

# Integrating Peers into Multidisciplinary Teams:

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## A Toolkit for Peer Advocates

### Supervisor's Guide



# Acknowledgements

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Each person and agency mentioned on this page is deeply committed to bettering the lives of other people. It is my sincere hope that "Integrating Peers into Multi-Disciplinary Teams: A Toolkit For Peer Advocates" assists people as they work towards this goal of improving lives.

Sincerely,  
Cornell Wrisby, MSW  
Project Director and Director of Community Education Projects  
Cicatelli Associates, Inc.

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# PART I: Supervisor's Guide

# Introduction to the Supervisor's Toolkit

Using a peer advocate in a multidisciplinary team can benefit both the agency and the clients. However, key to a peer advocate being successful is effective supervision. Supervisors need to let peer advocates know what is expected of them, and then provide training so peer advocates can develop the skills and knowledge to help them in their jobs. However, the training and clear expectations are only the beginning. Supervisors need to continue to guide the peer advocate in their work. Another essential task of supervisors is to develop and/or know the policies in their agencies that guide the Peer Advocate program, and the work of the peer advocates.

This Supervisor's Toolkit is divided into two parts: PART I: The Supervisor's Guide, and PART II, the Peer Advocate's Toolkit.

This Supervisor's Guide is intended to provide supervisors with sample policies, and materials to help the supervisor in overseeing the Peer Advocate program. PART II is a copy of the Peer Advocate's Toolkit. The supervisor can go through this toolkit with the Peer Advocate, and can coach the Peer Advocate in the use of the tools which are included. It is our hope that this toolkit will foster the learning that occurred at the four-day training entitled "Peer Advocates as Essential Members of Multi-Disciplinary Healthcare Teams".

# Section I: Policies and Procedures

Policies and procedures are essential to a successful Peer Advocate program. Policies tell you what to do. Procedures tell you very specifically how to do something.

- Policies are a high level overall plan embracing the general goals and acceptable procedures of a governing body.
- Policies protect clients, staff, providers and the agency.
- Policies provide information on what is expected, and on what providers can and cannot do.
- Policies guide the manager in managing the program.
- Procedures are the small steps that describe very specifically how you will carry out the policy.

Supervisors and managers need to develop and/or be familiar with the policies and procedures guiding the Peer Advocate program.

Sample Policies:

**Refer to:**

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## **The UAB Family Clinic Advocacy Service Procedural Guidelines**

The following outline is an established series of steps for the delivery of advocacy services and other support services rendered by the Patient Advocate(s).

### **INITIAL DIAGNOSIS**

- Upon receipt of HIV/AIDS diagnosis, Patient Advocate(s) or the PA may be utilized to provide peer counseling, comprehensible HIV education and emotional support. The PA will also assist patient with disclosure of status to partner.
- Upon a pediatric patient receiving an HIV/AIDS diagnosis, the PA may be utilized to provide peer counseling, comprehensible HIV education and emotional support to the caregiver and the pediatric patient. PA will assist team and family with the implementation of the Health Care Skills Checklist. **Note: *The Patient Advocate reserves the right to disclose serostatus to patient or family members as deemed necessary.***

### **PATIENT EDUCATION**

The PA provides current HIV educational information during individual client advocacy session during the clinic visit. Listed below are the topics of discussion and some of the most widely used resources distributed in the patient education packet.

- Transmission
- Disease progression
- Secondary prevention
- Sexual health
- Treatment adherence
- Abstinence education
- POZ
- HIV Plus
- A & U
- How HIV Works in Your Body
- Questions & Answers Living Healthy with HIV
- HIV Positive

**DOCUMENTATION**

- The PA enters data related to the advocacy portion of a patient and their relations into CAREWare within 48 hours of the encounter. (*Please refer to CAREWare Guidelines for Advocacy Services- pp. 47-48*)
- The PA maintains an Advocacy Service Note within the patient's chart after each clinic visit. The note is transcribed normally within 48 hours of the encounter and placed in the patient's chart under the Advocacy tab.

**MULTI-DISCIPLINARY TEAM COMMUNICATION**

- During pre-clinic meetings the PA provides insight to the team regarding the most effective ways to engage patients as participants in their care and to address barriers to treatment and or appointment adherence.
- Case conferencing (Montgomery site) is reserved for patients with multiple disparities that affect their quality of life and their ability to access medical care. The PA is utilized to provide insight to the team regarding the most effective ways to address the disparities.
- Team members communicate by email, phone or face-to-face impromptu meetings to share information relevant to the patient's care and well-being.

**CONSUMER INVOLVEMENT**

- The PA recruits for the Consumer Advisory Board (CAB) meetings, support groups other consumer activities during clinic visits and by mass mailings to patients that are able to receive mail.
- CAB meetings are scheduled on high volume clinic days for convenience.
- The PA provides program updates that are relevant to the consumer that receives services at The Family Clinic.
- Feedback or suggestions pertaining to patient satisfaction or grievance is received by administering surveys, CAB meetings, support groups or clinic visits. The PA serves as a liaison between the consumers and the program.



**The North Georgia Health District**  
**The Living Bridge Center**  
**Peer Advocate Orientation**

Welcome and Thank You!

We are glad you are interested in volunteering with The Living Bridge Peer Advocacy Program. Our funding sources encourage consumer involvement in our clinic and programmatic services. Your contributions as a peer advocate will provide our staff, clinic and program with another perspective of patient needs and how to effectively address them.

A Peer Support Assessment was a part of our 2004 comprehensive consumer needs assessment. Here is what we discovered about our clinic consumers:

*Most of the clients that responded to the survey from the Living Bridge Center, the Ryan White clinic for the North Georgia Health District, thought they would like to help other people with HIV. It was equally split as to which setting consumers preferred most, one-on-one or a group setting. The consumers of the Living Bridge Center would likely attend meetings on educational and informational topics on HIV. They would also be very likely to attend meetings for support and friendship. Most of the consumers said they would like to receive some education from other HIV positive people.*

We want you to know how important your volunteer contribution is and how much we appreciate your time, energy and dedication. Please remember that our staff is here and ready to help make your volunteer experience a good one.

As a volunteer of The Living Bridge Center Peer Advocacy program, you are a representative of our clinic and organization. Please take pride in your affiliation with us and thanks again for your support!

In January, 2005 a group of dedicated peer leaders met and developed a mission statement that depicts why they exist. Peer Advocacy and Support align with this mission and is one of the many steps this group will take to improve Ryan White services in the North Georgia Health District.

**Consumer Advisory Council's Mission:**

**The North Georgia Health District Living Bridge Center Consumer Advisory Council is a group of compassionate consumer leaders willing to educate, support, respect, and communicate with each other, our peers, and our community allowing dignity, promoting knowledge, and maintaining hope.**

**PEER ADVOCATE**

*Reports in the clinic to the RN Case Manager and programmatically to the District HIV Director.*

**Responsibilities:** As a peer advocate the service you provide is telephone, walk-in, and scheduled peer counseling and orientation for HIV+ individuals who are consumers of TLBC clinic and services. Peer advocates do not have to be HIV+ nor disclose their HIV status to patients with whom they interact and support. Peer advocates should have a positive living approach to their healthcare and their lives. You will provide clinic and program information, emotional support, help to locate treatment information, find community resources, referral sources and keep accurate documentation of peer counseling contacts. Peer Advocates need to have good listening skills, be willing to learn about HIV/AIDS and want to help people.

**PEER ADVOCATE RIGHTS**

- The right to confidentiality and privacy regarding your association with this agency.
- The right to a safe and comfortable working environment.
- The right to say no to work that can be dangerous to your health and well being.
- The right to have a positive volunteer experience.
- The right to adequate training, support, and supervision.
- The right to suggestion and grievance procedures.
- The right to be heard and have appropriate input.
- The right to be treated with respect and dignity by all patients, volunteers, and staff.
- Share your HIV status as you determine in your and your consumer's best interest.

## **VOLUNTEER RESPONSIBILITIES**

- To maintain confidentiality/privacy of all patients, volunteers, and staff.
- To convey a professional attitude when representing the North Georgia Health District and The Living Bridge Center.
- To actively participate in training and in-service updates.
- To know and accept time requirements of assigned duties.
- To submit volunteer time and service records in accordance with agency guidelines.
- To set reasonable limits about the type and amount of work you are willing to do.
- To follow the suggestion and grievance procedures of The Living Bridge Center.
- To perceive and respect other volunteers and staff as allies in a common cause.
- To assist and support the clinic and program in fulfilling its mission of being a bridge to patient-centered care, knowledge, and empowerment.

