

Designing a Peer-Based Early Intervention Program: Components, Strategies, and Key Decisions Mosaica Consumer LINC Project

0. **Overview:** A peer-based Early Intervention Services (EIS) strategy uses peers – people living with HIV/AIDS (PLWH) who are receiving HIV-related medical care, and often are or have been consumers of Ryan White services – as part-time or full-time community health workers (CHWs) who link other PLWH into HIV-related primary medical care and other needed services. The peers typically provide navigation assistance and other support to a client for 3-6 months, until the client is receiving needed services and has gained basic disease self-management skills.
0. **Rationale:** Among the highest priorities in addressing the HIV/AIDS epidemic are early diagnosis and entry into HIV-related medical care and other needed services and retention of PLWH in care. Experience with HIV and other chronic diseases like diabetes has demonstrated that the involvement of peers as paid community health workers contributes to earlier entry into care, retention in and a closer connection to care (e.g., making and keeping of regular clinical appointments), improved disease self-management, reduced complications, fewer hospitalizations, improved health outcomes, and reduced health care costs. Among the key success factors built into the model are connection with another person who is well matched with the client in personal background (e.g., gender, race/ethnicity), has been through the same experiences, builds a trusting relationship, and provides education, coaching, mentoring, and navigation assistance that prepare the client to manage his/her disease. Use of peers is both more effective and more cost-effective than models that depend on clinical personnel, many of whom can spend limited time with the client and may have more challenges in developing trust. Reports from clients indicate that peers who are themselves consumers of HIV care are better able to assist PLWH than individuals who are otherwise similar but lack personal experience in coping with the disease.
1. **Program Scope/Focus:** A peer-based EIS program, like all EIS programs, is designed to help people with HIV/AIDS *enter* and become *fully linked* to and *engaged* in medical and other HIV/AIDS care. Focus is typically on populations that are likely to be hardest to reach – for example, individuals who feel marginalized and disenfranchised, and/or have trouble navigating the HIV/AIDS service system because they have never had a “medical home” and have limited experience with the health care system. A peer-based EIS program can address three different Ryan White needs/priorities:
- **Early Identification of Individuals with HIV/AIDS (EIIHA):** EIS can target newly diagnosed PLWH, to help them enter care as soon as possible after diagnosis – and become fully linked to and engaged in care.
 - **Unmet Need:** EIS can focus on finding individuals who have been out of primary HIV medical care for at least one year (individuals with “unmet need”) and helping them enter or re-enter care and become fully linked to and engaged in needed services. The PLWH may have dropped out of care or had care interrupted for some reason (e.g., incarceration,

moving, life crises, bad treatment experience), may be receiving some HIV/AIDS services but not medical care, or may never have been in care.

- **Retention in Care:** EIS can target PLWH who are loosely connected to care or have missed medical appointments (but have not been out of care for a full year), to help them re-engage in care.

Decision Point:

- *What will be the focus of your EIS program? If you include all three, what will be the relative focus? (This is an important decision since it guides the selection of points of entry.)*

1. **Required Service Components:** An EIS program must work through key points of entry and must ensure that the following four service components are an integral part of program design, so they are available and accessible to clients (though Ryan White Part A or Part B funds need not be used to support all four components):

- **HIV Testing**, carried out in coordination with other testing programs, especially HIV prevention programs, and supported with Ryan White funds only if insufficient resources are available through the Centers for Disease Control and Prevention (CDC) and other funding sources. EIS funds must not duplicate or supplant other funding. *EIS is the only service category under Ryan White Parts A and B that can pay for testing, and testing is not permitted as a stand-alone service.*
- **Referral Services**, including linkage agreements with key points of entry, relationship building to create trust and instill client confidence in the system of care, an assessment of immediate PLWH needs that encompasses knowledge of HIV and care and attitudes about care, and sharing of information about available services with the client.
- **Health Literacy/Health Education (Counseling)**, to ensure an understanding of HIV disease progression and how to manage life with HIV disease, and to prepare clients to navigate the system of care, work with clinicians, and handle HIV-related problems and issues.
- **Access and Linkage to Care**, including assisting the client to enter and become engaged in HIV-related medical care and medical case management, obtain other needed medical-related and support services, and adhere to his/her treatment plan. This usually means providing system navigation assistance and personal coaching and support until the client has successfully completed 3-4 medical visits and is able to make and keep appointments and begin managing his/her own care. This component requires use of a system for monitoring and tracking client referrals, successful and unsuccessful.

