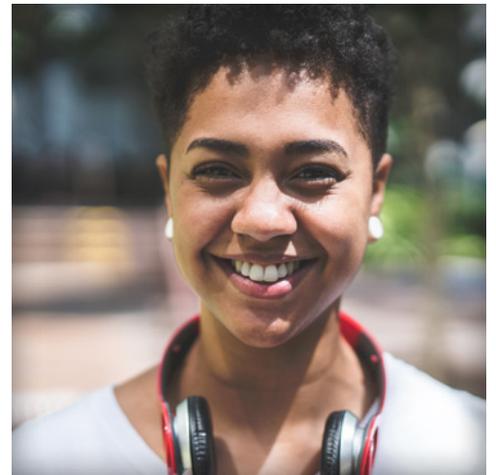
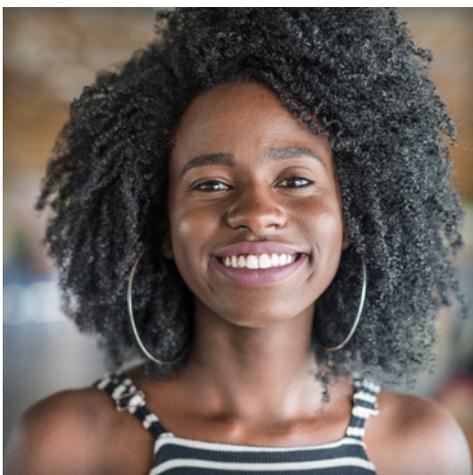


CARE AND TREATMENT INTERVENTIONS



Peer Linkage and Re-engagement of Women of Color with HIV

DISSEMINATION OF
**EVIDENCE-
INFORMED.**
INTERVENTIONS



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Executive Summary

Purpose of This Manual

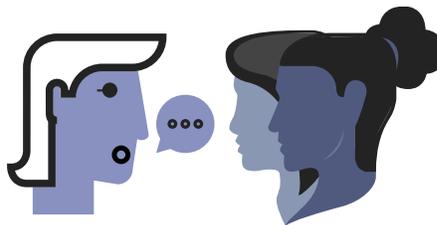
This manual is designed to share best practices for implementing a peer program to engage cis and transgender women of color in HIV care.¹ The manual is designed for policy and program directors working at state, city or county government; and hospital or health center administrative or clinical directors who provide direct care services for people with HIV. Peers have been shown to increase linkage to care for vulnerable, hard-to-reach populations. This manual details the staffing, training, and infrastructure needed to implement such a program at a health clinic.

Intervention Description

The Peer Linkage and Re-engagement intervention is designed to utilize peers—defined as people with HIV who have a shared experience and shared community membership as the populations they work with. Peers work to:



Link cis and transgender women of color (WoC)¹ who have recently been diagnosed with HIV



Re-engage WoC in HIV primary care



Support retention in HIV medical care

This is a short-term intervention in which peers work intensively with eligible women to achieve the following milestones within six months to one year:

- ◆ Attend two medical care visits with a primary care provider;
- ◆ Complete one lab visit; and
- ◆ Attend at least two visits with a case manager.

Rationale and Need

Peers have been studied in the United States and have been found to support linking and retaining clients in HIV care; however, studies are limited and have yielded mixed results on their impact on clients' adherence to treatment and viral suppression.²

¹Throughout this manual we define women of color to be cis and transgender women of color (WoC)

²Cabral, H. J., Davis-Plourde, K., Sarango, M., Fox, J., Palmisano, J., & Rajabiun, S. (2018). Peer support and the HIV continuum of care: results from a multi-site randomized clinical trial in three urban clinics in the United States. *AIDS and Behavior*, 22(8), 2627-2639.



Intervention Summary

Essential pre-implementation

- ◆ Establish an internal champion and organizational culture to support peer programs
- ◆ Work with human resources to develop an appropriate peer job description
- ◆ Set up clinical and administrative supervision system for peers
- ◆ Find private, confidential space for peers to conduct their work with clients and allow them to be integrated with other care team members
- ◆ Generate out of care lists at the clinic
- ◆ Establish referral systems with external partners for reaching newly diagnosed WoC and providing appropriate specialty medical, mental health, or substance use disorder treatment and obtaining resources with nonmedical needs

Essential elements for peer tasks and replicating the model:

- ◆ Finding, outreaching to, and re-engaging WoC lost to care or newly diagnosed
- ◆ Accompaniment to medical services
- ◆ Assistance with transportation
- ◆ Education about medical and social services
- ◆ Coaching on life skills
- ◆ Supporting adherence to HIV care and treatment
- ◆ Holding weekly supervision meetings
- ◆ Providing access to and documenting peer work with the client in the medical record

Evaluation of the Peer Linkage and Re-engagement for Women of Color with HIV intervention

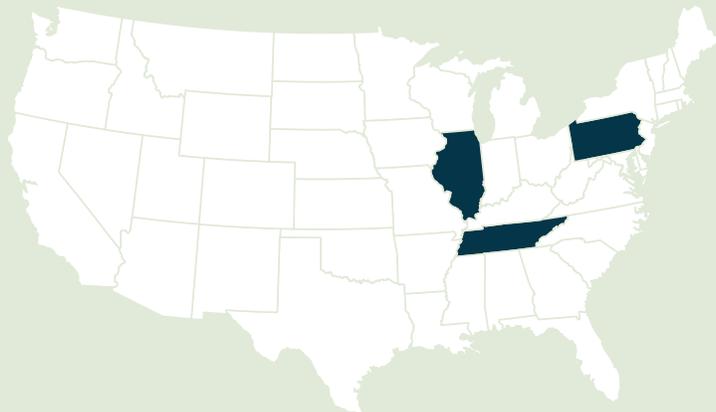
Over the course of this project, a **total of 196 cis and transgender women were served across the three sites from 2016-2019:**

- ◆ 95.5% of clients were linked to care in 90 days
- ◆ 73.3% were retained in care defined as 2 medical appoints at least 90 days apart in 12 months
- ◆ 81.1% achieved viral suppression at 12 months.



INTRODUCTION

From 2016 to 2019, three clinics (AIDS Care Group, Chester, PA; Howard Brown Health Center, Chicago, IL; and Meharry Community Wellness Center, Nashville, TN) were funded through a grant made available to AIDS United through the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau, Ryan White HIV/AIDS Program Part F, Special Projects of National Significance. The funding was part of a project called the “Dissemination of Evidence-Informed Interventions (DEII) initiative,” which focused on using an Implementation Science Framework to replicate models of care in diverse geographical and organizational settings. In this intervention sites were tasked with replicating previous intervention models that incorporated trained peers into the HIV care team with the goal of educating and assisting WoC to access and consistently engage in HIV primary care. This intervention supports organizations and health care teams to integrate peers into the HIV care team.



Three Ryan White HIV care providers implemented the Peer Linkage and Re-Engagement intervention through the Dissemination of Evidence-Informed Interventions project:

AIDS Care Group (Sharon, PA)

Howard Brown Health (Chicago, IL)

Meharry Medical College (Nashville, TN)

"This intervention supports organizations and health care teams to integrate peers into the HIV care team."

These three sites were selected based on their high HIV prevalence among WoC in their communities. These sites also represent organizational settings including outpatient HIV clinics in a larger hospital organization, a comprehensive HIV medical, dental and social service organization, and federally qualified health centers focused on serving the LGBTQ community.

Key Objectives

The main goal of the intervention is to link and re-engage WoC who are newly diagnosed or fallen out of care for at least six months into HIV primary medical care.

The specific objectives include:

- ☑ Attend two medical care visits with a primary care provider;
- ☑ Complete one lab visit; and
- ☑ Attend at least two visits with a case manager.

Implementation Science Approach

DEII sites implemented previously tested interventions that had demonstrated improved patient outcomes along the HIV Care Continuum. Rather than ask “does this intervention work?” DEII asked “what makes the intervention work?” To answer this question, the DEII initiative used an implementation science approach to study the implementation process itself. DEII evaluators used qualitative and quantitative instruments such as key informant interviews, patient encounter forms, and site visit reports to document key factors for successful implementation, challenges encountered by the interventionists, and adaptations needed for successful implementation. This manual reflects findings from implementation science data collected throughout the initiative.

At-a-Glance: Peer Linkage and Re-engagement of Cis and Transgender Women of Color with HIV

Main challenge: In the United States, Black/African American and Hispanic women are disproportionately affected by HIV, comprising about one in five of new diagnoses.³ Black/African American transgender women are among the most affected with an estimated HIV prevalence of 44%.⁴ Tailoring programs and services to engage these vulnerable populations in care is essential to reach the goal of ending the HIV epidemic.

Focus population: Cis or transgender Women of Color (WoC) with HIV who are 18 years or older, newly diagnosed in the past 12 months, or out of care for 6 or more months.

Model description: Three demonstration sites in Chester, PA, Chicago, IL, and Nashville, TN, conducted the following activities to link and re-engage WoC with HIV:

- ◆ Created an internal process to run “out of care” lists to identify clients who have not attended medical appointments or a lab test in 6 months
- ◆ Established a referral process internally with team members and externally with partners for recently diagnosed women
- ◆ Created a system for administrative and clinical supervision for peers as part of the team
- ◆ Provided clients continuous peer support for at least 6 months to ensure stability with needs and medical care
- ◆ Transitioned clients to a case manager for on-going support.