## **HOURS**

The clinic is open Tuesday and Thursday, 8:00 AM – 7:00 PM; Monday and Wednesday, 8:00 AM – 5:00 PM; and Friday, 8:00 AM – 2:00 PM. Regular peer advocacy appointments will be scheduled based upon clinic and patient need and peer advocate availability.

## **BASIC NEEDS**

- Restrooms are clearly marked within the Medical Access Clinic front corridor.
- Snack machines are located on the first floor—take elevator down to first floor, turn left and proceed to snack machines.
- Smoking is allowed outside the building (use exit just past snack machines on first floor).
- Employee parking should be used--- second floor entrance parking—back parking places near the 911 Center.
- You're welcome to use phones, but ask first.

**APPEARANCE**

We ask that you have a neat and clean appearance. Depending on the event or activity, we ask staff and volunteers to dress accordingly. If you have any questions ask a staff person. Please wear your name tag at all times to identify yourself.

**CONFIDENTIALITY**

Confidentiality is not revealing any identifying information such as names, health status, address, employer, description, or any information that cause harm or harassment of a person in some way. It very important to respect the right to privacy and confidentiality of everyone associated with TLBC and NGHD including patients, volunteers, and staff. If you have questions or doubt about confidentiality, ask the peer supervisor or any staff member.

**ABSENCES AND TIMES**

Be on time, we depend on you!! If you are going to be late or if you can't come for scheduled appointments, please call us and let us know as soon as possible.

**PERSONAL CONTACTS**

People coming to TLBC for services can be in a vulnerable position. It is important to focus on the needs of the individual asking for services and direct them to the appropriate staff or service they need. We ask that you do not give out your personal information to a visitor for any reason, this is for your protection as well as for the protection of the clinic. If you have any questions or are unsure, ask a staff person. It is inappropriate for peer advocates to develop social relationships (dating, etc.) with patients you serve through peer counseling.

**TRAINING**

Training and meeting requirements are necessary. Training includes orientation, on-going training, and peer support and counseling sessions.

**TALKING TO THE MEDIA**

Direct all media inquiries to the Director who will direct them to the District Media Specialist.

**DO NOT GIVE LEGAL, MEDICAL, OR RELIGIOUS ADVICE**

It is illegal to give medical or legal advice without a professional license. There are no legal standards about giving religious advice but is against TLBC and NGHD policy to do so. Refer the individual to a professional. Do not get involved arguing facts or policy with patients or staff. Never suggest specific drugs,

procedures, alternative therapies, or home remedies. This falls into the realm of practicing without appropriate licensure. We do have medical providers in the clinic and network of providers through written agreements that clinic staff will refer patients for their healthcare and preventive services. What we want to do is provide every patient with as many options as we know are possible, so they can make their own decisions about what is best for them.

### **THE FOLLOWING ACTIONS CAN BE CAUSE FOR DISMISSAL**

- Breach of confidentiality
- Falsifying records of any kind
- Inappropriate behavior (sexual or otherwise), comments or contact towards patients, staff or other volunteers.
- Soliciting or accepting gifts for patients, staff, or volunteers.
- Misuse of funds.
- Excessive, unnecessary, or unauthorized use of clinic property and supplies for personal use or for other organizations without staff consent.
- Using alcoholic beverages or illegal substances while engaged in clinic business in and outside the clinic setting.
- Fighting or using obscene, abusive, or threatening language or gestures.
- Theft of property from staff, patients, or volunteers while on clinic business.
- Disregarding safety or security regulations.
- Insubordination or not following the directions of the staff in charge.
- The distribution of information as verbal gossip or in writing that is false, inappropriate or harmful in any way to the patients, volunteers, or staff of TLBC.

### **MEANS FOR DISMISSAL**

Peer Advocates may be disciplined, suspended, or terminated if they are unable to uphold the guidelines as stated above. TLBC and NGHD reserve the right to terminate any peer advocate for inappropriate conduct. TLBC also reserves the right to prosecute any individual and seek compensation if necessary.

**St. Luke's Roosevelt Hospital Center****Center for Comprehensive Care****Peer Program****Policies and Procedures****MISSION:**

The Peer Program is designed to make the CCC a truly comprehensive, patient-centered organization with peers providing support to other patients through listening, sharing in the experience of living with HIV, and providing information. The volunteer peer program is consistent with CCC's mission, which is to provide highest quality services in partnership with those we serve. Peers provide hope and support in coping with a chronic condition, and contribute to the quality of life of people living with HIV.

**PROGRAM GOALS**

- To provide encouragement and comfort to other CCC patients through inpatient friendly visits, new patient orientation, co-facilitation of patient education groups, and outpatient waiting room support.
- Through the bonds that peers form with patients and each other, patients will become more educated, inspired and able to take care of themselves thereby promoting a more healthful life.
- To grow individually through peer work.

**DEFINITION OF A PEER**

- A CCC Peer is a person, at least 18 years of age, who is HIV positive and a patient of the CCC. Peers' particular role derives from this situation. Because of peers' shared experience with other HIV positive patients, they can listen with particular understanding and be supportive in a unique way. When appropriate, peers can share their own experiences.
- CCC Peers are volunteers of St. Luke's Roosevelt Hospital.
- Peers are not advocates, although they help patients to problem solve. Their role is to listen and provide support through their shared understanding of living with HIV.
  1. A peer is not a counselor or therapist. It is the role of professionals to diagnose and treat people's individual issues.

2. A peer offers a unique service, but does not work alone.
3. Peers are CCC patients first and Peers second. Any conflict of roles should be resolved in that context.

## **ELIGIBILITY**

In order to begin Peer work at the CCC, Peers must:

- Both a) be recommended to the program by a CCC staff member, and b) express interest to the facilitators of the program and go through an introductory interview.
- Complete at least 8 weeks of core training and participate in additional booster trainings as offered.
- Commit at least 5 hours per week of their time to the program, including volunteer work, supervision and additional support processes, unless otherwise approved by the facilitator.
- Be alcohol and drug free while working as a peer.
- Go through the St. Luke's Roosevelt Hospital Volunteer Department to be approved as a hospital volunteer.
- Review and agree to the Peer Position Description, Policies and Procedures and schedule.

## **DRESS CODE**

- Peers must report to work clean and free of strong odors. Some people are allergic to perfumes, so it is important to only wear deodorant and to not use perfume, cologne, or scented lotions.
- In order to maintain a professional appearance and reduce the spread of germs, peers must follow this modified dress code:
  1. Long pants (no shorts)
  2. Closed toed shoes
  3. Minimal jewelry; no long dangling jewelry
  4. No sleeveless shirts
  5. No white sneakers. Dark sneakers are acceptable

## **CONFIDENTIALITY**

- All information about patients should be kept private.
- Issues that patients raise that you feel should be shared must first be brought to the attention of the Peer Supervisor.
- You may share information about patients with your Peer Supervisor or therapist if for the purpose of getting questions answered or working through your feelings or concerns.

- You may share your own experience about peer work with CCC providers; however, you may not provide names or other identifying information about patients, unless it is appropriate (see “limits to confidentiality”)
- You may not share information about others that you learn through your peer work with your family, friends and acquaintances.
- There are limits to confidentiality. If information you learn from patients meets the following criteria, you must inform a Peer Supervisor.
  1. Patient poses danger to him or herself (such as plan to commit suicide).
  2. Patient poses danger to others (such as plan to abuse or kill another person).
  3. Patient has committed a serious criminal offense that has not been brought to the attention of authorities.
  4. Patient is committing child, spouse or elder abuse.

## **BEHAVIOR AND CONDUCT**

- Peers must work within their role and not attempt to answer questions, provide advice or give information that is beyond their knowledge or authority to give. For example, peers may not answer medical questions, but instead should refer patients to a doctor or hospital staff member who may help get the information requested.
- Peers are expected to respect hospital and clinic facilities, personnel, patients and visitors at all times.
- Peers are subject to the same behavioral guidelines as all CCC patients, which are outlined below.
- Any peer may be dismissed or removed from the program for disrespectful conduct, which includes:
  1. Name calling, foul and degrading language
  2. Shouting, yelling, screaming and cursing
  3. Excessive interrupting or continuous disruption of group process
  4. Lack of understanding /or lack of intent to understand
  5. Theft or destruction of property
  6. Violence or threat of violence
  7. Possession of weapon on hospital premises
- If you are dismissed from peer program, it will not jeopardize your care at the CCC in any way.
- Additional guidelines for peers are that they demonstrate appropriate behavioral boundaries. Examples of behavioral boundaries which must be followed:
  1. Treat every person with respect. Do not use language that is hurtful or negative about an individual. Do not roll your eyes, give the finger or use other body language that communicates disrespect.
  2. Refrain from being part of malicious gossip or activities.