Decision Points:

- *Should your EIS program allow test kits or other testing costs to be paid for by Ryan White, or are other resources sufficient to cover these costs? If test kits should be supplied through other funds, how should this be arranged?*
- *If Ryan White does not pay for testing, what kind of arrangement can be made to ensure that test kits are immediately accessible to EIS personnel and clients?*

1. **Roles/Responsibilities for Peer CHWs:** Peers often play most or all of the following roles in the EIS program:
 - **Outreach** to identify targeted individuals (people who know they are HIV-positive but are not in care and people who do not know their status and need to be tested) through points of entry, and sometimes through contacts with acquaintances and street outreach
 - **Testing or testing support**, which may involve administering rapid tests or being present when a person who tests positive is given his/her diagnosis, in order to provide immediate support and linkage to care
 - **Trust building** with newly diagnosed or newly identified PLWH, so they trust the peer and begin to develop trust in the system of care and the potential for effective treatment
 - **HIV literacy education** to inform PLWH about disease progression, living with the disease, prevention for positives, and the importance of early entry into care and regular medical monitoring
 - **Education about the system of care**, including available services and provider options
 - **Intake support** to refer individuals to entities that serve as intake points and support them during the intake process, which often includes accompanying them to a provider that does intake as well as helping them identify needed documents for determining eligibility
 - **System navigation** to ensure that PLWH are linked to a medical provider and a medical case manager as soon as possible after diagnosis or identification, and to help PLWH learn how to request, access, and use needed services, including how referrals are typically handled, how to make appointments, how to request a change in provider where necessary, and what services are readily available and which may be difficult to obtain; this includes accompanying clients to appointments (especially first appointments with a provider) where necessary
 - **Coaching/mentoring and support** to help clients overcome problems and fears and become committed to and engaged in care, deal with setbacks, and gain confidence in their ability to manage the disease; this requires being accessible to the client when difficulties arise
 - **Treatment adherence counseling**, to help clients newly in care adhere to medications, which includes helping them understand the importance of adherence, learn how best to take medications and minimize side effects, and know when it is necessary to contact their doctor
 - **Follow up** to help clients keep appointments, contact them when they miss appointments or do not adhere to medications, and bring them back into care and adherence
 - **Relationship building** with points of entry and providers, so the peer has personal contacts with key personnel at providers throughout the system of care and can assist PLWH in accessing services from these entities
 - **Support to the clinical team**, to provide follow up or address problems they have identified; this requires that the peer work collaboratively with the clinical team

Decision Points:

- *What services do you want peers to provide? Which, if any, do you NOT want them to provide?*
- *Should peers be trained and certified as HIV testers and counselors? If so, who should provide training?*

5. **Relationships:** Key relationships for this program model include points of entry into care and HIV/AIDS-related service providers.

- **Points of Entry:** Unlike the Outreach service category, EIS focuses on cooperation with points of entry into care rather than street outreach. These may be places where people are tested for HIV or where people who know they are HIV-positive are likely to be found. According to the legislation, these entities include but are not limited to the following: “public health departments, emergency rooms, substance abuse and mental health treatment programs, detoxification centers, detention facilities, clinics regarding sexually transmitted diseases, homeless shelters, HIV disease counseling and testing sites, health care points of entry specified by eligible areas, federally qualified health centers, and entities...that constitute a point of access to services by maintaining referral relationships.” Peer EIS programs need formal relationships with key points of entry for their target populations, and peers need to develop personal contacts and relationships with key individuals within these entities.
- **Providers:** This model depends on support from providers, including the staff of the providers that house the peers and others throughout the system of care. Of particular importance are relationships with staff of clinical providers and clinical and other case managers. Peers need personal contacts and positive relationships with individuals who can help ensure that their clients are able to get prompt appointments and also understand that they should contact the peer if a client misses an appointment or appears to be encountering problems that may interfere with his/her care or treatment adherence.

Decision Points:

- *Do you want to identify specific points of entry related to the focus areas of your program that must be included? For example, if EIIHA is a focus, points of entry will include a variety of venues where testing is done. If unmet need is a focus, other points of entry (e.g., homeless shelters) may be particularly important. If you want to target people falling out of care, medical and case management providers may be a priority.*
- *Are there specific points of entry that are sufficiently important that agreements with them should be a requirement for the program?*
- *What requirements should be specified regarding relationships with Ryan White and other HIV/AIDS service providers?*

6. **Peer Job Title:** The job title used for the peers in an EIS program should be descriptive of their roles and should contribute to respect for their work and importance. EIS and other linking to care strategies are beginning to describe their peers as Peer Community Health

Workers, since Community Health Worker is now a recognized occupation by the Bureau of Labor Statistics, and states are beginning to license CHWs. Using the term may facilitate certification or licensing of peer CHWs.

