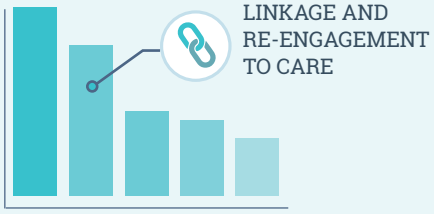
Peer Linkage and Re-Engagement of HIV-Positive Women of Color

DISSEMINATION OF EVIDENCE-INFORMED INTERVENTIONS

Intervention Summary

HIV Care Continuum



The Peer Linkage and Re-Engagement of HIV-Positive Women of Color intervention is designed to best serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained HIV-positive WoC known as "peers" will link and re-engage patients in HIV primary care. Patients will be considered linked or re-engaged once they have attended 2 medical appointments, attended 1 case management appointment, and have completed HIV lab work (all within a 4 month period). Peers offer a unique personal perspective and can provide coaching and emotional support to patients who may need assistance in managing medical and case management appointments. In addition, peers who work closely with case managers and the clinical team can better provide individualized patient-centered services over a short time period to address immediate patient needs and build trust between the patient and the clinic team.

This intervention is intended for organizations, agencies, and clinics considering a short-term, peer-focused model to increase linkage and re-engagement of HIV-positive Women of Color into HIV primary care to ultimately improve patient health outcomes.

Professional Literature

The involvement of peers has played a role in the Ryan White HIV/AIDS Program since its inception in 1990.[1] According to a HRSA consultation meeting assessing the use of peers in HIV care, "An array of peer education models have proven effective in helping people living with HIV/AIDS overcome barriers to accessing HIV care, and enabling them to build the skills, knowledge and self-confidence necessary to facilitate their retention in care. Everyone—patient, clinician, funder—benefits from the improved health outcomes and greater access to quality care."[2]

Peers are typically defined as HIV-infected, medication-adherent, usually virally suppressed role models who possess shared experience and shared community membership with their clients.[3] Peers' work has included case finding and community outreach; routine appointment reminders by phone or text; rescheduling medical appointments; accompaniment to appointments; transportation assistance; referrals and associated follow-up including follow-up after initial treatment initiation; treatment adherence; health education; and psychosocial support. Peers can help remove patient barriers and improve access to HIV primary care and support services because they have a unique understanding of these barriers, having often faced themselves.[4,5]

Integrating peers into the health care team is supported by research demonstrating that peers can motivate attitudinal and behavioral changes in PLWHA.[6] Using peers can also prove effective because the process relies on existing social networks, and hard-to-engage populations may be more likely to trust peers. This is done, in part, because an individual's belief in his or her own ability to change can be influence by witnessing health behaviors "modeled" in peers.[7]

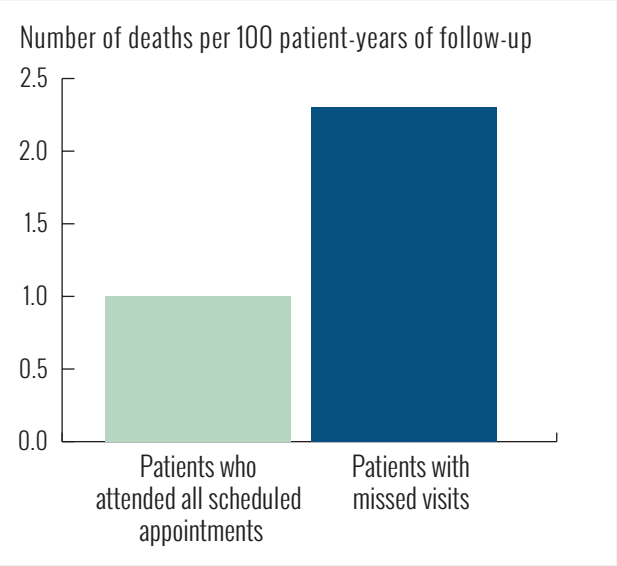
Underserved and marginalized populations, including many racial or ethnic minority communities, face numerous structural, financial, and cultural barriers to linking to, re-engaging in, and being retained in care.[8] Women of color, especially African American women, "currently represent the majority among women living with HIV/AIDS … and face numerous social and economic factors that both increase their vulnerability to HIV infection and decrease their access to care."[9] Subsequent negative outcomes are largely due to the inequitable distribution of power, money and resources.[10] In general, people of color experience worse access to health care and worse health outcomes than their white counterparts. In 2009, the rate of new HIV infections among black women was 15 times that of white women, and the rate of new infections among Latina women was over four times that of white women.[11] These disparities result in billions of dollars in additional medical care costs.[12]