3. Respect decisions of staff.
  4. Show proper care and respect for the clinic property and the property of others. Do not steal or vandalize.
  5. Make a reasonable effort to clean up after yourself when in group situations where materials are handed out or food is provided.
  6. Be aware of personal limitations and seek consultation when needing help. For example, if you are feeling overwhelmed, sad or angry, step away from the peer work and consult with your supervisor or therapist. If you don't know the answer to a question, ask someone or refer the person asking to someone who may know.
- Peers may not exchange money, food, gifts or any other material items with patients.
    1. Do not give or buy patients food, under any circumstances. If a patient complains to you of hunger, inform a clinic or hospital staff person who may be able to help.
    2. Do not accept money from patients or lend money to patients, under any circumstances.
    3. Do not give or recommend drugs of any kind, whether legal or illegal. This includes vitamins, herbs or any other homeopathic treatments. You do not know patients' particular health conditions, and violating this policy may cause significant harm to the patient.
  - Peers are expected to show up for their scheduled hours at least 10 minutes early.
    1. Peers must first report to St. Luke's, Stuyvesant 7 and sign in if working at the Morningside Clinic or St. Luke's inpatient unit. Peers must report to Roosevelt, 1<sup>st</sup> floor HIV Administrative offices to sign in if working at Samuels Clinic or Roosevelt Hospital.
    2. When the scheduled work time is over, peers must return to sign out and collect a metro card for travel reimbursement.

## **VIOLATION OF A CONDUCT CODE**

- If the Conduct Code is violated, disciplinary action will include the following:
  1. First Offense: Sign a behavioral contract with the Peer Supervisor.
  2. Second Offense: Be placed on a probationary period of three months.
  3. Third Offense: Termination from the program.
- Removal from the Peer program:
  1. Any peer may be dismissed from the program for not performing his or her role in accordance with the Peer Position Description, after discussion and guidance in group supervision and at least

- one individual supervision session with a Peer Supervisor.
2. Peers who violate the policies and procedures of the CCC will face disciplinary action and possible dismissal.
  3. Any peer who is dismissed as a patient of the CCC for behavioral misconduct will also be dismissed from the peer program.
  4. Any action, which involves weapons, violence or physical menacing, will be grounds for immediate termination.
  5. Any action that causes harm to yourself or another person will be grounds for immediate termination.

### **GUIDELINES FOR INPATIENT “FRIENDLY” VISITS**

- Peers must follow the schedule outlined by the Peer Supervisors to avoid confusion on the inpatient unit.
- Peer must complete a “log sheet” (sign in) with the inpatient social worker. This includes keeping track of the names of each patient visited that day and writing it on the log sheet.
- Peers should not spend more than 3 hours on the inpatient unit in one day, and no more than 35 minutes with one person on the day of the visit.
- Peer must meet with their co-counselor after peer work each day for 30 minutes, on the day that they do inpatient peer work.
- Peers should discuss their feelings and energy levels with their supervisors to determine if and when a short break (~1-3 months) may be needed to avoid “burn out”.
- Peer work takes place during inpatient visiting hours, and while patient is on unit. Once a patient is discharged, peer work is over, unless there is a clear, mutual peer/patient agreement to continue supportive listening on the outpatient side.
- The CCC inpatient social worker will know when the friendly visits will be, and he or she will inform the nurse manager. The social worker will also inform patients of peer visits. A peer may approach only patients that agree to be visited by a peer.
- Peers may not visit inpatients in respiratory isolation as it poses health risks for both peers and patients.
- On the inpatient unit, please be careful about using the words HIV/AIDS to patients or when referring to patients. At St. Luke’s, not all patients on the unit are HIV-positive. You must protect patients’ confidentiality with other non-infected patients on the unit.
- Peers should ask questions to the CCC social worker on the unit during working hours. If general questions arise and social worker cannot be found, peers should ask the Nurse Manager. In emergency situations, peers

may page a CCC social work director, Alan Rice (Roosevelt) or Jenny Mayer (St. Luke's).

- Peer must complete a brief evaluation after each inpatient rotation. Evaluations must be turned in to the Peer Supervisor or Assistant.

## **SUPERVISION**

- Peers will have group supervision once a week for one hour with Peer Supervisors, Christine Nollen and Kathy Boudin.
- Peers are encouraged to journal about their experiences on a weekly basis and bring journals to group supervision. Peers are not required to write their experiences and feelings in journals, but they must come to group supervision ready to share what happened in their peer work over the past week.
- Peer will be supervised by CCC social workers on the inpatient unit, and may get emergency assistance from Jenny Mayer, Co-Director of Social Work (Morningside Clinic, St. Luke's) and Alan Rice, Co-Director of Social Work (Samuels Clinic, Roosevelt Hospital).

## **SUPPORT**

- Peers will be co-counselors to their fellow peers. Peers will be paired up to do work and will serve as one another's co-counselor. The purpose of co-counseling is that you become a listener for the other person. The other person just talks without being interrupted until he or she is ready for co-counselor feedback. After the person has talked for uninterrupted time, they can ask for their co-counselor's impressions. Each person should get 15 minutes to be the focus of attention.
- Co-counseling sessions should last for up to 30 minutes, and immediately follow peer work.
- Peers are encouraged to have weekly, individual mental health support/therapy.
- If a peer is exhibiting behavioral issues, Peer Supervisors may encourage peers to seek a mental health provider.

## **North Georgia Health District**

### **The Living Bridge Center**

#### **Peer Advocate Policies and Process**

##### **PURPOSE**

To assure that peer advocates are competently prepared and trained to provide quality peer counseling services that empower peer counselors, consumers, and support the clinical and supportive services.

##### **DEFINITION OF PEER ADVOCACY**

Peer Advocacy services are services provided by trained Peer Advocates that include the provision of psychosocial support and assistance in obtaining a range of services and resources that will meet the needs of the client. Peer counseling services provide opportunities for sharing of information and resources and clinic and programmatic orientation. Peer Advocates are to be viewed as a valued member of the clinic team and staff who bring a unique perspective to program, clinic, and patient services, needs, and issues. A Peer Advocate does not have to be HIV+ but should be personally affected and informed in regard to HIV-related education and issues. A Peer Advocate does not have to disclose their HIV status to consumers with whom they work. The goals of Peer Advocacy are:

- Promoting self-advocacy for persons living with HIV.
- Facilitating the development of social and emotional support networks for persons living with HIV.
- Empowering clinic consumers with clinic, program-specific, and HIV/AIDS knowledge.
- Providing clinic and program staff an expanded perspective from a peer advocate's viewpoint on issues relating to specific patient issues and needs, quality management, and clinic and program policies and procedures.

##### **FIVE MAJOR ACTIVITIES OF PEER ADVOCACY**

- Enhanced Outreach
- Navigation
- Patient Education
- Adherence Support
- Advocacy with Multidisciplinary Clinic Team

**PEER ADVOCACY IS NOT**

- Case management services
- Coordination or determination of services
- Provision, coordination, consultation, or follow-up for medical and clinical care and treatment.

**ADDITIONAL INFORMATION**

- All Peer Advocates will complete the following formal and informal training:
  1. Peer Supportive Counseling Techniques and Skills
  2. Orientation to New Patient Intake Forms and Process
  3. Peer Advocacy/Volunteer Confidentiality
  4. Peer Advocate Group Support Meetings
- Peer Advocates will provide clinic and program staff contact information.
- Peer Advocates will be available when scheduled to meet with patients.
- Peer Advocates will provide clinic orientation and overview of clinic and program policies and procedures.
  1. Introduction of staff and roles
  2. Clinic tour
  3. Overview of Ryan White CARE Act
  4. Patient Information Form
  5. Client Agreement Form
    - i. Right to Refuse Services
    - ii. Right to Grievances
    - iii. Involuntary Suspension of services
    - iv. Policy and Procedures for Non-Adherent Patients
  6. Federal Poverty Guidelines and Assignment of Federal Poverty Level and Income Verification Requirements
  7. GA Law Code 16-5-60
  8. Picture ID
  9. Authorization to Obtain and Release Information (ROI)
  10. ADAP Process
  11. Emergency Financial Assistance Policies
  12. Referrals
    - i. Referral Missed Appointment Policy
    - ii. Oral Preventive and Dental Treatment
    - iii. Vision
    - iv. Nutrition
    - v. Mental Health/Substance Abuse Assessment/Counseling
    - vi. Support Group
  13. Consumer Advisory Council Members and Roles

14. Assessment of individual patient education needs
  15. Review of findings with RN Case Manager
- Peer Advocates will meet with established patients to assist and support clinic staff in identifying patient specific needs and to offer peer advocacy and needed support.
  - Peer Advocates will participate in individual case conferences and grand rounds.
  - Crisis Management and Psychiatric Emergencies
    1. See Clinic Policy
    2. Discuss immediately with RN Case Manager