The Community College of the District of Columbia (CCDC) is currently running a pilot eight-month community health worker training program in collaboration with the DC Primary Care Association (DCPCA). Some of the CHWs are PLWH, and are receiving extra training on HIV/AIDS from the Positive Pathways Project, funded through the Washington AIDS Partnership under a national Social Innovations grant.

Peers may have many other job titles. Among those appropriate for individuals who follow a client for 3-6 months include Peer Navigator, Peer Mentor, and Peer Coach. As described earlier, peers working in EIS programs play multiple roles, which makes the CHW title useful.

Decision Point:

- *What title is most appropriate for your EIS program and most likely to contribute to acceptance and support of the use of peers in the roles you have defined? Do you want to specify a title that is used consistently?*

1. **Matching Peers and Clients:** There is no one right way to “match” peers and clients, but programs have found that race/ethnicity, age, and gender/gender identity all influence success. Shared background and shared experiences have generally proved helpful in building trust and modeling health care-seeking behaviors. Some programs feel that race/ethnicity may be more important than age or gender. For example, one Los Angeles demonstration program targeting young Latino male MSM found that the peer needed to be Latino, but that an older Latina was sometimes more effective than a young Latino – the older sister/mother role proved beneficial. There are exceptions to the matching, particularly in some African immigrant communities. Due to stigma and confidentiality concerns, this population may prefer to interact with someone from a different nationality and often someone outside the African immigrant community, but PLWH have indicated a preference for peers who share the immigrant experience. In general, peers seem to be most successful when they are similar to the target population. For example, similar life experiences are very helpful. A peer who did not receive regular medical care until s/he became HIV-positive is more likely to understand the challenges of navigating the health care system than someone who comes from a higher-income background and never faced these challenges. One group of outreach programs compared their experiences and concluded that the peer *team* should where possible be diverse in such characteristics as race/ethnicity, language skills, gender, age, sexual orientation, and community of residence. This provides opportunities for various types of matching between peers and PLWH.

Decision Points:

- *What kind of matching makes most sense for your program?*
- *Do you want to test several particular types of matches? Define key target populations and select peers you believe will work best with those populations? Have a diverse peer team and try a variety of matching approaches?*

2. **PLWH Qualifications:** Models within this strategy require a range of skills, many of which can be taught through training, as well as some characteristics and life experiences that play a major role in peer success. For example, it is generally beneficial to have peers who have personal familiarity with the service area and the Ryan White system of care.

Basic Requirements: Some basic requirements should be set regarding such issues as peer status, education/literacy, and past criminal convictions.

- **Peer Status/Experience with the HIV/AIDS System of Care:** The requirement might simply be that the individual is receiving HIV-related medical care. Some sites want peers that are or have been Ryan White program clients. An important expectation is that the peer can bring practical experience with the regional or local system of care, so the requirement is usually designed to ensure some level of personal familiarity with that system. Sometimes peers have had experience as volunteers or staff of Ryan White service providers, which might substitute for having been a Ryan White client.
- **Criminal Convictions:** Most sites want to be flexible as possible since many PLWH who can be effective peer CHWs have had convictions in the past, but programs must also safeguard clients. Often, sex-related felonies and serious violent crimes will exclude a candidate, but other convictions will not. Some sites exclude candidates only for crimes committed in the past ten years. It is helpful to agree on what constitute exclusions and what will be examined on a case-by-case basis.
- **Education/Literacy:** Educational requirements vary. Some programs require a high school diploma or equivalent, primarily because peers will be required to read and interpret materials describing medications, eligibility requirements, and other topics and to keep detailed records. Others use practical tests to ensure reading comprehensive and necessary writing skills rather than specifying formal education requirements. For example, a candidate might be asked to read a description of a client encounter and then use the information to complete a client encounter reporting form – a test of both reading comprehension and writing skills.