In 2009, the rate of new HIV infections among black women was

15 times

that of white women.

Linkage and re-engagement in care leads to improved health outcomes[13] and retention in care is an independent predictor of survival.[14,15] Mortality rates have been shown to be 12 times higher for patients with missed visits, compared with mortality rates for patients who attended all scheduled appointments during the first year of care (2.3 vs. 1.0 deaths per 100 patient-years of follow-up).[16] Mugavero et al. found, "patients with missed visits in the year after establishing initial outpatient HIV care had more than twice the rate of subsequent mortality, compared with patients who did not miss visits, even when controlling for baseline CD4 count and antiretroviral receipt within the first year."[17] Giordano et al. found, "Patients out of care for as little as 3 months beginning in the first year of therapy had worse survival after adjusting for age, CD4 count, plasma HIV concentration, hepatitis C virus coinfection, and other comorbid conditions."[18]



Peers can contribute to moving patients along the HIV Care Continuum by ensuring a smooth transition into primary care; working closely with the primary care team to coordinate needed services; facilitating referrals to community and social services; promoting care management and autonomy by meeting with patients to discuss health care topics; and supporting patient engagement by providing emotional and practical support.[19] Peer interventions have the potential to improve patient self-efficacy, quality of life, HIV knowledge, ultimately leading to viral suppression.[20]

Theoretical Basis

A behavioral change theory is a combination of, "interrelated concepts, definitions, and propositions that present a systematic view of events or situations by specifying relations amount variables, in order to explain or predict the events or situations."[21] By grounding an intervention in theory, the component parts are intentionally sequenced to build off of one another to facilitate a change in health behavior.

The Peer Linkage and Re-Engagement of HIV-Positive Women of Color intervention is based on the conceptual framework presented in the 1993 Institute of Medicine (IOM) report *Access to Healthcare in America.*[22] The framework presented by the IOM includes four categories: barriers, uses of services, mediators, and outcomes. Barriers are categorized as being structural (availability, organization, transportation), financial (insurance coverage, reimbursement, public support), and personal (acceptability, cultural, language, attitudes, education/income). Uses of services included visits and procedures. Mediators included appropriateness, efficacy of treatment, quality of providers, and patient adherence. Outcomes included health status (mortality, morbidity, well-being, functioning) and equity of services.

The Peer Linkage and Re-engagement of HIV-Positive Women of Color intervention incorporates principles of the Social Cognitive Theory (SCT) to inform activities related to building relationships between peers and patients. Bandura initially referred to the theory as the Social Learning Theory, and made the connection between an individual's perceived self-efficacy and behavioral change.[23] The expanded SCT posits that an individual's knowledge can be directly related to their observation of an interaction with others.[24] An individuals' observation of behavior (and the consequences of the behavior) can be used to inform and guide future behaviors. The Peer Linkage and Re-engagement of HIV-Positive Women of Color intervention uses peer modeling of health behavior to patients to encourage linkage and re-engagement in care. Additionally, peers will work with patients to build their self-efficacy regarding scheduling and attending appointments.