**The Ruth M. Rothstein CORE Center**

**Qualifications for Participation in the Peer Program**

<b>POLICY</b> TITLE: Qualifications for Participation in the Peer Program		<b>POLICY NUMBER:</b>
DATE OF ORIGIN: 7/02 REVIEWED & REVISED: 5/05	<input checked="" type="checkbox"/> CORE POLICY <input type="checkbox"/> AREA SPECIFIC POLICY	Page 1 of 1
<p><b>PURPOSE:</b> To establish clear qualifications that a consumer must meet in order to be considered for participation as a peer leader in the peer program.</p> <p><b>AREAS AFFECTED:</b> Any program utilizing peers in a formal capacity.</p> <p><b>POLICY:</b> In order to be considered to be a peer (i.e. peer educator, new patient orientation guide, PEP counselor), consumers must meet specified criteria demonstrating compliance with their treatment plans, motivation to improve their life, coping and job skills.</p> <ol style="list-style-type: none"> <li>All consumers <b>considering becoming peers</b> must have a documented history of receiving their primary care at the CORE Center for at least the 12 months preceding their application to the peer program.</li> <li>Consumers that have received <b>chemical dependency treatment at the CORE Center or other appropriate program must be able to document at least six months successful treatment (sobriety)</b>. Applicants who cannot meet this requirement will not be considered.</li> <li>All consumers interested in becoming a peer must complete an application and an interview by appropriate CORE Center staff.</li> <li>All applicants to the peer program <b>must submit three letters of recommendation</b> as applicable and appropriate with their application.           <ol style="list-style-type: none"> <li>All applicants must submit a letter of recommendation from their medical provider <b>initially, every six months for the first three years and then annually</b>.</li> <li>Applicants receiving mental health services the CORE Center must also submit a letter of recommendation from their mental health counselor with their application.</li> <li>Applicants with a history of <b>chemical dependency treatment within the last 3 years must also submit letters of recommendation from either the sponsor or their chemical dependency counselor</b>.</li> <li>Applicants receiving case management services the CORE Center must also submit a <b>letter of recommendation from their case manager with their application</b>.</li> <li><b>If not receiving mental health, chemical dependency treatment and/or case management, letters from a former employee, pastor, community-based organizations and/or family are also acceptable</b>.</li> </ol> <p>Applications lacking these documents are considered incomplete and will not be considered.</p> </li> <li>Applicants will be selected for available positions based on their application and the interview process.</li> </ol>		
<b>APPROVED:</b>		
SIGNATURE		TITLE
		DATE

## Section II: Job Description and Orientation

The Peer Advocate position needs to be clearly described in order to find peers for the position and to help the peer and the agency know what to expect of the Peer Advocate. The job description provides a brief overview of the position, clearly describes the major tasks and job responsibilities of the Peer Advocate, may include the expected qualifications of a Peer Advocate and may include a description of how job performance is assessed or evaluated.

### Refer to:

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Sample #8: Position Description: Peer Advocate/Outreach Specialist	27
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Once Peer Advocates have been hired for the program, they can be given an overview of your agency, and an orientation to the agency and their position.

### Refer to:

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Sample #12: Job Description	37



**St. Luke's Roosevelt Hospital Center**  
**Center for Comprehensive Care**  
**General Support Peer Position Description**

**Position Title:** General Support Peer  
**Tentative Start Date:** August 14, 2006  
**Department:** Center for Comprehensive Care  
**Facility:** St. Luke's Roosevelt Hospital Center  
**Reports To:** Kathy Boudin, Sally Ellwein, Christine Nollen  
**Stipend:** \$10/hr

**JOB SUMMARY**

General Support Peers provide friendly visits and support to CCC patients in the clinic waiting areas and on the inpatient units.

**TIME COMMITMENT**

A General Support Peer will work up to three hours at a time on particular tasks assigned by his or her supervisor. A Peer will perform his or her job function within a 7 hour work week which includes time with patients and individual and group supervision.

**SPECIFIC DUTIES**

- Answer basic questions and refer CCC patients to appropriate resources.
- Provide encouragement and support to CCC patients.
- Share your knowledge and experiences with CCC patients, when appropriate.
- Journal your experiences on a weekly basis, if comfortable.
- Co-counsel other peers, as assigned.
- Seek guidance from your supervisor, within the limits set forth by policies and procedures.
- Co-facilitate and help to plan for patient education groups.
- Provide accurate information to patients about services and resources available at the clinic.
- Keep proper documentation of patient encounters (peer contact forms).

- Distribute flyers, as requested by your supervisor, to inform patients about upcoming workshops, resources and services available.
- Distribute and collect educational materials and/or evaluation forms when assisting with a group.
- Identify when it is not appropriate to give advice.
- Seek guidance during group supervision when you are experiencing frustration, strong feelings or are unsure what to do.
- Be a good listener.
- Set appropriate limits and boundaries.

**KNOWLEDGE/SKILL**

- Demonstrate ability to work well with all levels of staff, patients and other health care professionals.
- Demonstrate ability to work with a diverse group of people regardless of their, creed, race, and sexuality.
- Demonstrate ability to work constructively and cooperatively with other members of the health care team.
- Demonstrate a professional, courteous and respectful attitude in dealing with patients, families and significant others.
- Demonstrate ability to follow the policies of the Peer Support Program and the CCC.
- Possess basic knowledge of all fire codes and know how to contact emergency help.

**PROFESSIONAL CONDUCT/OTHER**

- Report to Stuyvesant 7 or Samuels Clinic at least 10 minutes prior to your scheduled work time to sign in.
- Fill-out weekly time-sheet and give to supervisor.
- Sign out and receive metro card each time you complete your work for the day.
- Attend individual and group supervision as scheduled.
- Participate fully in all training activities.
- Plan for absences and late arrivals, and inform the Program Coordinator, Suzanne White-Beckles.
- Maintain a neat and clean appearance.
- Maintain confidentiality at all times.

**St. Luke's Roosevelt Hospital Center**  
**Center for Comprehensive Care**

**Treatment Adherence Supportive Peer Position Description**

**Position Title:** Treatment Adherence Supportive Peer  
**Tentative Start Date:** August 14, 2006  
**Department:** Center for Comprehensive Care  
**Facility:** St. Luke's Roosevelt Hospital Center  
**Reports To:** Sally Ellwein, Treatment Adherence Counselor  
**Stipend:** \$10/hr

The Treatment Adherence Program (TAP) provides treatment adherence counseling, education and support services to patients in highest need of treatment adherence support.

**JOB SUMMARY**

Treatment Adherence Supportive Peers work as a part of the treatment adherence program team to provide support to CCC patients enrolled in the treatment adherence program and to co-facilitate patient education groups with a treatment adherence counselor or health educator.

**Time Commitment**

A Treatment Adherence Supportive Peer will work 10 hours a week, during which time s/he will perform his or her job function and attend individual and group supervision.

**SPECIFIC DUTIES**

- Provide encouragement and support to CCC patients enrolled in the Treatment Adherence Program.
- Share your knowledge and experiences with CCC patients, when appropriate.
- Co-counsel other peers, as assigned.
- Participate in Treatment Adherence Team meetings.
- Seek guidance from your supervisor, within the limits set forth by policies and procedures.
- Co-facilitate and help to plan for patient education groups about treatment adherence.

- Provide accurate information to patients about services and resources available at the clinic.
- Distribute flyers to inform patients about upcoming workshops, resources and services available.
- Distribute and collect educational materials and/or evaluation forms when assisting with a group.
- Keep proper documentation of patient encounters (peer contact forms).
- Identify when it is not appropriate to give advice.
- Seek guidance during individual or group supervision when you are experiencing frustration, strong feelings or are unsure what to do.
- Be a good listener.
- Set appropriate limits and boundaries.

**KNOWLEDGE/SKILL**

- Possess HIV 101 knowledge and basic knowledge of HIV treatment.
- Demonstrate ability to work well with all levels of staff, patients and other health care professionals.
- Demonstrate ability to work with a diverse group of people regardless of their, creed, race, and sexuality.
- Demonstrate ability to work constructively and cooperatively with other members of the Treatment Adherence team.
- Demonstrate a professional, courteous and respectful attitude in dealing with patients, families and significant others.
- Demonstrate ability to follow the policies of the Peer Support Program, the Treatment Adherence Program and the CCC.
- Possess basic knowledge of all fire codes and know how to contact emergency help.

**PROFESSIONAL CONDUCT/OTHER**

- Report to clinic at least 10 minutes prior to your scheduled work time to sign in.
- Sign out and receive metro card each time you complete your work for the day.
- Fill-out weekly time-sheet and give to supervisor.
- Attend group supervision and individual supervision as scheduled.
- Participate fully in all training activities.
- Plan for absences and late arrivals, and inform your supervisor.
- Maintain a neat and clean appearance.
- Maintain confidentiality at all times.