Characteristics: Characteristics of particular importance include the following:

1. **Commitment** to the role, including a deep belief in the importance of assisting PLWH to enter and remain in care and a desire to assist others by sharing their knowledge and experience
1. **Ability to empathize** – to put him/herself in the shoes of a PLWH from the same or a different background, in order to understand that PLWH’s needs and service barriers
1. **Strong interpersonal skills**, including the ability to work effectively with clients, points of entry, other team members, and diverse providers
1. **Ability to organize and implement multiple tasks**, working with several clients with differing needs, follow up, work independently with clients, and ensure that the work is appropriately documented
1. **Good judgment**, including the ability to advise clients, help them make appropriate decisions, and assist the client them while maintaining boundaries

Skills: In addition to the basic requirements and peer characteristics and personal experience, peers need to have or acquire the following skills; generally programs like peers to come to the program with knowledge and skills in the first four areas:

- a. **Detailed knowledge of one or more specific PLWH populations**, through membership in that group and/or significant work or personal experience with it
- b. **Detailed knowledge of a particular geographic area** (e.g., central city, specific neighborhood, suburb, exurb, county, or region of a State)
- c. **Understanding of how Ryan White programs work**, and the points in the continuum of care where individuals are likely to encounter problems or certain population groups will face access barriers
- d. **Strong and culturally appropriate communication skills** that enable the peer to conduct client interviews and convey necessary information in a manner that is easy for the client to understand
- e. **Mentoring, coaching, and emotional support skills**, including strategies for providing support, encouragement, and guidance to PLWH to help them deal with issues related to living with the disease and disease self-management
- f. **A solid understanding of professional and personal boundaries** that protect the client and the peer, including HIPAA and other confidentiality requirements
- g. **Computer and record-keeping skills**, including ability to record contacts, activities, and client responses regularly and accurately, using computerized forms
- h. **Skills in working with providers, including clinical staff** – to be able to build trust, establish credibility, and use provider relationships to assist a PLWH in entering care and help ensure responsive services

Decision Points:

- *What characteristics, knowledge, and experience are most important and should be identified as required qualifications? Which should be preferred but not required?*
- *Should there be a formal education requirement (e.g., high school or GED) or a more flexible skills-based literacy determination?*
- *What skills should be required, and which ones do you feel you can teach during training?*

8. **Training for PLWH:** One of the most important determinants of peer EIS program success is the quality, level, regularity, and context of peer CHW training, both pre-service and in-service. As already described, EIS programs require peers to have considerable knowledge and skills – some technical (like an understanding of particular medications, adherence, and side effects), others regulations-based (like HIPAA requirements), organizational and jurisdictional (like a knowledge of points of entry, the system of care, and providers in a particular geographic jurisdiction), or judgment-based (like boundaries). Some training needs to be completed before the peer begins to provide services, some can be paired with

structured on-the-job experience, and some is appropriately done as in-service training offered weekly or monthly.

The length of pre-service training ranges from 2-3 days to several weeks. If the program is new and the peer CHWs do not have prior experience in this role, 1-2 weeks of pre-service training is needed. Some programs combine the pre-service training with a practicum, so that peers spend part of their time in formal training and part working with their provider on defined tasks that help them apply key knowledge and skills. For example, there might be a one-month pre-service period that is half classroom training and half practicum, with the first week spent largely in the classroom and the last week doing practical work and the middle two weeks a mix of formal training and practical experience.

Typical pre-service training topics often include but are not limited to the following:

- Understanding HIV disease, including HIV 101, disease progression, and disease management
- Ryan White legislation, allowable services, policies, and guidelines
- Navigating the system of HIV care – understanding the system and points of entry, barriers to care, and building and maintaining relationships with providers – usually paired with field assignments involving the system of care in a particular jurisdiction
- Multicultural awareness, sensitivity, and competence, including the ability to communicate with diverse clients in culturally appropriate ways
- Techniques for developing trust with PLWH who are newly diagnosed and those who know their status but are not in care
- Maintaining professional boundaries, both in client relationships and boundaries needed to protect the health of the peer
- Problem solving and crisis management – including when to seek clinical advice or intervention
- Confidentiality and privacy, including HIPAA requirements
- Providing emotional support
- Self-management
- Self-disclosure
- Communication skills including active listening, motivational interviewing, and responding to emotion, as well as culturally competent communication
- Medications and treatment adherence, including knowledge of particular types of medications, how best to take them, side effects, and ways to encourage treatment adherence

Decision Points:

- *How long should the pre-service training be?*
- *Should there be a combination of classroom training and opportunities for peers to apply knowledge and skills with their provider?*

- *What topics should be required?*
- *Should the grantee or a special committee review the training design?*
- *Should the Planning Council develop a set of standards defining training content – and provide it to the grantee in time for use once a provider has been selected by the grantee?*
- *If the program is run first as a demonstration, what can be done to ensure that the training curriculum is fully documented, evaluated and refined as needed, and made available for use in other locations or by other providers?*
- *What existing curriculum materials should be specified for use in developing the training, to ensure that the program builds on tested, validated materials?*