Peers were full- or part-time paid employees as part of the care team. Caseloads among peers were generally about 30-35 active clients at one time. Peer tasks included:

- ◆ Working with team members such as Early Intervention Specialists, outreach workers, quality improvement/data managers, health care providers, and case managers to identify women who were out of care or recently diagnosed but not linked to care
- ◆ Providing emotional and social support on managing life with HIV
- ◆ Providing referrals to address basic needs, such as housing, food, and transportation services
- ◆ Providing education support with medications
- ◆ Ensuring that women attended two visits with their primary care provider, at least one visit with their case manager, and one lab work visit within a four-month period

³Centers for Disease Control and Prevention. HIV Surveillance Report, 2017; vol. 29. <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published November 2018. Accessed 9-24-2019.

⁴Jeffrey S. Becasen, Christa L. Denard, Mary M. Mullins, Darrel H. Higa, Theresa Ann Sipe, “Estimating the Prevalence of HIV and Sexual Behaviors Among the US Transgender Population: A Systematic Review and Meta-Analysis, 2006-2017”, *American Journal of Public Health* 109, no. 1 (January 1, 2019): pp. e1-e8.

Intensity of services: On average, clients received more than one encounter per month (one to eight encounters) with approximately four different activities performed per month. The average length of program intervention was 9 months, with a range of 7 to 13 months.

Resources needed:



Private space for confidential conversations



Computers and mobile phone for peers



List of community resources including mental health and substance use treatment services, housing support services, food banks, shelters, domestic violence support, legal services, and employment agencies



Transportation assistance for clients

Staff background and training:

- ◆ One full-time or two part-time WoC with HIV and other shared life experiences to serve as peers
- ◆ One clinical supervisor, a licensed mental health professional
- ◆ One administrative supervisor with experience with HIV or other chronic conditions
- ◆ One quality improvement specialist/data manager

Management and integration: An administrative supervisor managed the peers and their work. A quality improvement specialist/data manager identified WoC who were recently diagnosed or out of care. This person was also responsible for connecting community partners to build referral relationships. A clinical supervisor provided biweekly or monthly support to peers in managing clients and addressing self-care needs. All project staff met for weekly project and client updates, and at some sites, regular meetings were held with the health care team as part of clinic huddles. All staff communicated via email or phone when in-person team huddles were not feasible.

Financing: The adjusted average cost per participant across the three sites was \$4,731 (2019 dollars) with a range of \$3,458-\$7,260 per year. The number of clients served ranged from 86 to 173 per year. Personnel costs included for 2 FTE peers, 0.5 FTE administrative supervisor, and biweekly clinical supervision; other costs such as client and staff transportation for clinic and home visits, technology and communication support, such as cell phones and computers; training and professional development support for peers; and overhead costs of the agency if applicable. Start up costs for the intervention, including staff training, salaries, equipment and overhead (if applicable) averaged \$38,467 (range \$17,321-\$66,103). Data were gathered from financial reports provided by the agency at the close of the fiscal year and reported to AIDS United.

"Black/African American transgender women are among the most affected with an estimated HIV prevalence of 44%⁴"

Model At-a-Glance

<p>Step 1</p>	<p>Identify WoC eligible for the program Eligible clients are cis and transgender Women of Color (WoC) with HIV who have been out of care for 6 months or longer, or who are newly diagnosed within 12 months. Each month, generate lists of women who are out of care from your electronic medical record and appointment system. Talk with providers about clients who have not been in clinic.</p>
<p>Step 2</p>	<p>Obtain referrals and engage women Work with your outreach team, local health department, social services providers, Early Intervention Specialist, and other community partners, including testing agencies, to find more eligible women to engage.</p>
<p>Step 3</p>	<p>Assess client interest, needs, and develop a care plan Meet with clients to assess their interest in the program, medical, and social needs. Explain the goals of the intervention (to link the client to case management and medical care). Identify three goals to work on as part of their care plan.</p>
<p>Step 4</p>	<p>Provide services according to the care plan Assist client with obtaining services. Provide appointment reminders and accompany client to appointments if needed. Check in periodically and help obtain prescriptions. Talk with client about their medications and any side effects.</p>
<p>Step 5</p>	<p>Document services in the electronic medical record to share with care team As part of the client's chart, document peer services provided in the electronic medical record to keep care team informed.</p>
<p>Step 6</p>	<p>Attend regular care team meetings Attend regular care team conferences and huddles about client care and peer services provided.</p>
<p>Step 7</p>	<p>Reassess services needs at four months and provide warm hand off to case management Once the patient is linked to medical care and has met care plan goals, work with the supervisor and case manager to determine if client is ready to be transitioned to a case manager or should continue to work with the peer intensively to improve their stability. For clients who are ready, provide a warm hand off to the case manager, preferably via an in-person meeting.</p>



Resource Assessment Checklist

The Peer Linkage and Re-engagement Intervention was created specifically for health care settings that provide HIV primary medical care and have medical case management services readily available. Before implementing this intervention, determine whether your organization has the following resources:

- Private, confidential space available for peers to meet with clients
- Computers and phones for peers to use to communicate with providers and clients, and to document services
- A staff person (or the capacity to hire a staff person) to supervise and lead the peers as part of the care team
- The capacity and a staff person to generate “out of care” lists of clients who have not seen the health care provider in the past six months
- A referral system, including releases of information, to discuss and refer clients for services
- Relationships with county or city health departments, correctional facilities, hospitals, and other organizations that provide HIV testing services or care for people with HIV to obtain referrals for your program
- A community resources list that peers can use to link clients directly to needed services
- Staff with training in managing trauma, addressing treatment adherence, supporting HIV disclosure, and motivating clients to address their medical and social needs
- Sufficient resources to address transportation needs for clients, including use of bus/train passes, gas cards, Uber, Lyft, or taxi rides
- A plan for staff self-care, managing burn out, and professional development, including regular clinical supervision with a licensed mental health professional

PRE-IMPLEMENTATION ACTIVITIES



I. Getting Buy-in for Peers as Part of the HIV Care Team

- Establish an internal champion and create an organizational culture that supports peer programs. This internal champion does not have an established list of activities, rather the champion will help the intervention team (peers and appropriate supervisors) to gain the internal support and resources necessary to facilitate implementation. The intervention team, once hired, will provide ongoing programmatic updates to the internal champion (at intervals agreed upon by the intervention team and the champion). The internal champion may or may not be part of the intervention but must be on staff at the clinic and available to the intervention team.
- Since many peer programs are grant funded, the internal champion may need to meet with senior leadership for approval and to secure appropriate resources.
- The internal champion will need to work with human resources to develop a job description that aligns with institutional policies.

“You should hire people who are from the community to work within the community.”



Tips for establishing a champion

Consider integrating team members and partner agencies in new ways:

- ◆ The lead physician may set up meetings with clinic staff, sharing the job description and answering questions from staff regarding the peer’s role in relation to client care.
- ◆ The lead physician can be a liaison with institutional leadership and other departments, such as Human Resources, to build support for the project and to troubleshoot early challenges.
- ◆ The Director of Social Services can serve as a champion as medical providers may not have the time to work through or brainstorm about these issues. Since the Director of Social Services may oversee programs, including Ryan White HIV/AIDS Program services, this person can identify the daily operations “on the ground.” It also provides an opportunity for team members to be Principal Investigators of projects, whom may not always have the opportunity to serve in this position.
- ◆ Promote a fundamental agency culture by employing clients as part of the service delivery system. One agency focused its peer program using existing peers and identified current clients to serve in the role. The agency also provided training on peer roles to all staff, from the front desk to practitioners. All personnel in the clinic need to be on board with peers.



II. Hire and Identify Staff to Implement the Program

Key Roles for the Intervention

- ◆ One full-time or two part-time peers. Peers are defined as cis and transgender WoC with HIV from the community who share characteristics and/or life experiences with the population that they serve, are engaged in medical care and are adherent to treatment, and are willing to openly share life experiences related to their HIV status.
- ◆ One clinical supervisor, a licensed mental health professional.
- ◆ One administrative supervisor with HIV experience or other chronic conditions.
- ◆ One quality improvement specialist/data manager.

Hiring Peers

Developing a peer job description

- ◆ Work with human resources to develop a job description.
- ◆ Define what it means to be a peer and the specific kind of peer that you are looking to hire.
- ◆ Create clear boundaries and differences in tasks between case managers and peers to avoid power dynamic concerns.
- ◆ Ensure that the description aligns with the mission of hiring people who are from the community to work with in the community.
- ◆ Keep in mind that some agencies' policies may not allow for candidates to be asked about HIV status.
- ◆ Choose a job title that is appropriate for your organization. The title may not include the word "peer" in order to maintain confidentiality and to garner more respect for the role from other staff. Potential titles could include "Treatment Adherence Specialist" or "Linkage to Care Specialist."
- ◆ See appendix for a detailed staffing plan and job descriptions.

Recruiting peer applicants

Program managers or supervisors should be proactive in recruiting appropriate candidates by:

- ☑ Recruiting from within—approach clients or volunteers who have grown professionally and personally
- ☑ Reaching out to partners and clients who are known to the clinic and care team; those who know the clinic best will be able to support others and the care team
- ☑ Soliciting names of possible candidates from clinic providers and other staff
- ☑ Generating emails, postings on websites, and e-blasts on local clinic listservs
- ☑ Sending flyers or other materials to clinics, community-based organizations, AIDS service organizations, planning councils, and other community groups that work with WoC



Special considerations for hiring peers

Peers bring many unique qualities to their work, but given their life circumstances, some peers may need additional support. Be prepared to address the following issues during the hiring process and soon after the peer is hired to create an environment in which they can thrive.