**OSU Center for Health Sciences**  
**College of Osteopathic Medicine**  
**I.M. Specialty Services Clinic**  
**Position Description**  
**Peer Advocate/Outreach Specialist**

**POSITION SUMMARY**

The Peer Advocate functions as a member of the integrated, multidisciplinary health team. The Peer Advocate/Outreach Specialist will perform in a hybrid role, performing duties in the “In-Reach/Outreach” Peer Testing/Counseling Role inclusive of HIV testing/counseling in the clinic setting and in the community. The Position will also perform peer advocacy functions under the direction of the In\_Reach/Outreach Coordinator in the clinic setting as needed for optimum patient care.

**PRINCIPAL DUTIES AND RESPONSIBILITIES**

The following represents the majority of duties performed by this position, but are not meant to be inclusive nor prevent other appropriate duties from being assumed when necessary:

- Conducts pre-and post-test counseling sessions and performs HIV testing in the clinic setting, for patients’ partners, spouses and friends, as well as in the community.
- Offers risk reduction education and counseling to active patients of the clinic, and distributes safer sex supplies as indicated.
- Performs outreach and testing counseling activities in own particular social network in the community, in order to identify persons who are HIV-positive and unaware, and facilitate entry into care.
- Helps orient new patients to the clinic and the services available. Provides light client information and referral activities, and facilitates connections to care and services for persons testing positive.
- Performs testing record keeping and data entry as needed to fulfill the State’s counseling/testing documentation/tracking responsibilities.
- Assists the Data Entry Coordinator in entering C/T data into PEMS database.
- Assess patients’ risks and encourages new partners to be tested.

- Consults with Nurses, Physicians, Therapists, and other members of the healthcare team to coordinate care needs of patients presenting to the clinic.
- Assists in the coordination of day-to-day patient care activities to ensure continuity of care.
- Performs peer advocacy role as part of transportation assistance team, actively driving patients to and from clinic appointments (under the RAIN umbrella).
- Performs other duties commensurate with education and experience as assigned by the Clinical Director, and/or as requested by the Nurses, Physicians or In-Reach/Outreach Coordinator.
- Participates in all Staff meetings and CQI and program evaluation activities.

## **QUALIFICATIONS/SPECIFICATIONS**

**Education:** Must successfully complete OSDH C/T Certification program.

**Experience:** Must be HIV positive to fulfill peer advocacy roles and responsibilities. Must have HIV Counseling/Testing certification from OSDH. Experience using the OraQuick Rapid Test a plus. Previous work experience in C/T and HIV clinic work highly preferred. Must have good verbal and written communication skills; demonstrated sensitivity to populations most affected by HIV; demonstrated ability to work with community based organizations

**Licenses:** OSDH Testing Counselor certification.

**Internal and External Working Relationships:** Internal contact with other departments. External contact with other HIV providers and community-based programs and at-risk communities.

**Physical Effort:** Occasional physical effort is required to lift supplies or assist patients.

**Working Conditions:** Regular exposure to fast-paced work environment. Regular exposure to contaminated blood, and possibly communicable diseases.

## **The UAB Family Clinic**

### **Job Description for Patient Advocate**

#### **GENERAL SUMMARY**

This position provides input to the multidisciplinary team as it relates to the cultural diversity and socioeconomic background of the patients for the appropriateness and relevance of service delivery; works within a multidisciplinary team consisting of a physician and or nurse practitioner, nurse and a social worker to provide guidance, advice and assistance to patients in obtaining medical, social community, legal, financial and other needed services for the overall purpose of retention in medical care; educates patients living with HIV/AIDS and their families regarding HIV transmission, secondary prevention, risk reduction and treatment adherence to improve their health status; provides mentorship and leadership training to patients to promote empowerment and self-advocacy through support and counseling activities; ensures involvement of patients in the development, implementation and evaluation of the program; assists in the coordination of HIV education and testing outreach activities in the community.

#### **KEY RESPONSIBILITIES**

- Administer advocacy services to patients and the families at Birmingham clinic sites during weekly clinics.
- Provide psychosocial support services that address the ongoing social problems of HIV infected individuals, their partners, families and caregivers by conducting individual advocacy sessions during weekly clinics and support groups.
- Provide treatment adherence services to ensure readiness for and adherence to complex HIV/AIDS treatments.
- Provide HIV/AIDS educational material to patients and their families to help improve their knowledge and health status.
- Consult with other medical clinicians during pre-clinic meetings to provide insight into the most effective way to engage and educate patients as participants in their medical care and treatment.
- Document services in CAREWare database and patient charts within 48 hours of the provision of the service.
- Build partnerships internal and external to the organization to promote collaboration and cooperation in developing and providing HIV/AIDS prevention initiatives. These organizations include: Birmingham

AIDS Outreach, Montgomery AIDS Outreach, Alabama Department of Public Health, HIV/AIDS Division, Selma AIR, AIDS Alliance for Children, Youth and Families etc.

- Coordinate community outreach activities such as HIV/STD workshops, testing campaigns, support groups and educational trainings.
- Assist in the development and implementation of needs assessments.
- Co-chair the Montgomery Consumer Advisory Board; identify, train and mentor board member(s) to subsequently assume a leadership role as CAB Spokesperson.
- Participates in continuous quality management projects to improve overall service of The Family Clinic.
- Coordinate patient-related activities such as Lunch and Learn education sessions, CAB meetings, mental health group meetings, sexual health education sessions, etc.
- Carry out duties and responsibilities as outlined in the Title IV work plan.
- Participate in other duties and outreach projects as assigned by program management.
- Participate in program in-services and meetings designed to improve professional performance and enhance the quality of services to patients.
- Act in a professionally courteous manner toward all patients, family members, staff, and students.



**The North Georgia Health District  
The Living Bridge Center  
Peer Advocate Orientation Assessment Questions**

**Please remember to use available resources to document where you found your answers—this is not to assess your personal knowledge or opinions.**

1. I am HIV+ and have no income. What are my options based upon my health status?
2. I need housing. What are my options?
3. I am moving to Arkansas and need to know what resources are available to me. Where can I find a clinic, medical provider, and other AIDS service organizations?
4. I am uncomfortable going to my local pharmacy for my meds. Are there any HIV-friendly pharmacies I can go to? What is there address and phone numbers?
5. Where can I go for mental health/counseling for myself and my family?
6. I had unprotected sex last night with my HIV- partner. Should she get an HIV test and how long after a possible exposure will it take for the test to be accurate?
7. Through what body fluids is HIV transmitted?

8. What are a CD4 count and a viral load?
9. How can someone tell if they are resistant to HIV medications?
10. What is the CDC definition of AIDS?
11. Can I get assistance with paying my utility bills and whom can I contact for help?
12. I cannot afford to pay for my HIV meds. Is there anyone who can help and how can I contact them?
13. How and when do I apply for disability? Will I be eligible because I am HIV+?
14. What is Ryan White and how does it benefit me?
15. I am HIV+ and am unclear about the laws surrounding disclosure. Do I have to tell every sexual partner about my status?
16. What is the difference between a will and a living will? Who can help me create a will or a living will?
17. I think I was fired due to my HIV status. What are the laws surrounding discrimination of people with HIV?
18. Can you tell me five opportunistic infections that I could have due to having HIV?

19. What is the difference between SSI and Social Security Disability?
20. Who is eligible for Medicare Part D, how do I apply, and what does it cover?
21. I am thinking about going back to work. Are there advantages and disadvantages I should know about?
22. What is HAART? How long can a regimen last until I become resistant? What can I do to prevent resistance?
23. I am thinking of taking a holiday from my meds. What are some potential benefits and problems to taking medication holidays?
24. What are the dangers of having unprotected sex with another person who is HIV+?
25. Do I need protection during oral sex? What should I use?
26. What are some reasons that cause HIV to replicate rapidly in the body?
27. What are some of the dangers of having HIV and Hepatitis C and taking street drugs?
28. What are complications that can occur from mixing prescription drugs like Viagra and poppers?

29. What are some of the most important vitamins and supplements that I can use to support my immune function while on HIV medications?
30. How often should a women receive a Pap smear and why?
31. What opportunistic infections are most common in women?
32. I am HIV+ and pregnant. How can I best prevent my baby from being born with HIV?
33. What does the RN Case Manager do?
34. What does the Clinic RN do?
35. What does the Program Associate do?
36. What does the Clinic Clerk do?
37. What does the District HIV Prevention Coordinator do?
38. What does the District HIV Director do?
39. Why do you want to be a Peer Counselor?
40. What days/times would work best for you for appointments to see patients in the clinic?
41. What are your contact phone numbers/email address?