9. **Supervision/Staff Support:** Because peer EIS programs place significant demands on the peers and involved extensive interaction with points of entry and with clinical and other providers, they require a high level of supervision and support for peer community health workers, particularly during their first year in the role. The EIS provider’s organizational infrastructure and culture must enable it to attract and retain peer staff. Peer staff need structured, consistent advice, guidance, on-the-job training and other professional development opportunities, and assistance in gaining cooperation from points of entry and providers within the system of care. Supervisors need to ensure regular training opportunities, communications, and joint problem solving around challenging cases, as well as appropriate Memoranda of Agreement (MOAs) with providers and facilitation of peer relationships with providers. Peers need to be recognized as valued employees and full members of service teams, and supervisors need to take leadership in explaining and championing the use of peers, both within the organization and with other providers. Supervisors must provide clear guidance and expectations to peers and to other agency staff.

Capable and knowledgeable supervision is also necessary because the activities that are a part of EIS require careful monitoring. For example, supervisors must ensure that only allowable activities are being implemented with Ryan White funds. This includes, for example, an understanding of how EIS should link to but not overlap with prevention outreach and CDC-sponsored testing. Supervision is also extremely important in helping peers set and maintain boundaries and learn and follow HIPAA and other confidentiality and privacy requirements.

EIS programs often require a specified level of supervision, such as a half-time supervisor for 2-3 peers, or a full-time supervisor for 5 or more peers. Some allow for greater supervision during the first 6-12 months of a program. Others allow the provider to decide on the hours per week a supervisor will be engaged in the project, but state clear expectations for supervisor responsibilities and tasks.

Decision Point:

- *What specific supervisory requirements should be specified, such as a set of supervisory tasks or a particular level of supervision?*

10. **Program Structure:** An EIS model can be centralized, have centralized training but decentralized supervision, or be entirely decentralized.

- In a centralized structure, one organization hires, trains, and supervises peer CHWs, providing pre-service and in-service training, and assigning peers to work collaboratively with specific points of entry and HIV/AIDS service providers but retaining full responsibility for program management and peer supervision.
- In a partially centralized structure, one provider is responsible for training, and may also hire or at least approve the hiring of peers. However, once pre-service training is complete, the peers are employed by a number of different provider agencies, which are responsible for supervision, data gathering, and reporting. The central provider provides regular in-service training and serves as a support to the peers and their supervisors. Often an MOA is required between the providers and centralized training and support entity to clarify required cooperation and to ensure that peers are made available for in-service training.
- In a decentralized structure, multiple providers receive funding to hire, train, and supervise peers. Each entity is responsible for training its own staff, although training content may be specified by the funder.

Experience with all these models suggests that it is extremely helpful to have a centralized provider of pre-service and in-service training, both because this is cost-effective (only one entity develops and delivers the pre-service training) and because this allows for funder review and approval of the training design and for quality control, assurance that all peers receive the same core training, and regular opportunities for peers to learn from each other and become a support group for each other.

Centralized supervision has the benefit of ensuring consistent supervision and tends to support a higher level of supervision than decentralized models. However, there is also value in having peers be an integral part of a provider's clinical or service team – which can be easier to accomplish if the peers are paid staff of the provider.

Decision Points:

- *What kind of structure do you want to use for your EIS program – centralized, partially centralized, or decentralized?*
- *If you want to use the partially decentralized model, what will be the specific roles and responsibilities of the centralized training/support entity and the individual providers that employ the peer CHWs?*

2. **Salary and Benefits:** Many peer EIS programs hire a combination of full- and part-time peers. Programs may prefer part-time personnel so they can match and reach more populations or geographic areas, or may prefer full-time peers who will focus on a limited number of populations and/or communities within the service area.

- **Salary:** Peer community health worker salaries vary by jurisdiction, but starting pay for peer CHWs in large metropolitan areas is often between \$13 and \$17 per hour (\$27,000

to \$35,000 for full-time work), and in other areas \$11 to \$15 per hour (\$23,000 to \$31,000).