- ☑ When hiring clients who receive services from the clinic, discuss how their medical information will remain confidential. Potential candidates may wish to create an alias name in the system (but maintain their medical ID) to protect confidentiality, or seek medical services at another agency.
- ☑ Assess peer readiness to disclose their HIV status to others and how to work with providers.
- ☑ Conduct a background check and drug screen. Understand if the person has a history of substance use and be aware of any struggles they may have with recovery. Examine work history to see and understand gaps in their work.
- ☑ Assess readiness to get off public benefits: Educate and ensure that peers who receive federal/state benefits are ready to be employed and understand how their benefits will be impacted when hired. Have someone on staff check in with peers about benefits on a consistent basis to help them understand any potential changes and provide guidance for questions and concerns about benefits and pay.
- ☑ Provide education and support for learning to budget. The peer may now need to manage copays for medications, or if traveling for the first time to conferences and meetings, the peer may wish to buy new clothes or have their hair styled.



Hiring Clinical and Administrative Supervisors

Administrative supervisors provide daily support for the peer with managing client caseloads, finding resources, ensuring their work is documented as part of the client's clinic records, and managing relationships and communications with other team members and partners. Administrative supervisors have project management experience, preferably with HIV or other chronic conditions, may have a master's degree in public health or social work, and may be from a similar racial/ethnic community. Ideally, they should have established relationships with care teams and partners so the peer can be easily introduced and gain credibility.

Clinical supervisors help peers manage complex boundary issues with other staff and clients and support a peer's mental health and wellbeing. Because peers are also living with HIV, their work with clients may be difficult for their own health and trigger feelings of past trauma. Clinical supervisors can also help ensure that the peer is working with clients and staff in a productive and effective way for the team and client. They are licensed professionals, either psychologists, social workers, or counselors. It is critical that they have experience with the community being served, HIV, homelessness, substance use and/or mental health. Both of these roles may be filled by current employees or new hires.

Key points to consider when establishing the structure for a peer supervision system:

- ◆ Offer clinical supervision at least biweekly by a licensed clinician
- ◆ Offer administrative supervision every week and check in daily on specific cases and/or boundary issues with other team members
- ◆ Ensure the administrative supervisor can spend at least 50% of their time managing the peer program
- ◆ Provide training on supervision techniques
- ◆ Create a network and shadow supervisors who are doing similar work; this creates a knowledge base for the supervisor and a bridge for resources



Involve other staff and care team members to support the program

A successful peer program goes beyond the peer and their supervisor. Consider how other members of the team can be involved:

- ☑ Front desk staff can help identify clients who have been lost to care and can connect a client to a peer.
- ☑ A quality improvement specialist or manager can run reports on out of care lists and keep track of clients who were due for visits but did not attend.
- ☑ Electronic Medical Record (EMR) specialists can train peers on the electronic health records system.
- ☑ Early Intervention Specialists (EIS) and/or the outreach team can identify the people who have been lost to care, and the peer can attempt to make contact with them or do a home visit.
- ☑ Health care providers can facilitate a warm introduction between the client and the peer. If clients have an established relationship with their provider, this introduction can help to facilitate trust and buy-in for the intervention.
- ☑ For a new supervisor, other team members (case managers, health care providers, peers and managers) should discuss their roles on the team and how the supervisor can help the team function smoothly.

III. Preparing to Implement the Program

- Assess clinic space and secure space for intervention activities.** Peers need to have private space to have confidential conversations with clients—this step cannot be short-changed. Sites should review staff schedules and appointments with clients. Peers are in constant contact with their clients and community service providers to address unmet client needs. One option for managing a scarcity of space is to create a hoteling schedule (assign staff to space at different times).
- Provide a phone.** Peers need to have a phone provided by the clinic to stay in touch with clients, but also to maintain the boundary between their personal and professional lives. When peers use their personal phones to reach out to their clients and vice versa, they are not able to take time off to recharge, and can end up experiencing burnout or vicarious trauma. Before providing the phone, discuss expectations for the work phone, the minutes available on the phone, and the data package, so the peer can appropriately use the phone.
- Obtain other necessary technology** (e.g., laptop, tablet).
- Create a transportation plan.** Peers may travel around the clinic’s service area to meet with their clients. Provide reimbursement for either public transportation or gas mileage.
- Provide peers with read and write access to the electronic medical record (EMR)** to be fully integrated into the clinical team. Peers can provide valuable insight to the medical team about a client’s medication adherence, specialty medical visits, and the outcomes of referrals to medical and social service providers. Peers will need access to the EMR to both record their activities and to review pertinent information prior to meetings with clients.
- Review institutional policies on safety and liability** for conducting outreach.
- Develop and implement policies that address safety and boundary issues** between peers and clients.
- Work with the clinic administration** and the internal champion to create daily “open” appointment times for peers to schedule clients for HIV medical appointments as needed.
- Create a staff communication and decision-making plan** so the team knows who to approach about various concerns or needs.
- Plan for future Medicaid reimbursements** (if applicable).
- Plan for obtaining billing codes for peer-delivered services** (if applicable).
- Ensure HIPAA training is provided and completed annually by staff.**



Addressing patient and staff safety and the discharge process

Develop a plan for handling safety and difficult interactions. Howard Brown Health Center in Chicago works very hard to not discharge patients and instead keep them engaged in care. Case managers and peers will work together to address a person's needs and first focus on de-escalating any negative or threatening behavior. Some clients are put on a "behavioral contract" especially if the peer feels they are being threatened: security would be the first line of defense, then they would work with the director of social services and the chief medical officer to alert staff. Alerts should be in placed in the EMR for clients who have negative or violent interactions with other clients and/or other staff.



IV. Training and Orienting Team Members

Peers may come to their position with an advanced degree or without a high school diploma. They may have extensive training in health care or none at all. All new peers or peers who are currently working at your agency in different roles should participate in a standard new-hire orientation, as well as job-specific training. Include the following areas in the orientation period:

Organizational Information

- ☑ **Review general organizational policies.**
- ☑ **Identify workflows and clear tasks** for each member of the care team, so the peer is seen as a core member that offers essential services.
- ☑ **Discuss boundaries** between peers and clients, e.g. not loaning money to a client.
- ☑ **Introduce new peers to community partners.** Take new team members to community meetings, organize one-on-one meetings, and orient new team members to where community partners are physically located and what services they provide. It's one thing to receive a list of community partners in an orientation packet, but in order to best support clients, team members need to know who to call for specific services as well as have familiarity with processes to acquire services. Encourage peers to meet regularly with partners, such as the AIDS Consortia, the health department, planning councils, and jail staff who could refer women to the program.

Job-Specific Training and Resources

- ☑ Provide up to 30 hours of training on a range of topics, including HIV core competencies, trauma-informed care, cultural humility, and motivational interviewing.
- ☑ Shadowing an experienced peer is a great way for new peers to learn about clinic operations. The experienced peer can demonstrate how to navigate the EMR system and help make sure the new peer understands information, employs skills from the trainings, and is prepared to take on the role. Peer-to-peer training creates a nonthreatening and supportive learning environment. Shadowing in the clinic also creates understanding of different team members' roles. It can also happen in a group setting; for example, a peer could sit in on a group to learn about group facilitation and client communication skills.
- ☑ Provide a list of client resources and contact information. For example, Positive Women's Network (<https://www.pwn-usa.org/>) has helpful resources to share.
- ☑ Discuss how to motivate clients to talk about their experiences (See section on project implementation)
- ☑ Identify continuous learning and professional development opportunities for supervisors and peers. An organizational environment that supports learning is the best way to ensure that peers are adequately prepared to do their job. Peers and administrative supervisors should take classes that will assist their intervention activities and broader clinic skills. Opportunities may be available through college classes, webinars, and other local trainings. Community partners may offer trainings on cross-cutting issues (like trauma informed care) or skills (motivational interviewing and mental health first aid).

Technology

- ☑ EMR system training: Peers must understand what is captured in the EMR and how to enter case notes, as well as conduct any site-level data collection activities.
- ☑ Ensure that peers are comfortable using technology in general and any other online systems used at your organization. At one site, the peer team went to sessions offered at the local Apple store to learn how to use their computers and tablets.
- ☑ Train staff about passwords and the importance of writing them down to help with recall as needed to enter systems.



The peer training manual is available here

Key topics include:

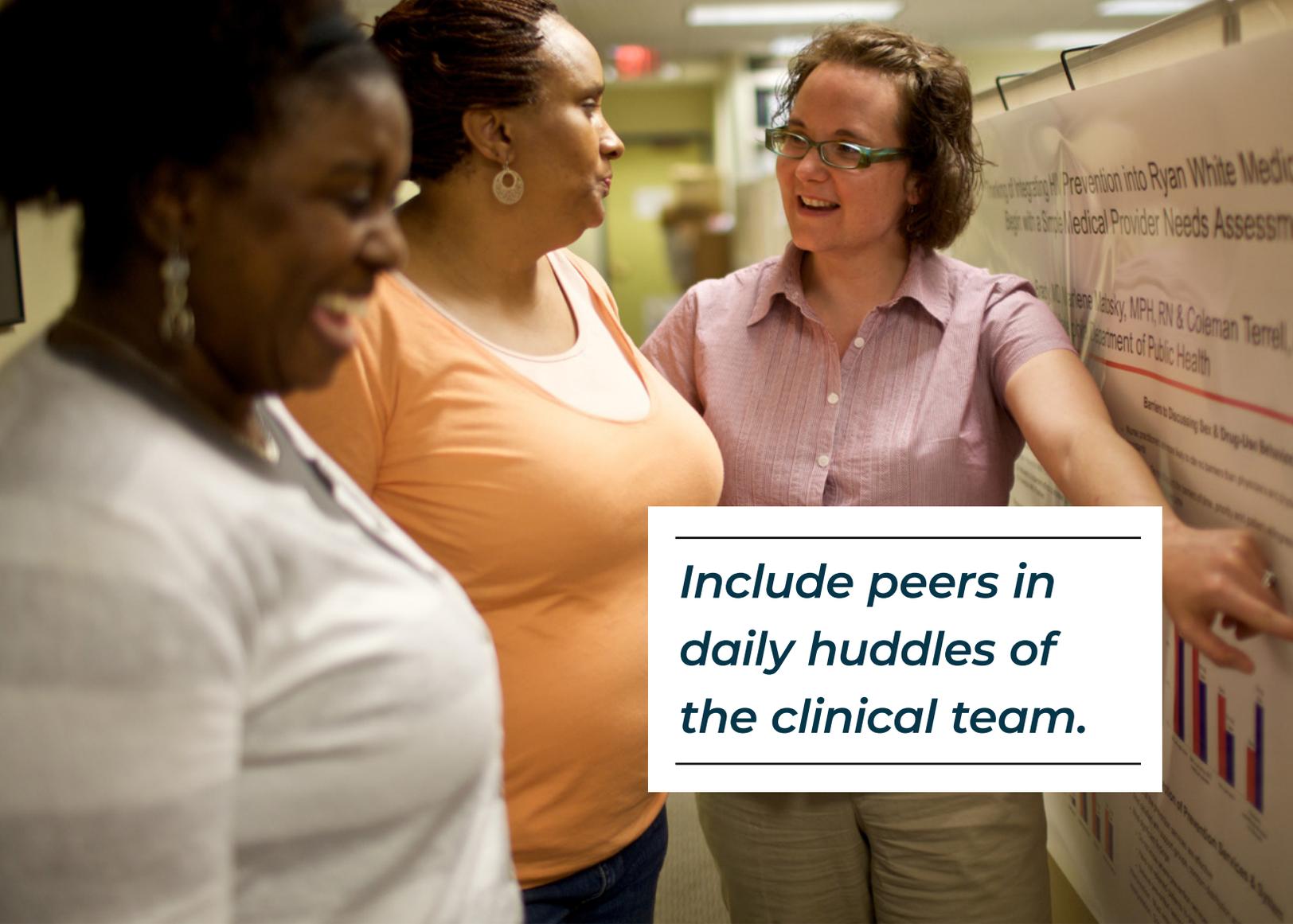
- ◆ Motivational interviewing techniques
- ◆ Outreach and retention in care
- ◆ Harm reduction
- ◆ Trauma-informed care
- ◆ Cultural humility
- ◆ Understanding vicarious trauma
- ◆ Self-care techniques
- ◆ HIV medical adherence and side effects
- ◆ Supporting clients with mental health disorders
- ◆ Making appropriate referrals
- ◆ How to communicate more effectively and advocate for oneself
- ◆ Professional skills development: Communicating with partners; boundaries with clients



V. Create a Team Communications Plan

- Set up consistent communication channels to remind health care team about peer services. Suggested outlets include:
 - Provider meetings
 - Biweekly emails to department with updates about the program
 - Daily huddles with the clinical team
 - Routing clients to the front desk staff

- Use team huddles or case conferencing forms with different providers. Be sure to have at least weekly face-to-face huddles to review any form completed via email.



Include peers in daily huddles of the clinical team.

Integrate peers into the clinical team and clinic operations

- ◆ Offer an orientation for all clinic staff members about the peer intervention to secure buy-in and cooperation.
- ◆ Create effective feedback loops to engage peers in contributing to research meetings, social service coordination meetings, interdepartmental meetings, and strategic planning sessions.
- ◆ Engage clinicians in peer training and professional development (e.g. helping peers to understand the health of their clients).
- ◆ Engage clinicians in teaming up with peers to provide client education when necessary and appropriate.
- ◆ Integrate peers into the clinical team and case conferencing meetings. Case conference meetings can be appropriate times to identify clients who are eligible for intervention services, find clients who have lost contact with the intervention and peers, and identify clients who are ready for and who are struggling with transitioning to the standard of care.

IMPLEMENTATION ACTIVITIES



Eligibility Criteria for the Intervention

- ◆ Women age 18 years or older; and
- ◆ Living with HIV; and
- ◆ Identify as being female; and
- ◆ Women who identify as belonging to one or more of the following racial or ethnic categories: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latina, Native Hawaiian or other Pacific Islander;
- ◆ Are receiving their HIV primary care at the clinic or satellite/affiliated offices offering the peer intervention;
- ◆ AND at least one of the following criteria:
 - Are newly diagnosed in past 12 months; OR
 - Have never linked to care (newly engaged) not in the state system; OR
 - Have fallen out-of-care (i.e., have not attended the clinic where they receive HIV primary care) for 6 months or more; OR
 - Are not virally suppressed; OR
 - Are missing primary care appointments without rescheduling.



In this program intervention the exclusion criteria for eligible clients included:

- ◆ Under age 18; or
- ◆ HIV negative; or
- ◆ Identify as being male;
- ◆ White, non-Hispanic of no other race or ethnicity; and
- ◆ Are currently linked to and retained in care at the clinic offering the peer intervention.



Patient populations for peer intervention in HIV care

Other programs may want to expand or focus the peer role within the health care team. For example, as part of the federal “Ending the HIV Epidemic: A Plan for America” (EHE) initiative, the peer could play a role in educating and supporting clients who are prescribed PrEP to reach the goal of reducing new infections in the next decade. As a result, the organization may wish to serve at-risk youth and men with a peer program, in addition to cis and transgender women.

I. How to Identify and Recruit Clients

-  **Build a referral process.** Intervention team members should establish or strengthen relationships with community partners to develop newly-diagnosed client lists. Intervention team members should create and document protocols for internal, external, and community-based referrals. This work will include connecting with health department supported staff and community agencies that specialize in client outreach and identifying hard to reach individuals. For example, referrals from the county health department could go directly to the medical team, who then communicate with peers to follow up with clients.
-  **Create an out-of-care list of eligible clients.** Review clinic appointments and EMR to identify eligible clients or those who have been out-of-care for six months or more.
-  **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 clients meet the eligibility criteria.
-  **Review the list at weekly clinical team meetings** and use clinicians to assist in the identification of additional clients who may be eligible and/or clients who are at high risk of dropping out of care or not linking into care due to comorbidities.
-  **Using the morning team clinic huddle to identify clients** who may benefit from peer support and can be referred to the peer.
-  **Work with other team members who can identify clients for the program** such as client educators, navigators, nurses, and front desk staff who may know who is coming to the clinic for an appointment and may need peer support.
-  **Review HIV testing data** to identify eligible clients who are newly diagnosed or who have never linked to care. If sites don't offer testing but partner sites do, have the supervisor or data manager reach out to partner agencies to identify clients who meet the eligibility criteria and who would benefit from a peer linkage and re-engagement intervention.
-  **Client outreach** (conducted by peers). Once eligible clients have been identified, intensive outreach to link clients should take place 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 get out of the office and into the community to find and meet with eligible clients (“feet in the street”).



Strategies for referrals

- ◆ Ask providers who they have not seen in a while or who they have lost to care.
- ◆ Running consistent data reports can find people who have not been seen in a while; these reports can also highlight opportunities to improve the clinic's quality of care for patients. For example, you may find women who missed a pap smear or mammogram or have elevated viral load tests.
- ◆ Build relationships and memoranda of understanding with hospitals and jails for people with HIV who are being discharged.



Identifying clients in a new clinic and community setting

When the Howard Brown Health Center in Chicago expanded by opening a clinic in a new community, Englewood, the agency needed to develop trust with that community and a reputation for serving women. To reach potential clients, the agency implemented a multi-pronged strategy that included:

- ◆ **Developing partnerships to reach cis and trans women** including The Meow University (sexuality workshops and events), Haymarket Center (maternal substance use services), Chicago House (LGBTQ social services), Chicago Department of Public Health, libraries, community colleges, and the AIDS Foundation of Chicago.
- ◆ **Hosting a monthly peer support group**, Phenomenal Women, focusing on HIV and other women's health issues.
- ◆ **Advertising** with a multimedia marketing campaign throughout Chicago, purchasing ads on public transportation, and promoting services on social media platforms such as Facebook and Instagram.



Set up referral systems with community organizations that provide non-medical services to meet the needs of women with HIV. One agency participated in regular meetings with partners who had leadership training and employment programs to referral WoC to needed services.

Engaging lost to care or newly diagnosed cis and transgender women in care: Sample implementation process from AIDS Care Group (ACG), Chester, PA

1. QI staff and the administrative supervisor generate a list of clients who meet eligibility criteria from CareWare or the EMR. Clients are then assigned to peer.
2. For referrals, use the EMR to find any recent visits and to confirm if people are truly out of care; create a system for one person to receive referrals by the health department, hospital, or private practices.
3. Share the referral list with the front desk so the client can make an appointment.
4. Work with the front desk staff to ensure that newly diagnosed clients are able to be seen within 1-2 days. If the client needs to be located, the referral goes to the peer or outreach team to establish contact.
5. At the first visit conduct an intake appointment: the peer meets with the clients and tells them about the peer program and that it is designed to be a short-term intervention to connect the person with medical and nonmedical services; ask client if they would like to work with a peer. At ACG there was a 90% acceptance rate; most people enrolled on day of their first visit.
6. On the first day meet with the peer and the health care provider. Ask about a care plan.
7. The Administrative Supervisor works with the peer to create an internal spreadsheet for tracking client's needs.
8. At ACG, the case managers (CM) works with a partner agency, co-located within the ACG building. To ensure that there is sufficient time to have a client assigned to a case manager, ACG's peer connects with a CM after the first client visit to inform them that a client will be calling them to engage in CM. Peers can be positioned to be their client's advocate with CMs and providers.
9. Provide services and reassess at 4-6 months if client still needs services from peer or ready for regular follow up with Case Manager.