**The North Georgia Health District  
The Living Bridge Center  
Peer Counselor Initial Interview and Orientation**

Peer Counselor: \_\_\_\_\_ Date: \_\_\_\_\_

Staff: \_\_\_\_\_

**AREAS FOR ORIENTATION AND REVIEW**  
**Circle as completed and make needed comments.**

1. Introduction of staff and staff roles
2. Clinic Tour
3. Overview of Ryan White CARE Act
4. Patient Information Form
5. Client Agreement Form
  - a. Right to refuse services
  - b. Right to grievances
  - c. Involuntary suspension of services
  - d. Policy and procedure for non-adherent patients
6. Federal Poverty Guidelines, Assignment of Federal Poverty Level and Income Verification Requirements.
7. GA Law Code 16-5-60
8. Picture ID
9. Authorization to Obtain and Release Information (ROI)

10. ADAP Process
11. Emergency Financial Assistance Policies
12. Referrals
  - a. Referral Missed Appointments Policy
  - b. Oral Preventive and Dental Treatment
  - c. Vision
  - d. Nutrition
  - e. Mental Health/Substance Abuse Assessment/Counseling
  - f. Support Group
13. Consumer Advisory Council members and roles
14. Assessment of individual patient education needs
15. Review of findings with RN Case Manager
16. Crisis management and psychiatric emergencies
  - a. Clinic policy

Discuss immediately with RN Case Manager

**Ruth M. Rothstein CORE Center****DRAFT JOB DESCRIPTION**

**Job Title:** BUP Peer Advocates

**Department:** Behavioral Sciences or Chemical Dependency

**Program/Service:** Buprenorphine (BUP) Study

**Reports To:** Intervention Coordinator .....

Date Prepared: **12/13/05**

**Job Summary:**

Under the direction of the BUP team, the BUP Peer Advocates shall conduct outreach to potential participants identified by the BUP team. BUP Peer Advocates will serve as new Buprenorphine (BUP) Patient Orientation Guides. Under the direction of the BUP team, the BUP Peer Advocates will co-facilitate a BUP support group and conduct outreach visits along with a BUP team member. BUP Peer Advocates shall maintain up to date knowledge regarding HIV, buprenorphine and issues related to substance abuse. The BUP Peer Advocates are required to maintain accurate records of all BUP client encounters and submit service delivery reports as required. BUP Peer Advocates will participate in all administrative meetings, BUP Program and staff development meetings.

***SPECIFIC RESPONSIBILITIES***

**Responsibility:** Conduct outreach activities to potential program participants identified by the BUP team.

**Specific Duties:**

- 1) Distribute BUP and Methadone fact sheets to potential BUP participants.
- 2) Interface with patients during clinic visits and direct them to the BUP team for potential enrollment.

**Responsibility:** BUP Peer Advocates will serve as new Buprenorphine (BUP) Patient Orientation Guides.

**Specific Duties:**

- 1) Greet and assist patients through BUP process.
- 2) Provide patient education on BUP program, substance abuse, HIV and related topics.
- 3) Engage patients during waiting periods.
- 4) Accompany BUP participants to and from the pharmacy.
- 5) Refer clients to follow-up medical care and other prevention programs as needed and schedule future appointments as necessary.

**Responsibility:** Co-facilitate weekly BUP check-in group.

**Specific Duties:**

- 1) Under the direction of the BUP team members, the BUP Peer Advocate will assist with weekly support group facilitation.

- 2) The BUP Peer Advocate will refer clients to the BUP team members who are in need of other services, i.e. mental health, case management, etc.

**Responsibility:** Conduct outreach activities with BUP team members.

**Specific Duties:**

- 1) Accompany BUP team on outreach visits.
- 2) Assist with outreach tasks including making telephone reminder calls and follow-up appointments.
- 3) Provides BUP program education, offer risk reduction strategies and provide appropriate referrals.

**Responsibility:** Completion of reports.

**Specific Duties:**

- 1) Input data as directed.
- 2) Complete monthly reports and submit to \_\_\_\_\_.

Other duties as assigned by the BUP team.

## **QUALIFICATIONS**

Completion of the Adult Peer Education Training Program at the Core Center. Compliant with medical and social services appointments. Experience working with HIV positive persons. Basic knowledge of current HIV/AIDS information. Experience with substance abuse a plus.

## **CONTINUING EDUCATION**

Must complete training regarding BUP and methadone treatments. BUP Peer Advocates are required to attend appropriate training as directed.

## ***AGE SPECIFIC***

Adult populations.

## **PHYSICAL DEMAND/HAZARDS/ENVIRONMENTAL CONDITIONS**

Able to walk up and downstairs. Computer screen exposure and wrist and hand movements.

## ***EQUIPMENT***

Operational knowledge of computers and computer programs, copy and fax machines, shredder and laminator.

## **APPROVALS**

Department Head:

Date:

Administrator:

Date:

Human Resources:

Date:



# Section III: Performance Appraisal

An important task of Supervisors is assessing or evaluating the job performance of the Peer Advocate. Peer Advocates should receive feedback on their performance on a regular basis. "Feedback" is a way of letting someone know the effect their behavior has on you, or of helping another person to consider changing a certain behavior.

Constructive feedback is:

- descriptive rather than evaluative
- specific rather than general
- responsive to the needs of both the giver and the receiver of feedback
- directed toward behavior that the receiver can do something about
- well-timed

In addition to informal feedback, a formal performance appraisal at pre-determined times (for example, once a year on the staff's anniversary date). The peer advocate should be informed of the appraisal, and be an active participant in the process.

**Refer to:**

	<b>PAGE</b>
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Sample #14: Performance Appraisal	42

**St. Luke’s Roosevelt Hospital Center  
Center for Comprehensive Care  
Peer Program Evaluation- Patient Survey**

A Supportive Peer (Peer) is an HIV+ individual who is in care at the CCC and who has been specially trained to provide support and information to CCC patients.

Please help us evaluate our peer program by answering the following questions. Please circle your responses. Thank you.

1. Did you talk to a Peer here at the CCC in the last 3 months?  
 Yes  
 No  
 Unsure

<p><b>Evaluation administrator-</b> Please note how the patient identified his/her contact with a peer:</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/>
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2. Did you speak with a peer . . .  
 On the inpatient unit  
 In the outpatient clinic  
 Both on the inpatient unit and in the clinic

Please reply to the following statements by circling the response that best describes your feelings:

3. I felt comfortable enough with the Peer to share my problems and/or feelings.  
 Strongly Disagree    Disagree    Agree Strongly    Agree    Neither  
 Agree nor Disagree
4. The Peer I spoke to understood the problems I spoke to him/her about.  
 Strongly Disagree    Disagree    Agree    Strongly Agree    Neither Agree  
 nor Disagree

- 5. The Peer I spoke to was able to refer me to someone who could answer any questions that I had.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 6. The Peer provided me with the emotional support I needed.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 7. The Peer provided me with information that I didn't already know.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 8. I found it helpful to talk to the Peer.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 9. The Peer I spoke to was good at explaining the CCC's services to me.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 10. The length of time I spent talking with the Peer was:  
Too long Just right Too short
- 11. The Peer was accepting and non-judgmental of my life and health care choices.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 12. I felt like the Peer was someone I could trust.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 13. I would rate my experience with the Peer as:  
Excellent Very Good Average Fair Poor Not Sure
- 14. As a person living with HIV, I think it is important to be able to talk with a Peer who is also living with HIV.  
Strongly Disagree Disagree Agree Strongly Agree Neither Agree nor Disagree
- 15. Would you like to say more about your experience speaking with a peer at this clinic?

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## **Children's Hospital Performance Appraisal**

90 Day: \_\_\_\_\_

Annual: \_\_\_\_\_

Overall Rating: \_\_\_\_\_

### **RATINGS SUMMARY**

**Recommended process:** Assess each task or indicator under a competency area, then assign a letter indicating your evaluation of the area as a whole.

**The rating scale includes:**

- NR (Needs Review – improvement plan must be attached or included in the appraisal)
- -C (Competent with a few areas of development needed—action steps to get performance up to C must be included)
- C (Competent in all tasks), C+ (Competent in all tasks and clearly superior in some tasks),
- RM (Role Model; benchmark for this area of expertise).

After assigning rating letters to each competency area, take an average of all these assessments and provide a **summative evaluation letter** in the box provided on the first page of the appraisal form. Please remember to **assign a percentage of merit increase**, if any, on the HR1 Form.