Intervention Components and Activities

In the Peer Linkage and Re-engagement intervention, HIV-positive peers:

- Link WoC who have recently been diagnosed with HIV to HIV primary care; and
- Re-engage HIV-positive WoC who have fallen out of care (have not attended an HIV primary medical appointment in the last 6 months) back into HIV primary care.

This is a short-term intervention (up to 4 months). The peers will work with patients (both recently diagnosed and those who have fallen out of care) to achieve the following milestones in 4 months: attendance to 2 medical care visits with a prescribing provider, completion of 1 lab visit, and completion of 1 visit with a case manager.

Intervention components and peer activities that occur at the individual patient level include:

- Conducting outreach to newly diagnosed patients and patients who have fallen out of care
- Assisting 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;
- Providing assistance with transportation related to linkage or re-engagement appointments;
- Accompanying patients to linkage or re-engagement appointments; and
- Providing coaching and trauma-informed emotional support to patients including supporting patients in navigating the clinic (or healthcare) system and community resources.

Intervention components and activities that occur at the systems level include:

- Creation of a monthly "out-of-care" list using both electronic systems and clinic team members to identify patients who have not attended an appointment in the past 6 or more months;
- Collaborate with HIV testing staff (either internal to the agency or external partners) to create a list of newly diagnosed patients;
- Peer outreach to clients;
- Access for peers to read and document activities in the electronic medical record;
- Accept referrals from electronic systems and staff and make referrals based on client need;
- Incorporate peers into the clinical team to facilitate regular communication between clinicians and peers to best meet patient needs; and
- Facilitate weekly administrative and monthly clinical supervision session.

Staffing Requirements

The following staff positions need to be developed and filled in order to successfully implement the intervention and contribute to the multi-site evaluation.

STAFF TITLE	DESCRIPTION
Linkage staff	
PEER	Peers are responsible for: - Conducting outreach to newly diagnosed patients and patients 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 patients to linkage or re-engagement appointments; - Providing coaching and emotional support including supporting patients in navigating the clinic (or healthcare) system and community resources; - Documenting linkage and re-engagement activities on behalf of patients.

ADMINISTRATIVE PEER SUPERVISOR 	The Administrative Peer Supervisor is responsible for: ▸ Working with peers, clinical team and partner agencies to identify newly diagnosed patients; ▸ Assigning and managing the peers' caseloads; ▸ Providing guidance and support on a daily basis to the peers (programmatic and administrative); ▸ Providing weekly administrative supervision; ▸ Coordinating clinical supervision of the peers; ▸ Facilitating and supporting open communication between the clinical peer supervisor, peers, 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 	The Clinical Peer Supervisor is responsible for: ▸ Participating in case conferencing (as needed); ▸ Conducting 1 hour, monthly individual clinical supervision with each navigator; and ▸ Conducting 1 hour, monthly group clinical supervision with the intervention team.
DATA MANAGER 	The Data Manager is responsible for: ▸ Creating monthly out-of-care lists to identify eligible patients (may need to work with other staff to create list); ▸ Consenting patients into the study; ▸ Collecting and submitting data required for multi-site evaluation; ▸ Coordinating the collection of patient surveys, encounter forms, basic chart data abstraction, and implementation measures, and reporting them to the Dissemination and Evaluation Center (DEC); and ▸ Providing quality assurance reports and updates to intervention team about study referrals, enrollment retention, etc.
Staff Characteristics	
	There are additional clinic staff who are important to the success of the intervention. These positions may not be considered "intervention staff", yet their training, support, and engagement is essential. All staff need to demonstrate: ▸ culturally sensitive services to reduce stigma; ▸ ability to provide trauma-informed care; ▸ commitment to support the aims and activities of the intervention; ▸ a team-based, inter-professional approach; ▸ genuine desire to work with hard-to-engage populations (which includes meeting patient priorities first, be able to engender patient trust, and be welcoming and accessible); and ▸ thorough and documented communication under HIPAA requirements.