II. Meeting with Clients



At the initial meeting, the peer explains their role as part of the health care team, the services provided by the peer, and the timeline of the intervention. As a peer, their role is to work with the client for 6-12 months intensively to assist with needed services and support their case manager and their health care team.

Below are some conversations prompts for the initial meeting:

- ◆ My name is _____ and I having been living with HIV for the past 18 years. 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 living with HIV.
- ◆ My role is to give you health information and be someone you can turn to for support for the next 6-12 months. Our goal together over the course of the next 6-12 months is to get you back in to:
 - Get your lab work done
 - See your doctor
 - See a/your case manager
- ◆ But today, let's talk about what your needs are and how I can help you address those.
- ◆ Tell me about yourself. When did you receive your diagnosis and how have you been coping with the disease (medically, home life)? Who in your life knows about your HIV status? How would you describe your relationship with your family? What is your relationship with your friends like?
- ◆ What do you know about HIV? Where did you get this information?
- ◆ What particular questions do you have about HIV?
- ◆ How have things been going since you last came in for an appointment or since you found out that you were HIV positive (depending on client)? What are some of the reasons you haven't come back in for an appointment with your primary care doctor?
- ◆ Thanks for taking the time to meet with me today.
- ◆ Let's plan to meet again next week on _____.



Promoting services other than HIV

“Have programs that focus just on women coming together. Have something for their kids too. **Focus on health promotion in general, not just HIV. So, yes, it's important you get your Pap smears, you get your mammograms.** Yes, it's important that you have the support in taking care of all of the other chronic things, too, so that it's not just HIV, I think having and expanding where the care coordinators, could sponsor or work with the **group of women having a girls' night out where they just do something either collectively or, you know, let's have a spa day.** Something of that sort where the emphasis is not on HIV. It's on them being a woman.”

—Client of Peer Linkage and Re-engagement intervention

- ✓ **Create a care plan focused on addressing non-medical and medical needs.** A sample care plan is provided in Appendix D.
- ✓ **Support clients in obtaining referrals for needed services** (including transportation, housing, legal services, food, employment, mental health or substance use treatment, or other specialty medical appointments like hormone treatments). All referrals should be made in conjunction with or by the case manager.
- ✓ **Offer to accompany clients** to internal and external appointments and assist with completion of paperwork for appointments, benefits, and referrals.
- ✓ **Assist with finding appropriate child or elder care** (when applicable). Many WoC, especially those who are recent immigrants, may have other care giving responsibilities and may not prioritize their own health.
- ✓ **Talk with clients about the medical information received from health care and other social service providers** to ensure the client understands and can take appropriate **next steps with the information.**
- ✓ **Provide appointment reminders** for linkage or re-engagement appointments with the primary care provider and the case manager.
- ✓ **Provide coaching and trauma-informed emotional support** to clients, including supporting clients in navigating the clinic (or healthcare) system and community resources. Make referrals to mental health services as appropriate.
- ✓ **Provide assistance with transportation** related to linkage or re-engagement appointments and accessing social services.
- ✓ **Connect and maintain communication with clients throughout the intervention**
- ✓ **Continually update contact information.** Clients may change phone numbers or run out of cell phone minutes, so peers will need to have back-up plans for how to reach clients to maintain consistent contact.

Provide weekly client check-ins by phone, in-person meetings, or text message, email, social media, or other method of communication that is preferable for the client and permissible by the policies of the clinic site. During the weekly client check-in, peers should provide appointment reminders when appropriate. Focus on total wellness; check in about food, employment, housing, and family. Ask the following questions during their check-ins:

- ◆ What services do you need? In particular:
 - Mental health?
 - Housing?
 - Substance use?
- ◆ What referrals or appointments have been made for you, and which ones have you attended?
- ◆ Would you like me to go with you to your medical or social services visit?
- ◆ How can I help you connect with people/services you need?
- ◆ How are things going for you in general?
- ◆ Let's schedule our next visit/check-in.



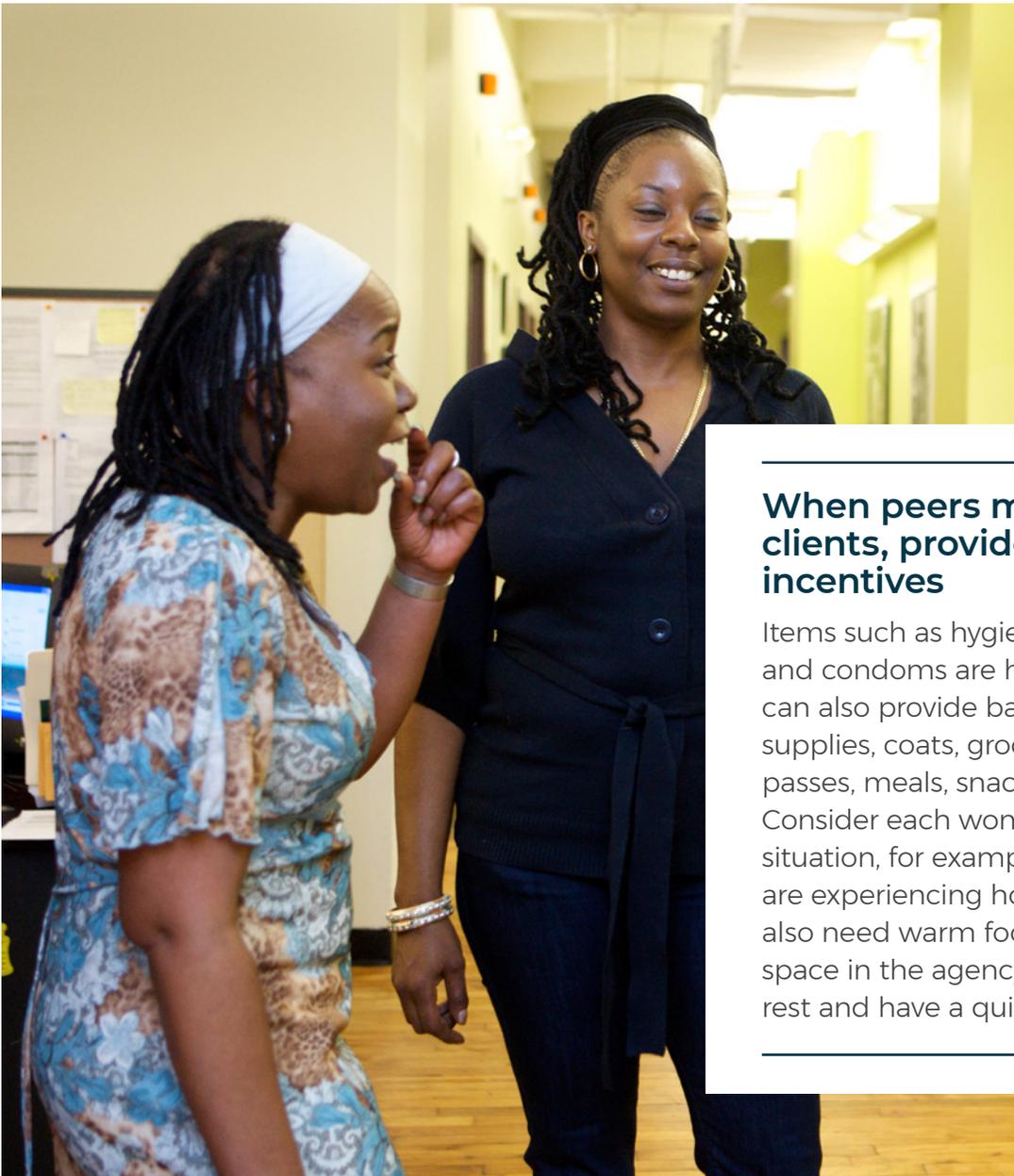
Direct the patients to where they may need help. There's a lot of mental health issues too, a lot of depression, a lot of anxiety. And so, just giving some kind of road map, not a script but something to help navigate a conversation other than the general, "Hey, come, we need you to stay in care"... give them something to help and guide the patient and how to educate the patient in a standardized way.

—Medical provider in the Peer Linkage and Re-engagement intervention

Developing and sharing a care plan with the care team

The team at Howard Brown created a care plan with a client who had fallen out of care during the initial meeting. For clients who are newly diagnosed, the Howard Brown team waited about a month to start the care plan to ensure a trusting relationship was built.

- ◆ Get as many clinical team members (medical and behavioral health providers, peers) as possible to work with clients to have an integrated care plan.
- ◆ Use an integrated care plan consisting of goals for medical, behavior, and social needs.
- ◆ The care plan is in the EMR so it is centralized and everyone has access to important information (for example, applying for the AIDS Drug Assistance Program) and reduces miscommunication.
- ◆ The only notes that are kept private in the EMR are psychiatry and behavioral health.
- ◆ Part of the intake is a depression screening tool, the PHQ-9, which triggers a behavioral assessment (which is included in the open notes, but behavioral health notes are not included).



When peers meet with clients, provide tangible incentives

Items such as hygiene kits, towels, and condoms are helpful. Agencies can also provide back-to-school supplies, coats, grocery cards, bus passes, meals, snacks, and water. Consider each women's living situation, for example, women who are experiencing homelessness may also need warm food. Create a safe space in the agency for women to rest and have a quiet space.