**Validation Method:** DO (Demonstrated by Observation); CF (Customer Feedback);

P (Preceptorship); PR (Peer Review); PS (Patient Satisfaction Survey); R (Productivity Report); SRR (Service Record Review)

<b>Mandatories</b> —Fill-in information below or attach CHEX printout List additional mandatory education as appropriate.	<b>Date Completed</b>	<b>Not Required</b>
Child Abuse & Neglect		
Corporate Compliance		
Fire Safety		
Hazardous Chemicals		
Latex Allergy		
National Patient Safety Goals		
Tuberculosis Prevention		
<b>Staff Core Competencies</b>	<b>Rating</b>	<b>Validation Method</b>
<u>Customer Service Principles</u> Treat each family as my top priority. Treat each other as valued customers. Take responsibility to resolve customers’ concerns. Assure that the customers’ expectation drives behaviors. Continuously improve the quality of the services offered.		
A. The following <u>Key Service Targets</u> and their indicators are how CHI employee’s demonstrate the five Customer Services Principles. These targets are for all situations, live or electronic and whether or not your customer is external or internal.		

<p><b><u>Interaction</u></b></p> <ul style="list-style-type: none"> <li>• Demonstrates courteous and respectful communication and behavior in all situations</li> <li>• Acknowledges their customer and offers assistance as appropriate and needed.</li> <li>• Uses NOD (name, occupation, and duties) at initial customer interaction and subsequently as appropriate.</li> <li>• Demonstrates understanding and willingness to maintain appropriate behavior in onstage/offstage situations.</li> <li>• Listens empathetically and responds appropriately, assuming good intentions, using open ended questions.</li> </ul> <p><b><u>Resolution</u></b></p> <ul style="list-style-type: none"> <li>• Assesses and sets expectations with their customer</li> <li>• Available and willing to answer questions and address concerns demonstrating <i>Interaction</i> standards of behavior.</li> <li>• Shares adequate instructions and/ or explanation of service interaction.</li> </ul> <p><b><u>Wait Times</u></b></p> <ul style="list-style-type: none"> <li>• Informs and explains delays, checking back appropriately, offering service amenities during wait.</li> <li>• Answers phone, voicemails, emails per dept guidelines for timeliness.</li> <li>• Shares accountability in attending to the customers during greeting and wait time duration.</li> </ul>		
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<p>B. Maintains an appropriate environment</p> <ul style="list-style-type: none"> <li>• Immediately reports all problems/broken items on appropriate forms</li> <li>• Maintains a well-organized, clutter-free work area</li> <li>• Reports spills and hazardous situations immediately</li> <li>• When encountering litter in work areas or public areas, picks it up</li> <li>• Keeps hallways free of clutter and safety hazards</li> <li>• Is responsible for properly disposing of own litter and debris</li> <li>• When encountering an unclean restroom, contacts Environmental Services immediately</li> <li>• Maintains an awareness of cost control measures, avoiding ordering excessive or unnecessary supplies</li> <li>• Assures that all waste is disposed of properly</li> </ul>		
<p>C. Maintains appropriate demeanor</p> <ul style="list-style-type: none"> <li>• Maintains personal cleanliness, neatness and good hygiene in the work environment</li> <li>• Maintains a quiet and respectful environment</li> <li>• Allows patients and visitors the right of way when entering elevators or walking down hallways</li> <li>• Is punctual for meetings and appointments</li> <li>• Confidential information is not discussed in any public areas or where staff and visitors can overhear conversations</li> <li>• Assures information is released only to those with a need to know</li> <li>• Uses CHI systems such as patient database and email with discretion</li> </ul>		
<p>D. Demonstrates self management skills</p> <ul style="list-style-type: none"> <li>• Maintains priorities in alignment with departmental needs</li> <li>• Produces quality work in a timely manner</li> <li>• Copes positively with changing or ambiguous situations</li> </ul>		

<ul style="list-style-type: none"> <li>• Demonstrates willingness to change duties or work flow to improve output</li> <li>• Identifies/presents opportunities for improvement</li> </ul>		
<p>E. Maintains behaviors in accordance with <b>Children’s Corporate Integrity Program</b> as well as any and all <b>CHI Policies and Procedures</b></p> <ul style="list-style-type: none"> <li>• Demonstrates knowledge of CHI Policies &amp; Procedures including Children’s Corporate Integrity Program</li> <li>• Maintains self and demonstrates behaviors in accordance with those defined within Children’s Corporate Integrity Standards of Conduct and all CHI Policies and Procedures</li> </ul>		
<p>F. Demonstrates awareness of and support for <b>Diversity and Inclusion</b></p> <ul style="list-style-type: none"> <li>• Behaves respectfully and caringly toward all people</li> <li>• Avoids potentially offensive language (including slang, jargon, jokes) or gestures and body language</li> <li>• Identifies personal challenges in relating to persons from diverse environments and works to address these challenges</li> <li>• Takes responsibility for becoming informed about diverse cultures, ethnic groups, religions (E.g., attends Multicultural Brown Bag Lunches, scheduled educational activities or engages in self-studies)</li> <li>• Actively engages in and supports efforts to develop an atmosphere of mutual respect and inclusiveness</li> <li>• Respectfully, privately, and professionally challenges comments that demean others</li> </ul>		
<p>G. Demonstrates awareness of and support for the principle of Family Centered Care</p> <ul style="list-style-type: none"> <li>• Ensures information sharing and collaboration between patients, families and staff</li> <li>• Maintains recognition by self and staff of the vital role that families play in ensuring health and well being of patients</li> </ul>		



<ul style="list-style-type: none"> <li>• Acknowledges emotional, social, and developmental support are integral components of health care and empowers patients and families to support this</li> <li>• Supports families rights by supporting decision-making and care-giving and respecting individual and family choices</li> <li>• Involves patients and families in all aspects of planning, delivering and evaluation of health care services.</li> </ul>		
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<b>Job Specific Competencies</b>	<b>Rating</b>	<b>Validation Method</b>
<p><b>Recommended Use:</b>  <i>Please take the position job description and identify the core competencies that are specific to that position. Type the competency category right in this form (the box will enlarge as needed). It is highly recommended to identify the specific performance indicators under each category that indicate the employee is competent in performing this particular competency. It is also recommended to discuss and/or identify this section with the incumbent in the position.</i></p>		

<b>Strengths and Areas of Interest</b>	<b>Areas for Improvement</b>
<b>Special Contributions/Achievements</b>	<b>Development Goals</b>
<b>Employee Comments</b>	

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewer Title

\_\_\_\_\_  
Department/Administrator Signature

\_\_\_\_\_  
Date

# Section IV: Confidentiality

Peer Advocates will be learning all sorts of sensitive information in their jobs. They need to know how to determine what information is confidential and the legal and ethical limits of confidentiality.

Supervisors need to explain confidentiality regulations to Peer Advocates so that confidential client information is not shared inappropriately.

**Refer to:**

	<b>PAGE</b>
Sample #15: Peer Counselor/Volunteer Confidentiality Agreement	49

**North Georgia Health District  
The Living Bridge Center**

**Peer Counselor/Volunteer Confidentiality Agreement**

I, \_\_\_\_\_, am volunteering my time to work with The Living Bridge Center (TLBC). I understand in the course of my work for The Living Bridge Center, I may learn facts about patients/clients/consumers, staff, and volunteers of The Living Bridge Center and its affiliates which are of a highly personal and confidential nature. Examples of such information are: HIV positive status, medical condition and treatment, finances, living arrangements, employment, sexual orientation, relations with family members and friends, and even the fact that an individual is a volunteer. I understand that all such information must be treated completely confidential. I agree not to disclose any information of a personal and confidential nature to any person not also affiliated with The Living Bridge Center and authorized by The Living Bridge Center. Disclosure of this information without the specific consent of the individual to whom such information pertains is prohibited. The violation of confidence will cause my immediate termination as a TLBC volunteer and may also lead to possible legal action. In case of doubt about a situation, I will first contact the District Program Director or the clinic staff person with whom I am working and assisting in the clinic.

I agree to abide and uphold all of The Living Bridge Center Volunteer Guidelines.

Volunteer (Print Name): \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Clinic Staff Signature: \_\_\_\_\_

District HIV Director Signature: \_\_\_\_\_

# Section V: Integrating Peers into Teams

Supervisors can help to smooth the integration of Peer Advocates into the multidisciplinary team by introducing the role of peer advocate to the other team members, and discussing with them the benefits of Peer Advocates for the client and the agency.

**Refer to:**

Sample #16: Peer Advocacy and Process Team Planning

**PAGE**

51

**North Georgia Health District**  
**The Living Bridge Center**  
**Peer Advocacy and Process Team Planning**

Brief team discussion:

- What is a peer advocate?
- How can peer advocates be used in The Living Bridge Center?