- **Benefits** are an important consideration. A peer must have access to health care, either by having employer-provided health insurance or by maintaining eligibility for Medicaid or Ryan White services.
- **Employment of people on SSI or SSDI:** Some programs employ peers who are living with AIDS and are on disability – Social Security Disability Income (SSDI) or Supplemental Security Income (SSI). Such individuals remain eligible for benefits only if their pre-tax earnings are less than the amount of earnings considered to be “substantial gainful activity” (SGA). However, a person on disability who earns above the monthly limit after a nine-month trial period may remain eligible for Medicare or Medicaid for 93 additional months. Detailed information about how this works – and the differences between SSI and SSDI – are explained in a Social Security Administration publication called *Working While Disabled: How We Can Help, 2011*, which is available online at <http://www.ssa.gov/pubs/10095.pdf>. The SGA amount for non-blind people on SSDI for 2011 is anything over \$1,000 per month gross income. If you want to hire PLWH on SSDI, they will probably be able to work 35-50% time. If you pay \$11 per hour, the individual can work about 20 hours a week; if \$15, about 15 hours a week; if \$17 per hour, only about 13.5 hours a week – and still retain full SSDI benefits and Medicare. Medicare Part A coverage will generally continue for at least 93 months. For SSI, the first \$85 of a disabled person’s monthly earnings is not counted, and the SSI payment goes down 50 cents for every dollar earned beyond the \$85. The amount a person can earn before losing benefits entirely varies by state. If earnings are below the state limit, even if SSI payments end, Medicaid coverage usually continues.

Decision Points:

- *Should the program specify whether peers may be full- or part-time, or state a minimum number of hours per week for peers to work?*
 - *Should the program specifically allow or require consideration of peers who are on SSDI or SSI?*
 - *Should the program require a minimum salary or hourly rate and/or benefits?*
2. **Challenges:** The main challenges associated with this model involve the hiring, training, supervision, and support of peer community health workers, and the need to ensure that providers and partners value and work effectively with these peers.
- **Training:** Training is a key factor in determining program success. It is often challenging for a provider to ensure both sufficient initial orientation and pre-service training and regular, ongoing staff development. This is particularly true if the provider has a small number of PLWH in these roles – the group may seem too small to justify formal training sessions, and providing the same level of training on the job can be very difficult. The peers may lack related job experience, which can make the adjustment to the position challenging. The program design must address this challenge.

- *Boundaries:* Boundaries are a key issue at several levels. There is the continuing challenge of how to build trust with a client and provide individualized support without crossing professional lines. PLWH also need to ensure that they don't become so actively engaged in the work of their organization or in serving clients that their own health is jeopardized. For example, peers often give clients their cell phone numbers in order to manage appointments, etc., but this can lead to calls at all hours of the day or night. Program supervisors and peer CHWs need to carefully consider how to meet client needs while maintaining boundaries.
- *Recognition of peer health issues:* Peers have a serious health condition, and maintaining good health must be a continuing concern. Health problems may lead to high absenteeism and reduce productivity. Some EIS programs with centralized structures maintain one or two "floater" peers who can be assigned to fill in for a peer CHW who is ill.
- *Compensation:* Many of the early peer initiatives designed to link PLWH to care provided stipends rather than hiring peers as part- or full-time staff. Where peers are unable to work or are afraid of losing their SSDI or SSI payments, stipends may be appropriate. However, stipends are often very small, and often do not adequately compensate peers for their work. With careful planning, EIS programs can provide part-time employment for individuals on disability and offer a living wage, while protecting their disability payment or ensuring that they retain eligibility for medical care under Medicare or Medicaid. Moreover, because individuals on disability have a nine-month "trial period" when they become employed and most can move back onto disability if their health worsens even after that period, most PLWH on disability can accept employment without risking their disability status.
- *Provider and partner attitudes:* Not all provider and partner staff recognize the value of using peers, and many aren't sure how to work with them effectively. There are often concerns about a peer's ability to maintain confidentiality, maintain professional boundaries, and deal with technical issues such as medications and side effects. Research supports the value of peers in treating both HIV/AIDS and other chronic diseases, but introduction of a peer EIS program can meet with resistance. Other staff need to be educated about the value of peers and expectations for including them in communications and in discussions about clients – this is often just as important as providing appropriate training for the peers themselves.
- *Helping PLWH enter care/Level-of-effort limits:* Outreach and linkage to care have historically been difficult tasks. It is very important that peers have solid training in ways to build trust in the system of care and prepare PLWH for entering care. Peers also need to be prepared to recognize that some PLWH will ultimately choose not to or remain in enter care. A time or level-of-effort limit needs to be established so that peers do not spend unreasonable amounts of time working with a few PLWH who are not ready to engage in care, when they could be successful in working with many other PLWH. Guidance is needed on how to assess progress and set limits.
- *Understanding EIS:* Many Part A and Part B grantees have limited experience with EIS, the service category definition was confusing until recent clarification at the 2010 All-Grantees Conference, and detailed guidance from the HIV/AIDS Bureau is just becoming available. Grantees need to educate providers about EIS and to carefully monitor EIS

programs, requiring documentation of levels of activity and evidence of success. In addition, monitoring is needed to ensure that guidance from HRSA/HAB is followed and required services are provided.