Communication strategies for clients

- ◆ Try texts or Facebook (which is great for clients without phones but who do have access to wifi).
- ◆ Some clients will just walk in looking for the peer or supervisor.
- ◆ The peer should connect with clients about once a week.
- ◆ If the peer hasn't heard from a client during the week, or if they miss an appointment, they should reach out to them.
- ◆ The peer should not allow more than three weeks to go by without communicating with a client.



III. Conducting Regular Supervision

The following supervision schedule is recommended for initiating a program and when a new team member joins the intervention team:

- ☑ The administrative supervisor provides weekly in-person supervision.
- ☑ The clinical supervisor provides clinical supervision of peer(s) biweekly.
- ☑ The intervention team holds weekly case conferencing meetings with clinical team, case managers, peers supervisors, and peers.

Some peers may need weekly supervision or daily check-in, as determined by the needs of the peer and the supervisor. For new peers, it may be necessary to meet more often based on the competency and comfort of the peer. This schedule can be revisited over time and adjusted to meet the needs of all team members. Additional ad hoc meetings are always encouraged when a team member is dealing with a challenging situation or needs additional support.

Suggested topics for clinical supervision include:

- ☑ Burnout, vicarious trauma, and compassion fatigue
- ☑ Boundaries with clients
- ☑ Transference and counter-transference

Administrative supervisors can check in on:

- ☑ Quality of work and specific tasks with clients
- ☑ Documentation in the EMR
- ☑ Performance
- ☑ Training needs
- ☑ Any documentation or accountability for funds received for client services or programs



IV. Transitioning Clients to the Standard of Care

Aim to complete the goals of the care plan in four to six months. Across the three sites, peers worked intensively with clients on a weekly basis and transitioned clients to the standard of care after they attend two visits with their primary care provider, one visit with their case manager, and one lab work visit within a four-month period.

On average this took six months if case management was in place to continue to support the clients.

For clients who met their care plan goals, peers can:

- ◆ Document in the EMR case notes that the client is stable and worked with the case manager to continue regular support.
- ◆ Check in with the health care team and case manager to see if the client may need to reconnect with their peer on an as-needed basis.
- ☑ Work with the client, case managers, peer supervisors, and clinical team to determine if a person is ready to be transitioned to the standard of care. Completion of the peer intervention is driven and decided by the client, peer, and case manager, with support from the supervisor.
- ☑ Convene a meeting with the case manager and the client so the client can ask questions and schedule the next appointment with her case manager. Try to bundle the case management appointment with a time that the client is already coming into the clinic so that the client doesn't have to come back to the clinic a second time.
- ☑ Introduce the client to the case manager and talk about how the case manager provides more services than the peer can offer.
- ☑ After transition, do a check in by phone or in person at three months to see how the person is doing so they don't fall out of care.



The client can re-engage with the peer in the following scenarios:

- ◆ If a client is unresponsive to peer outreach efforts and stops working toward completing the intervention goals, then later determines that they want to re-engage with a peer.
- ◆ If additional needs emerge that could benefit from ongoing work with a peer. In this case, the peer would adapt or develop a new care plan with the client. Across the three pilot sites, most clients had multiple care plans.
- ◆ If a person completes the transition to the standard of care and then becomes eligible for the intervention again at a later time (client falls out of care for six months or more), they will then be eligible for peer services.

If they agree to receive peer services, the peer will complete a new care plan and “restart” the six-month intervention time period.



Transitioning clients to the standard of care

- ◆ Start the conversation early with the case manager and client.
- ◆ If the case manager is in the same office or part of the team, conduct ad hoc case conferencing.
- ◆ Educate the client about the services from case managers vs. peers:
 - Case managers can assist with insurance, social security benefits, ID, and housing.
 - Peers can assist with transportation, for example, setting up Uber health.
 - Peers refer clients to case managers for AIDS Drug Assistance Program (ADAP) applications, applications for health marketplace plans, establishing insurance payments, electricity and other utilities, guardianship, payees to set up benefits for a third party.

PROMOTING SUSTAINABILITY AND INTEGRATION ACTIVITIES

The following activities should be conducted by the intervention team members in partnership with clinic administration and clinical team members:

- Continue to recruit, hire, and train peers.
- Provide ongoing professional development and mentorship to peers. Peers could present at national conferences including the National Ryan White Conference on HIV Care and Treatment, United States Conference on AIDS, and the National HIV and Social Work Conference.
- Incorporate peer linkage and re-engagement work into the standard of care at the clinic.
- Train clinic staff who interact with clients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to be able to identify clients who may benefit from peer services, and train these staff members on how to connect these clients with the intervention.
- Add peer linkage and retention as a regular field in the EMR.
- Routinely assess clients to determine which clients could benefit from the peer linkage and retention intervention.
- Facilitate ongoing conversation among providers about clients who could benefit from the intervention.
- Continually engage peers in client case conferencing.
- Explore the potential for funding through Medicaid programs and other agencies such as Accountably Care Organizations, and other program income streams.

Examples of peers in the care team

At Meharry Community Wellness Center in Nashville, Tennessee, one of the peers transitioned to be a Community Health Worker with additional funding provided by Ryan White Part A. She will continue to work with women to re-engage and retain them in care, and her caseload is expanding to serve men as well.

At the Howard Brown Health Center in Chicago, the peer's role was expanded to conduct more outreach and testing as well as linkage to care.

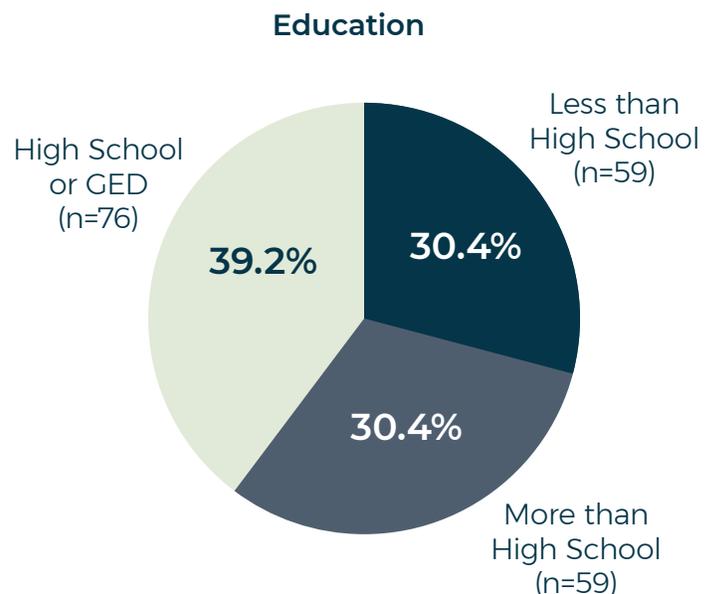
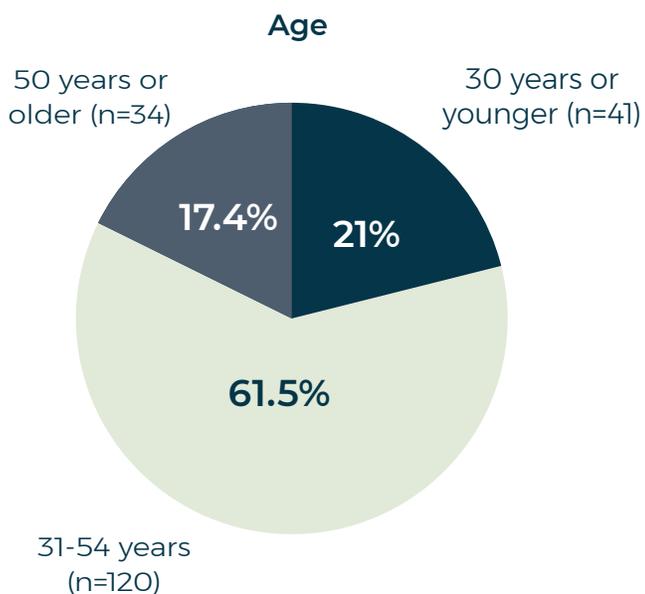
Sustainability is an important component of implementing this evidence informed intervention—both to support continuity of services for clients as well as strengthen investments by individual staff and organizations. DEII grantees had the option to use the Program Sustainability Assessment Tool (PSAT) to evaluate the sustainability capacity of their program and engage in sustainability planning processes. The PSAT was developed by the Center for Public Health Systems Science (CPHSS), Brown School, Washington University in St. Louis through a comprehensive literature review and expert-informed Concept Mapping. Whether your organization uses the PSAT or another resource, have conversations about sustainability early and often.

