peer will notify the health care team (during a regular case conference or team huddle meeting) when a patient has completed the PREP Program and is ready to be transitioned into standard-of-care case management. The peer or other designated staff (Peer Supervisor or Program Coordinator) will convene a meeting with Case Manager and patient. At this point the patient can ask any questions and schedule the next appointment with his or her case manager. This meeting will be documented in the Peer Contact Form under "Other," and it will be noted that the patient has been officially transitioned to standard-of-care case management. Patients who have completed the PREP Intervention may later re-engage with their PREP peers on an as-needed basis (these encounters will be documented in the Peer Contact Form).

Procedures

Assessing Patient Readiness for Completion and Transition

Patients will be considered for transition into standard-of-care case management once the following two requirements are met:

- Completion and documentation of 8 sessions of the PREP Intervention
- Enrollment in the PREP Peer Program for 12 months

Once both of these requirements have been met, the peer will complete the "Level of Need Assessment Tool" found in Appendix H with the patient (by phone or in-person) to determine next steps for the intervention. Completion and score of this assessment will be documented in the Peer Contact Form under "Other." Completed assessment will be stored in the locked participant study record. Intervention recommendations:

- Low Level of Need (score of 4-6) recommendation:
    - Execute Completion and Transition Policy (see above).

- Moderate Level of Need (score of 7-9) recommendation:
    - **Bi-weekly** face-to-face meetings to review topics from 8 sessions or **bi-weekly** supportive phone calls.
    - **Quarterly face-to-face meetings** at time of medical or lab appointments.

PREP Completion and Transition Policy and Procedure (cont.)

- High Level of Need (score of 10-12) recommendation:
  - o **Weekly face-to-face meetings** to review topics from 8 sessions or **weekly** supportive phone calls.
  - o **Quarterly face-to-face meetings** at time of medical or lab appointments.

Patients that remain in the PREP Intervention after the 12-month anniversary/completion of 8 session assessment (i.e., patients that are determined to have moderate to high level of need) will complete the “Level of Need Assessment Tool” **every 6 months** thereafter to determine next steps. For these subsequent assessments, the recommendations for each level of need are the same as listed above. Completion and scores of subsequent assessments will all be documented in the Peer Contact Form under “Other.” Completed assessment will be stored securely in the participant’s record. These assessments may be helpful to refer to in future discussions with other team members and in follow-up visits or assessments with the patient.

Other Reasons for Patient Completion and Transition

- If, at any point, the patient is no longer willing to work towards achievement of goals and no longer wishes to work with or be contacted by the peer, the patient and peer will agree to discontinue the PREP Intervention project. The completion and transition policy will be executed at this time.
- If at any point, the patient relocates outside of the agency catchment area, the peer will follow agency protocol regarding case closure under these circumstances.
- If the patient, at any point, is terminated from all agency services, the peer will follow agency protocol regarding termination.

Continuation of PREP Research Activities

Completion or early withdrawal or termination from the PREP peer program **does not automatically withdraw the patient from being a PREP research participant.** Therefore, data may continue to be collected for participants that have completed the PREP Peer Intervention for the remainder of the study period, as described in the signed consent form. Data collected will include:

- Patient interview data
- Chart data
- Intervention encounter data (i.e., if the patient completes the program but later re-engages with the PREP peer, intervention contact forms should still be completed.)

If a participant wishes to discontinue data collection and participation in the PREP study, he or she should contact the study coordinator to officially withdraw from the research study.