2. **Measures and Evidence of Success:** Evidence of success for this strategy includes such measures as the following:

- Increased understanding of the care system among targeted PLWH
- Number of newly diagnosed PLWH who enter care within three months after diagnosis
- Number of out-of-care PLWH (a) identified, (b) served, (c) linked into care (e.g., completing program intake), and (d) fully engaged in care (e.g., complete 3-4 medical visits) – and the percent of those identified and served who enter and remain in care
- Levels of engagement in care for those served – e.g., percent of appointments kept, treatment adherence
- Percent retention in care among clients who received EIS services, after 3, 6, and 12 months

2. **Names and Locations of Model Programs:** An increasing number of Part A and B areas fund peer-based EIS programs. Part C and D have a long history of using peer strategies in case finding and linkage to care. Among the programs that may provide valuable input to decisions about program design are the following:

- **Positive Pathways**, Washington, DC, funded by the Washington AIDS Partnership through a Social Innovations grant to AIDS United, and operated in collaboration with the DC Health Department. Community health workers being trained through a demonstration community health worker certification program at the Community College of the District of Columbia, supplemented by HIV-specific training. Funding for the CHW demonstration was obtained by the DC Primary Care Association. Positive Pathways provides additional HIV-specific training to peers that are then employed by several different clinical and community-based HIV/AIDS programs. The focus is on assisting HIV-positive African Americans living in Wards 5-8 in Washington, DC to become fully linked to HIV-related medical care. The focus is primarily on women, but also serves men who are recently incarcerated, have a history of injection drug use, and/or are partners of the targeted women.
- **Linking to Care**, a project of Positive Connections, in Charlotte, NC. Operated by a PLWH group through a fiscal sponsor, the project was designed to link PLWH to care and keep them in care, including the newly diagnosed and individuals with unmet need. Positive Connections members received training and certification for counseling and testing from the county health department, and for one year had Part A funding under EIS, Outreach, and Health Education and Risk Reduction (HERR). Consumers were paid stipends. A number of the peers were hired by providers and continue to do similar work, but the project did not continue.

- **P2P**, a demonstration project of the African American AIDS Task Force (AAATF), Minneapolis, MN. Funded by the Part B program, P2P is a demonstration designed to develop a peer training curriculum and test a stipend-based peer model to identify PLWH who are out of care, convince them to enter care, accompany them to their first doctor's visit, and connect them to case managers to facilitate the connection to care. Peers work under a supervisor (also a PLWH) and often work with hard-to-reach PLWH, often individuals who have been out of care for a long time. Experience has shown that it often takes 2-3 months of contact with such PLWH to convince them they should re-enter care, and they may need longer-than-expected follow up, with support provided for 3-6 months. The stipended peers were originally expected to earn a little less than \$3,000 over 12 months; the stipend structure has been redesigned to reflect the greater level of effort required to help PLWH enter and remain in care. The program's success has led the State to expand it to include additional providers.
- **The Youth Link Project of AIDS Partnership Michigan** in Detroit, funded by the Michigan Part B program. The project helps young African American MSM ages 18 to 24 enter and remain in care. The coordinator, a peer who is a young African American MSM, uses peer MSM networks, including online networks, to identify out-of-care PLWH and convince them to enter care. The peer continues to serve as their mentor and coach, and helps PLWH navigate the system of care and learn disease self-management.
- **Wayne State University Physicians Group (WSUPG) Peer Navigator Program**, Detroit, MI. In this program peer navigators serve as members of an integrated clinical care team, helping patients who are new to care, experiencing issues with treatment adherence or missing appointments, or returning to care after being lost to follow up. Peers receive 32 hours of pre-service training (eight 4-hour sessions), with each session including 2 hours of HIV core competency training and 2 hours focusing on communications skills, plus another 8 hours of training on motivational interviewing. Monthly meetings of the peers include educational updates.
- **Patient Navigation Program**, Sacred Heart Rehabilitation Center, Saginaw, MI. Funded by the Michigan Part B program, this EIS program, which operates in the Flint and Saginaw communities, is designed to provide support, advocacy, and assistance to PLWH who have dropped out of HIV/AIDS-related medical care or may be on the verge of dropping out. Peers work to identify and overcome the barriers that have prevented these PLWH from remaining in care and help them navigate the HIV/AIDS medical care system. Navigators are involved in HIV testing, one-on-one work with clients, and a variety of education and support activities to help PLWH enter or re-enter medical care. Partners include local health departments, medical case management providers, hospitals, doctors' offices, and various health and human service agencies.
- **Christie's Place** (<http://www.christiesplace.org>) in San Diego, CA, which uses peer family case workers to identify HIV-positive women and children out of care and bring them into care. Christie's Place peers conduct outreach activities and provide case management to their peers.
- **OASIS Clinic at Charles Drew Medical Center**, Los Angeles County, which has a long history of employing HIV-infected peers to identify PLWH and bring them into care and/or prevention interventions and was part of a Special Projects of National

Significance (SPNS) funded outreach initiative focusing on young African American and Latino MSM.