OUTCOMES/IMPACT



- ◆ 196 WoC were served by the peer intervention
- ◆ 173 were enrolled in a longitudinal study with data up to post 12 months follow-up
 - One-fifth were young women under the age of 30 years
 - 17% were 55 years or older
 - One-third had experienced a night of homelessness in the past 12 months
- ◆ 96% were linked to medical care within 90 days of enrollment
- ◆ 73% were retained in care, defined as having 2 appointments at least 90 days apart in 12 months post enrollment
- ◆ Viral suppression increased from 58% at baseline to 81% post 6 months. This rate remained consistent at 12 months post enrollment

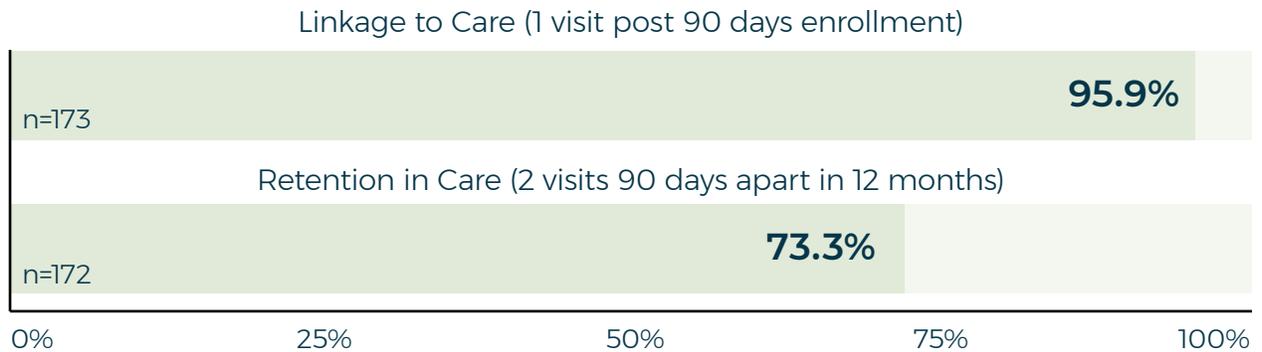
Women of Color Reached



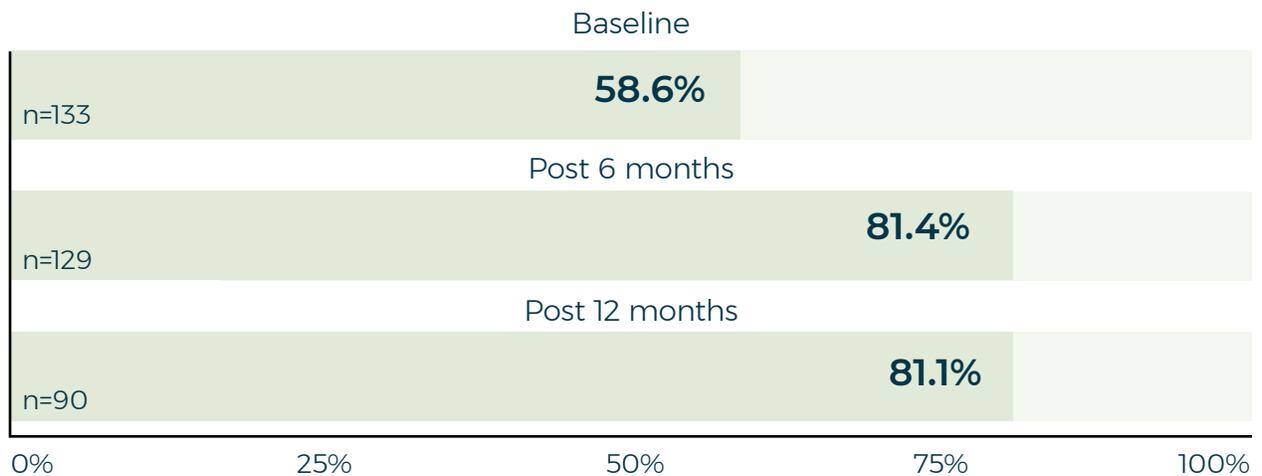
Women of Color Reached (cont.)



HIV Care outcomes



Viral Suppression



Considerations for Replication

- ◆ Identify a champion (health care provider, program manager, supervisor) to maintain support and integration of the peer as part of the care team.
- ◆ Provide private, confidential space for a peer to meet with clients.
- ◆ Set up an orientation and training program for up to 30 hours of skills development for peer staff and for other clinic staff to ensure smooth integration.
- ◆ Educate and provide support resources for peer staff to understand the potential impact of increased earnings on any health, food, housing, or other benefits.
- ◆ Use multimodal recruitment strategies to identify and outreach to WoC. Potential ideas include: running out of care lists and working EIS and outreach teams to find women; use of support groups and social media and marketing in high risk communities.
- ◆ Keep caseloads to 30-35 women for peer staff.
- ◆ Ensure access to electronic health records for documentation.
- ◆ Conduct regular in-person administrative and clinical supervision.
- ◆ Bring case managers early in the process to work with peer and clients to ensure smooth transition from intense services to standard of care.
- ◆ Create opportunities for self-care and professional development for peer staff.

Conclusions

Peers, as part of a health care team, can play a vital role in identifying, recruiting, and linking newly diagnosed women of color to care, and re-engaging women who have been out of care. Findings from this intervention show that having peers work with clients for an average of 6-12 months as part of the health care team can help address the unmet needs for medical and social services that can hinder care and treatment, and lead toward viral suppression.

Care and Treatment Intervention (CATIs) are a series of evidence-informed interventions supported by HRSA/HAB to promote linkage, retention and viral suppression across Ryan White Programs. The CATIs replicate four previously HRSA/HAB/SPNS initiatives:

- ◆ Transitional Care Coordination from Jail Intake to Community HIV Primary Care
- ◆ Peer Linkage and Re-engagement for Women of Color living with HIV
- ◆ Integrating Buprenorphine Treatment in Opioid Use Disorder in HIV Primary Care
- ◆ Enhanced Patient Navigation for Women of Color living with HIV

Where to find resources from the HRSA/HAB's Dissemination of Evidence-Informed Interventions Initiative:

<https://targethiv.org/deii/>

Appendices

Appendix A: Logic Model

Resources	Activities	Outputs	Short Term Outcomes	Long Term Outcomes	
<ul style="list-style-type: none"> ◆ Intervention staff (peer, administrative peer supervisor, clinical peer supervisor, quality improvement or data manager) ◆ Community health centers ◆ Community partners ◆ Clinic champion and buy-in from administrative support (front desk staff), medical and behavioral health team (physician, nurses, social workers) and outreach teams ◆ Clinic space for private meetings between clients and peers ◆ Laptop/phone ◆ Tangible reinforcements such as transportation assistance, food and hygiene kits for clients who are in need ◆ Access to EMR ◆ Standard of care case managers or social workers who can work with clients in collaboration with the peer and for transition to standard of care 	<p>Pre-implementation</p> <ul style="list-style-type: none"> ◆ Hire and train: <ul style="list-style-type: none"> – Peers – Supervisors – Other clinic staff: medical providers, case managers, front desk staff ◆ Hold Community Partner meetings to introduce peer and set up referral system ◆ Establish supervision and internal referral systems ◆ Create monthly out-of-care lists 	<p>Ongoing Implementation</p> <ul style="list-style-type: none"> ◆ Conduct outreach to newly diagnosed clients, and clients who have fallen out of care ◆ Develop care plans with each client ◆ Provide reminders for HIV linkage or re-engagement appointments ◆ Provide support accessing ancillary services (transportation, employment, housing, food, benefits) ◆ Accompany clients to linkage and re-engagement appointments ◆ Provide coaching to clients on medication adherence and engagement in HIV care ◆ Conduct administrative and clinical peer supervision meetings ◆ Document services in electronic medical record ◆ Provide and follow up referrals to community partners 	<ul style="list-style-type: none"> ◆ Eligible individuals identified ◆ Outreach attempts made and types of outreach (phone, home visit) ◆ Individuals who engage with peers ◆ Care plans in place ◆ Appointments made ◆ Appointments attended ◆ Clients who are transitioned into the standard of care ◆ Weekly encounters with clients ◆ Unsuccessful outreach attempts with clients ◆ Clients requiring transportation ◆ Clients need of social supports/ ongoing care management (mental health, substance use disorder, dual diagnoses, homeless, continued history of incarceration) ◆ Referrals made ◆ Referrals kept 	<ul style="list-style-type: none"> ◆ Increase in client: <ul style="list-style-type: none"> – Understanding of the importance of care – Adherence to ART ◆ Reduction in barriers to care ◆ Reduction in client unmet need for services (housing, food, other social, legal and economic services) <div style="background-color: #e0f0e0; padding: 5px; text-align: center; margin: 10px 0;"> <p>Intermediate Outcomes</p> </div> <ul style="list-style-type: none"> ◆ Clients are linked and re-engaged in care ◆ Attendance at 2 clinical, 1 case management, and 1 lab visit in a 6-12 month period 	<ul style="list-style-type: none"> ◆ Long term retention in care ◆ Improvement in the following client outcomes: <ul style="list-style-type: none"> – HIV viral load suppression – Quality of life – Engagement in behavioral health treatment as needed (substance use disorder, mental health) ◆ Increase in client satisfaction with care ◆ Integration of the Peer Linkage and Re-engagement of Women of Color Living with HIV intervention into the clinic

Appendices

Appendix B: Staffing Plan and Job Descriptions

Peer	<p>Peers are responsible for:</p> <ul style="list-style-type: none">◆ Conducting outreach to newly diagnosed clients and clients who have fallen out of care;◆ Providing assistance in making a linkage or re-engagement appointment for HIV primary care and case management services;◆ Providing appointment reminders for linkage or re-engagement appointments;◆ Assisting with transportation related to linkage or re-engagement appointments;◆ Accompanying clients to linkage or re-engagement appointments;◆ Providing coaching and emotional support including supporting clients in navigating the clinic (or healthcare) system and community resources; and◆ Documenting linkage and re-engagement activities on behalf of clients.
Administrative Peer Supervisor	<p>The administrative peer supervisor is responsible for:</p> <ul style="list-style-type: none">◆ Working with the data manager, peers, clinical team, and partner agencies to identify newly diagnosed clients;◆ Assigning and managing the peers' caseloads;◆ Providing guidance and support on a daily basis to the peers (programmatic and administrative);◆ Providing administrative supervision every other week;◆ Coordinating clinical supervision of the peers;◆ Facilitating and supporting open communication between the peers, clinical peer supervisor, case managers, and the clinical team; and◆ Coordinating and implementing fidelity monitoring of the peer intervention in collaboration with the data manager.
Clinical Peer Supervisor	<p>The clinical peer supervisor is responsible for:</p> <ul style="list-style-type: none">◆ Participating in case conferencing (as needed);◆ Conducting one-hour, clinical supervision meetings every other week and as requested with each peer.
Quality Improvement Specialist/Data Manager	<p>The quality improvement specialist/data manager is responsible for:</p> <ul style="list-style-type: none">◆ Generating lists to identify potential clients who are out of care;◆ Tracking client progress and outcomes and sharing with health care team members.