Programmatic Requirements

The following are programmatic requirements that need to be addressed prior to implementation in order to facilitate a successful intervention:

- Establish an internal champion for the peer program;
- Assess the ability to recruit and hire peers as agency staff;
- Define peers' roles and responsibilities, including development of job descriptions for peers and clarity around how they engage with case managers and other care staff (e.g. establish a standardized title, position, protocol, and procedure for peers and train peers as well as supervise and monitor peer-led activities);
- Identify who will provide clinical and administrative supervision of peers (sites need to consider the implications of managing peers who are also clinic patients);
- Training supervisors of peers;
- Establish administrative, programmatic, and clinical support for intervention-related training of peers;
- Establish or strengthen working relationships with community partners to develop newly diagnosed patient lists and to provide community-based referrals; and
- Provide hired and trained peers access to patient/patient information to both record their activities and review record for pertinent information prior to meetings with patients.

The following are programmatic requirements that need to be addressed during implementation to support a successful intervention:

- Provision of weekly administrative and clinical supervision of peers;
- Peer access to read and document their work with patients in the EMR system;
- Support for open lines of communication between peers, case managers, and clinical staff;
- Implement policies that address safety and boundary issues between peers and patients; and
- Inclusion of peers in team case conferencing meetings in order to:
  - Validate and support the role of the peer in the clinical team;
  - Provide an opportunity for peers and clinicians to exchange information about patients, building a working relationships between the peers and the clinical team; and
  - Provide an opportunity for peers to share pertinent client issues (shared exclusively with the peers) with clinicians to best meet the needs of the client.

Costs

There is no published information about the cost of peer interventions in linking PLWHA into HIV primary medical care. A recent study examined five navigation-like interventions which used a variety of community level approaches including peer/patient navigation estimated the cost to range from $97 to $536 per month per patient from a provider perspective and $44 to $545 per month per patient from a societal perspective.[25]

Unpublished results of the SMAIF Peer Re-Engagement study, found the cost per patient retained in care per month was $289. The intervention included 8 structured educational session and weekly check in for re-engaging and retaining newly diagnosed patients and patients who had fallen out of care in the prior 4 months.

Resources

OVERVIEW OF PRIOR SPNS INITIATIVES

- The Peer Re-Engagement Project (PREP): www.hdwg.org/prep.

IMPLEMENTATION/REPLICATION MATERIALS

- Peer Re-Engagement Project: Peer Program Resources and Training Curricula: www.hdwg.org/prep/curricula.
- The curricula includes:
  - Peer Re-engagement Project Enhanced Peer Intervention Manual (in English & Spanish)
  - Peer Core Competency Training Curriculum (English & Spanish)
  - PREParing Peers for Success Peer Supervision Curriculum in English & Spanish)
- Building Blocks for Peer Program Success: http://peer.hdwg.org/program_dev
- Best Practices for Integrating Peer Navigators into HIV Models of Care: www.aidsunited.org/data/files/Site_18/PeerNav_v8.pdf.

HRSA PUBLICATIONS ON PEER LINKAGE AND RE-ENGAGEMENT

- HRSA, HAB. *The Utilization and Role of Peers in HIV Interdisciplinary Teams. Consultation Meeting Proceedings:* http://hab.hrsa.gov/newspublications/peersmeetingsummary.pdf.
- The Power of Peers on Engagement and Retention in Care Among People of Color. *What's Going on @ SPNS:* www.hab.hrsa.gov/abouthab/special/cyperspnsoctober2013.pdf.
- Peers Can Play a Vital Role in Prevention With Positives. *What's Going on @ SPNS:* www.hab.hrsa.gov/abouthab/files/cyberspns_peers.pdf.
- *Use of Peers in Special Projects of National Significance Initiatives, 1993–2009:* www.hab.hrsa.gov/abouthab/files/spns_useofpeersreport.pdf.

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