- **Projects funded under the Ryan White Part F, Special Projects of National Significance (SPNS)**, especially the Targeted HIV Outreach and Intervention Initiative that began October 2001. Its focus was on implementing and evaluating interventions designed to connect underserved vulnerable populations living with HIV who knew their HIV status with HIV primary care. Only a small number of programs used peer outreach workers. Particularly relevant to this strategy are the following projects:
 - **The Fenway Institute of Fenway Community Health** and its community-based partners in Boston, which targeted people of color, transgender individuals, active drug users and individuals in recent recovery, ex-offenders, homeless individuals, and women who were “not stable in care.” The Institute provided and evaluated Health Systems Navigation (HSN) training.
 - **The Horizons Project** in Detroit, affiliated with Wayne State University Medical School and the Detroit Medical Center, which employed peers to reach out to low-income African Americans aged 13-24, both male and female, to help these young PLWH enter and stay in care. The project continues to use peer advocates for one-on-one mentoring and peer-led HIV prevention education, among other roles.
 - **Montefiore Medical Center and CitiWide Harm Reduction** in New York, which did door-to-door peer outreach in single room occupancy hotels (SROs) to provide support, inform people about available services, provide harm reduction supplies, arrange some limited home-based medical care, and engage people in a variety of care and prevention services.
 - **Konnect II**, a peer support and advocacy program operated by the People of Color Against AIDS Network (POCAAN) in Seattle, which targeted PLWH of color who were either out of care or received sporadic primary care. The project is ongoing, with its focus now on newly diagnosed PLWH.

17. References and Resources:

- *Community Health Workers National Workforce Study*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, March 2007. Conducted by the Regional Center for Health Workforce Studies, University of Texas Health Science Center, San Antonio. Available online at <http://bhpr.hrsa.gov/healthworkforce/chw/>.
- *Building Blocks to Peer Success: A Toolkit for Training HIV-positive Peers to Engage PLWHA in Care* and *Building Blocks to Peer Program Success: Peer Program Development Toolkit*. Peer Education and Evaluation Resource (PEER) Center, Boston, MA, April 2009. Both toolkits were funded through a cooperative agreement from HAB’s Division of Training and Technical Assistance (DTTA). First toolkit provides resources to support the training of PLWH who work as peer community health workers to engage and retain people living with HIV in health care. The toolkit is designed for use by experienced trainers and by providers that employ peers, to develop pre- or in-service

training programs and individual sessions. Second toolkit is designed to help create programs that use peers as members of multidisciplinary teams. The PEER Center has other resources related to peer programs. Toolkits are available at http://www.hdwg.org/peer_center/training_toolkit. Mosaica's website also has PEER Center materials, including training modules organized for easy access; see <http://www.mosaica.org/Resources/HIVAIDS/ProjectConsumerLINC.aspx>.

- *Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates and Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates – Supervisor's Guide*. Cicatelli Associates, New York, 2007. The advocates toolkit provides extremely useful and practical tools that can be used for peer training. The toolkit covers such varied topics as outreach, referrals and system navigation, how to talk to PLWH about HIV/AIDS, treatment adherence, peer safety, and client confidentiality, as well as working effectively with provider staff. The supervisor toolkit provides guidance and sample tools in such areas as policies and procedures, confidentiality, job descriptions, and orientation. Both toolkits available online at <http://careacttarget.org/library/peers/ToolkitForPeerAdvocateSupervisors.pdf>.
- “Measuring Return on Investment of Outreach by Community Health Workers,” in *Journal of Health Care for the Poor and Underserved*, Volume 17, No. 1 Supplement, Feb. 2006. This article documents the positive financial impact of outreach by community health workers employed by Denver Health Community Voices. The study documents the economic contributions of peer CHWs to the safety net system. See http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu17.1S.html.
- “The Utilization and Role of Peers in HIV Interdisciplinary Teams.” Report on a Health Resources and Services Administration-HIV/AIDS Bureau consultation held February 23, 2009 in Bethesda, MD. See http://www.ask.hrsa.gov/detail_materials.cfm?ProdID=4399.