Appendices

Peer

Job Description

Description of the Peer:

The Peer Linkage and Re-Engagement intervention is designed to serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained WoC living with HIV known as “peers” will link and re-engage clients in HIV primary care. The intervention is designed to link and re-engage clients by attending two medical appointments and one case management appointment in a four-month period. Clients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of Position

Peers offer a unique personal perspective and can provide coaching and emotional support to clients who may need assistance in connecting to, and managing medical and case management appointments. In addition, peers who work closely with case managers and the clinical team can better provide individualized client-centered services over a short time period to address immediate client needs and build trust between the client and the clinic team.

Key Responsibilities

1. Conduct outreach to newly diagnosed clients and clients who have fallen out of care
2. Initiate contact with clients who have missed appointments
3. Provide assistance in making a linkage or re-engagement appointment for HIV primary care and case management services
4. When engaging and linking a client to an initial health care appointment, accurately communicate verbally and in writing, the following information: the date, time, location, provider name, information about what to bring to the appointment and any other facility-specific information needed to have a successful appointment
5. Educate client about the clinic flow and resources available in the community and the clinic
6. Provide appointment reminders for linkage or re-engagement appointments
7. Assist with transportation related to linkage or re-engagement appointments
8. Accompany clients to linkage or re-engagement appointments
9. Establish and maintain strong working relationships with clinic staff and the clinical team
10. Work in tandem with the case manager to reduce barriers to care, housing, food, transportation
11. Address health literacy needs of the clients to ensure client understanding of medical advice

Appendices

12. Provide coaching and emotional support
13. Document client activities including maintaining accurate data on forms and in electronic database systems
14. Work as part of the multi-disciplinary clinical team to provide tools and strategies using a client-centered approach to educate and support clients in taking their medications every day as prescribed and keeping clinical appointments
15. Work with supervisor to outreach and connect with partner agencies about the program for client services and also strengthen system for identifying women out of care
16. Refer clients back to health care providers to discuss any issues (i.e., side effects) that may be affecting their ability to adhere to a treatment regimen.

Qualifications/Requirements

- ◆ A person who is currently engaged in HIV care (may be a client from the clinic)
- ◆ Demonstrates a commitment to personal self-management of health conditions and treatment regimes
- ◆ Representative of the intervention client population (e.g. women of color living with HIV)
- ◆ Demonstrated ability to work collaboratively in a team environment
- ◆ Demonstrated computer literacy in Microsoft and web-based applications
- ◆ Excellent verbal and written communication skills
- ◆ Excellent interpersonal and organizational skills
- ◆ Ability to be hired as a full-time employee. If part-time, then person is willing to understand the risk for impact on benefits
- ◆ Able to provide the time commensurate with case load and responsibilities
- ◆ Shares their personal experience in a strategic, compassionate, and responsive manner and comfortably discloses status

Preferred Skills

- ◆ Experience working in a medical, clinical, or social services environment (including documenting client needs)
- ◆ Knowledge of community-based programs and providers
- ◆ Bilingual as needed to serve client population

Appendices

Administrative Peer Supervisor

Job Description

Description of the Peer:

The Peer Linkage and Re-Engagement intervention is designed to serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained WoC living with HIV known as “peers” will link and re-engage clients in HIV primary care. The intervention is designed to link and re-engage clients by attending two medical appointments and one case management appointment in a four-month period. Clients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of Position

The purpose of the Administrative Peer Supervisor is to coordinate and support the administrative components of the intervention.

Key Responsibilities

1. Supervise the creation of a monthly eligible client list, confer with clinical team to finalize monthly eligible client list
2. Ensure that up-to date data from the electronic medical record system are provided to peers
3. Assign eligible clients to peers
4. Recruit, train, supervise, coach, and evaluate intervention team staff
5. Provide administrative supervision to the peer
6. Coordinate clinical supervision of the peers
7. Facilitate and support open communication between the peers, clinical supervisor, case managers, and the clinical team
8. Assist data manager with the implementation and monitoring of the evaluation plan, ensuring timely data collection
9. Determine long-term strategic alliances with external partners and maintain program collaborative relationships
10. Facilitate intervention team meetings and case conferencing meetings

Qualifications/Requirements

- ◆ Bachelor’s degree required, Masters preferred.
- ◆ 10 years working with people with HIV/AIDS, clients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color
- ◆ Minimum of 5 years of experience supervising staff
- ◆ Minimum of 5 years of experience with budget, contract, and program management

Appendices

Clinical Peer Supervisor

Job Description

Description of the Peer:

The Peer Linkage and Re-Engagement intervention is designed to serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained WoC living with HIV known as “peers” will link and re-engage clients in HIV primary care. The intervention is designed to link and re-engage clients by attending two medical appointments and one case management appointment in a four-month period. Clients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of the Position

The purpose of the Clinical Peer Supervisor is to coordinate and provide clinical support to the intervention staff.

Key Responsibilities

1. Participate in weekly case conferencing
2. Conduct clinical supervision meetings for one hour every other week, and as requested with each peer

Qualifications/Requirements

- ◆ Licensed mental health clinician (e.g., licensed clinical social worker, psychologist, or psychiatrist)
- ◆ 2-4 years counseling or case management experience in assessing and managing the psychosocial needs of people with HIV
- ◆ Experience working with clients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color
- ◆ Knowledge of harm reduction philosophy, client centered counseling, and motivational interviewing techniques
- ◆ Excellent oral and written communication skills
- ◆ Excellent interpersonal skills. Able to build relationships with individuals, groups, and organizations

Appendices

Data Manager/Quality Improvement Specialist

Job Description

Description of the Peer:

The Peer Linkage and Re-Engagement intervention is designed to serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained WoC living with HIV known as “peers” will link and re-engage clients in HIV primary care. The intervention is designed to link and re-engage clients by attending two medical appointments and one case management appointment in a four-month period. Clients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of the Position

The Data Manager is responsible for the overall coordination of the data collection and management for the Peer Linkage and Re-Engagement intervention at the site level.

Key Responsibilities

1. Work with the administrative supervisor and clinical team to create monthly lists of potential eligible clients from internal clinic records/EMR
2. Ensure that all data collection and management activities are performed with the utmost attention to participant confidentiality, as well as HIPAA and any applicable IRB requirements
3. Track program outcomes and conduct quality assurance review

Qualifications/Requirements

- ◆ Knowledge of fundamental concepts of collecting and processing research data
- ◆ Ability to communicate clearly and concisely, both verbally and in writing
- ◆ Understanding of HIPAA and IRB requirements for health care research
- ◆ Ability to manage competing priorities; willing and able to work flexible hours
- ◆ Ability to work in a team as well as independently and to establish and maintain cooperative, supportive relationships with project staff
- ◆ Experience with MS Office software (e.g. Access, Excel) is strongly preferred
- ◆ Familiarity with basic computer programming and statistical software packages (SAS, Stata, SPSS) is preferred
- ◆ Bachelor’s degree required

Appendices

Appendix C: Care Plan

Date of Care Plan:		
Suggested Activity Goal	Goal	Obtained Goal
<ul style="list-style-type: none"> ◆ Housing ◆ Employment / employment goals ◆ Patient identified goals ◆ Mobile phone ◆ Education goals ◆ Insurance/ insurance goals ◆ Safety ◆ Food security ◆ Legal services ◆ Family goals (and any needs the children have) ◆ Transportation ◆ Taking medication ◆ Viral suppression 		
Notes about goals		

	Printed Name	Signature	Date
Client			
Peer			
PCP			

Appendices

Appendix D: Client Contact Form

Complete this form with the client at the time of introducing the intervention, when conducting informed consent in your office, or at the first scheduled visit. Update every four months, with any major changes affecting the logistics for peer encounters.

Note: Consider adding this to your organization's current contact form (for contact information, emergency contacts, etc.), as well as your HIPAA and confidentiality forms.

- 1. What days and times are best for you to meet with me in person?** Check as many days as client says they can meet, and fill in available times for each day checked.

Day(s) of Week:	Time(s) of Day:
<input type="checkbox"/> Monday	
<input type="checkbox"/> Tuesday	
<input type="checkbox"/> Wednesday	
<input type="checkbox"/> Thursday	
<input type="checkbox"/> Friday	
<input type="checkbox"/> Saturday	
<input type="checkbox"/> Sunday	
<input type="checkbox"/> Other answer (Specify:)	

Where would you most like to meet? Note to Peer: Read choices:

- At home
- At another person's home (specify the home and relationship _____)
- Client's PCP clinic within the care coordination program
- Other location (specify: _____)

- 2. For reasons of confidentiality, how would you like me to identify myself when calling you or visiting you?** For example, should I go by my first name, say I am a "friend," or say I work with you? Is it okay to leave a voicemail? Text? What is your preferred communication style?



For more resources from the Dissemination of Evidence-Informed Interventions Initiative visit: <https://targethiv.org/deii>