PREP LEVEL OF NEED ASSESSMENT

PATIENT ID:____________ **DATE:**____________

INTERVIEWER___________________

TRANSPORTATION **Circle the number corresponding to the statement that best describes current transportation needs.**	
No Transportation	**3**
No Transportation; Requires assistance with gas/train/bus voucher	**2**
Has Transportation	**1**
MENTAL HEALTH **Circle the number corresponding to the statement that best describes current mental health needs**	
Danger to Self or Others/Depressed/Psychiatric Referral/Mental Health Referral	**3**
Needs Emotional Support but functional/ Engaged in Mental Health Services	**2**
Mental Health Stability	**1**
HOUSING **Circle the number corresponding to the statement that best describes current housing needs**	
Currently On The Streets/ Evicted from Home	**3**
Temporary or Transitional Housing/Difficulty Maintain Housing	**2**
Stable Housing	**1**
SUBSTANCE ABUSE **Circle the number corresponding to the statement that best describes current substance needs**	
Chronic Drug Use / Does Not Recognize or Seek Assistance	**3**
Sporadic Drug Use / Ready to Seek Help / Referral to SA Counseling/Engaged in SA Services	**2**
None Reported or Observed	**1**

DETERMINED LEVEL OF NEED **L M H**	**4 – 6 LOW** **7 – 9 MODERATE** **10 – 12 HIGH**	**OVERALL TOTAL SCORE**	
		Please Circle HIGH AREAS OF NEED- T, MH, SA, H	

References

1. White House Office of National AIDS Policy. National HIV/AIDS Strategy for the United States. Washington, DC: White House Office of National AIDS Policy; 2010.
2. US Department of Health and Human Services, Health Resources and Services Administration. Minority AIDS Initiative Retention and Re-Engagement Project Funding Opportunity Announcement: HRSA-11-186; July, 2011.
3. Bozzette SA, Berry SH, Duan N, et al. The care of HIV-infected adults in the United States. HIV Cost and Services Utilization Study Consortium. N Engl J Med 1998; 339:1897-904.
4. Campo R, Alvarez D, Santos G, Latorre J. Antiretroviral Treatment Considerations in Latino Patients. AIDS Patient Care STDS 2005; 19:366-74.
5. Giordano TP, Visnegarwala F, White AC, Jr., et al. Patients referred to an urban HIV clinic frequently fail to establish care: factors predicting failure. AIDS Care 2005; 17:773-83.
6. Catz SL, McClure JB, Jones GN, Brantley PJ. Predictors of outpatient medical appointment attendance among persons with HIV. AIDS care 1999; 11:361-73.
7. Ebrahim SH, Anderson JE, Weidle P, Purcell DW. Race/ethnic disparities in HIV testing and knowledge about treatment for HIV/AIDS: United States, 2001. AIDS Patient Care STDS 2004; 18:27-33.
8. Tobias C, Cunningham WE, Cunningham CO, Pounds MB. Making the connection: the importance of engagement and retention in HIV medical care. AIDS patient care and STDs 2007; 21 Suppl 1:S3-8.
9. Klinkenberg WD, Sacks S. Mental disorders and drug abuse in persons living with HIV/AIDS. AIDS Care 2004; 16 Suppl 1:S22-42.
10. Joyce GF, Chan KS, Orlando M, Burnam MA. Mental health status and use of general medical services for persons with human immunodeficiency virus. Med Care 2005; 43:834-9.
11. DeLorenze GN, Satre DD, Quesenberry CP, Tsai AL, Weisner CM. Mortality after diagnosis of psychiatric disorders and co-occurring substance use disorders among HIV-infected patients. AIDS Patient Care STDS 2010; 24:705-12.
12. Azar MM, Springer SA, Meyer JP, Altice FL. A Systematic Review of the Impact of Alcohol Use Disorders on HIV Treatment Outcomes, Adherence to Antiretroviral Therapy and Health Care Utilization. Drug Alcohol Depend 2010; 112:178-93.
13. Ghebremichael M, Paintsil E, Ickovics JR, et al. Longitudinal association of alcohol use with HIV disease progression and psychological health of women with HIV. AIDS care 2009; 21:834-41.
14. Davis K, Abrams M, Stremikis K. How the Affordable Care Act Will Strengthen the Nation’s Primary Care Foundation. J Gen Intern Med 2011; 26:1201-1203.

More information about the Peer Re-Engagement Project can be found online at http://www.hdwg.org/prep

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