Benefits of having Peer Advocates (PA):

- Assistance and support for patients in overcoming barriers that hinder their adherence and facilitating their high quality and effective clinical and supportive care.
- Linkage and retention in HIV clinical care.
- Contribution of a new and unique perspective to team work and decisions.
- The patient perspective is given more consideration.
- Staff support.
- More informed, better educated, and empowered patient caseload.
- Peer Advocate-to patient prevention with positives (patients living healthier lifestyles and making healthier safer choices.
- Future considerations: DOT.
- Better educated and informed patient caseload.
- Demonstration of clinic's commitment to patient-centered care.
- Facilitate referrals to supportive services.
- PA's can advocate and facilitate more open, honest, non-threatening conversations between patient, provider, and staff.
- Allowing PA's an opportunity to "give back".

Roles of the Peer Advocate:

- New Patient Intakes
- Patient Surveys and Needs Assessments
- Follow-up on New Patients and Patient Adherence Plan (cell phone idea)
- Participation in Grand Rounds
- Participation in Quality Management Team, Projects, and Activities
- Others:

### Review of Process

- Staff identified needs

### Review of Policies and Procedures

- Staff identified needs

### Boundaries:

- For Peer Advocates
- For Staff
- For Patients
- What do staff want them to know
- What do they need to know
  
- What do staff want back from peer advocates

### Documentation:

- Where
- What
- In what format
- Review by staff

### Clinic space:

### Potential Challenges:

### Training Needed:

### Patient education classes:

- Living Well with HIV

# PART II:

## Peer Advocate Toolkit

# Integrating Peers into Multidisciplinary Teams:

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## A Toolkit for Peer Advocates



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# ACKNOWLEDGEMENTS

The creation of this toolkit would not have been possible without the talent and commitment of numerous people.

First, I thank Helen Rovito, MS, HIV/AIDS Bureau, Health Resources and Services Administration. Helen's guidance throughout this project has been invaluable.

I thank our team at Cicatelli Associates Inc. Barbara Cicatelli, MA, President and CEO of Cicatelli Associates Inc., provided the opportunity for my participation in this exciting project. Barbara's support and encouragement were vital elements of this achievement. Rusty Chambliss, BA, Cicatelli Associates' Vice President/Director of Training offered his enthusiasm and expertise in the development and delivery of this toolkit and other training materials. Keran Deli, Ph.D., Cicatelli Vice President/Director of Curriculum and Distance Learning, was largely responsible for the creation of the valuable and unique resources contained in this document. Bryan Kutner offered consultation during this project, and his insight contributed significantly to the success of this endeavor. Paulo DeSousa, Program Coordinator at Cicatelli Associates, spent countless hours perfecting the design and layout of this toolkit. Lastly, Miriam Grill-Abramowitz, Program Associate at Cicatelli Associates, contributed to the editing, formatting, and coordination processes.

This project of course would not have happened without the Peer Advocates and their Supervisors. The energy, dedication, and talent of these individuals provided tremendous motivation to everyone involved. They voiced their questions candidly and frequently, and due to this communication, we were able to produce a document that meets the needs of people working in the field. Furthermore, Peer Advocates and Supervisors willingly shared their best practices with other agencies so that successes became learning tools for everyone. We specifically thank the following agencies for allowing us to include their documents in this toolkit: The University of Alabama at Birmingham Family Clinic, The Living Bridge Center of the North Georgia Health District, The Center for Comprehensive Care at St. Luke's Roosevelt Hospital Center, The Ruth M. Rothstein CORE Center, Children's Hospital FACES Program, and the I.M. Specialty Services Clinic at Oklahoma State University's Center for Health Sciences.

Each person and agency mentioned on this page is deeply committed to bettering the lives of other people. It is my sincere hope that "Integrating Peers into Multi-Disciplinary Teams: A Toolkit For Peer Advocates" assists people as they work towards this goal of improving lives.

Sincerely,  
Cornell Wrisby, MSW  
Project Director and Director of Community Education Projects  
Cicatelli Associates, Inc.

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# Introduction

Not all people share common experiences in life. Nurses, physicians, social workers and other medical staff can relate to a person living with HIV, whether or not they live with the virus themselves. But a Peer Advocate is someone who shares certain qualities with consumers, in a way that makes the peer more of an equal to the client than any other staff in the clinic.

This “sameness” could be based on living with HIV, on racial or ethnic culture, sexual orientation, drug use, gender, age, national origin, language, class or some combinations of these life experiences. These commonalities can make a helping relationship easier and more effective for someone living with HIV.

A Peer Advocate in a multidisciplinary team can share personal experiences and insight with the team while providing support for the consumer that can ease the process of dealing with HIV. Peers also facilitate communication between the client and medical providers, educate the client about prevention, infection and disease progression, and serve as a role model.

As a member of a multidisciplinary team, the Peer Advocate:

- conducts enhanced outreach and navigation;
- provides patient education;
- supports client treatment adherence; and
- advocates for clients within the multidisciplinary team.

This tool kit will provide tools for the Peer Advocate to use in each of these tasks.

# Section I: The Enhanced Outreach Model

Enhanced Outreach refers to an outreach model that is very interactive and intensive. Other outreach models might involve meeting a client at a particular venue and distributing clinic information or other brochures and handouts. Enhanced outreach involves developing an ongoing relationship with the client, making referrals, providing education, navigating the client to services, and supporting the client in a variety of ways including helping the client with adherence. Through the work of enhanced outreach, the Peer Advocate also represents the client's interest to the multidisciplinary team, and advocates for the client.

The Relational Outreach and Engagement Model (ROEM) provides the framework for the Peer Advocate's work in Enhanced Outreach. Following the principles of this model will allow the Peer Advocate to develop and strengthen relationships with clients. This section covers the following topics:

1. The Relational Outreach and Engagement Model
2. Preparing for Outreach
3. Conducting Outreach

# 1. THE RELATIONAL OUTREACH AND ENGAGEMENT MODEL

The foundation for the enhanced outreach is the Relational Outreach and Engagement Model<sup>1</sup> (ROEM). **ROEM:**

- provides a theoretical framework for outreach and engagement;
- offers specific practices appropriate to each stage of the work;
- suggests benchmarks by which movement along the outreach and engagement continuum of care can be assessed; and
- describes *HOW* the outreach relationship will develop and take shape from moment to moment over time.

**ROEM** includes the four phases described below.

## **Phase 1: Approach**

- Honor the tentativeness of the relationship
- Outreach worker needs to be present and try to establish a connection
- Should not attempt to rush
- Meetings are random, spontaneous, loosely planned
- Visits are brief with little or no agenda
- Role of the worker is varied – *neighbor, caring observer, passerby, etc.*
- Specific activities are minimal - *a smile, a nod, offer to assist, etc.*

### ***How to do it:***

- Greet the person
- Introduce yourself
- Initiate casual conversation
- Identify yourself in your specific role

## **Phase 2: Companionship**

- Peer Advocate offers and is permitted to share the client's journey
- Peer Advocate is recognized, greeted, welcomed
- Peer Advocate seen as increasingly trustworthy

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<sup>1</sup> The ROEM model is adapted from unpublished papers by Craig Rennebohm, Mental Health Chaplaincy as seen in CAPC Enhanced Outreach Institute, March 2003.

- Peer Advocate provides a reliable presence – *listens to client’s story, offers empathy, acts with knowledge and proper timing*
- Peer Advocate is attuned to client’s current situation – *perception of self, world around them, ability to meet their needs for care*
- A series and accumulation of events together suggest shift from approach to companionship

***How to do it:***

- Hear client’s story
- Do activity together
- Identify client’s perceived needs
- Provide material assistance
- Accompany client to services
- Provide information
- Respond to emergencies
- Client initiates contact
- Meet in public venue

**Phase 3: Partnership**

- Capacity of worker and client to open their relationship of trust to a significant third party – *social worker, case manager, nurse, doctor or counselor*
- Individual’s acceptance of growing circle of care
- Worker’s companionship role continues to be critical
- Client still needs the trustworthy presence of the worker

***How to do it:***

- Identify mutual longer-term goals
- Enhance motivation to positive change
- Plan for meeting these goals
- Provide education
- Connect w/other longer-term services

#### **Phase 4: Mutuality**

- Completes the outreach and engagement process
- The growing, common human bonds shared between client and worker allows for this
- Will lead eventually to an appropriate termination
- Worker celebrates accomplishments with client
- Worker prepares for separation and transition

#### ***How to do it:***

- Adjust your helping role
- Advocate within new support systems
- Meet together to review client's work
- Monitor client's progress
- Terminate formal provider-client relationship

#### **Refer to:**

	<b>PAGE</b>
Tool #1: An Overview of ROEM	8
Tool #2: ROEM Worksheet	9

# 1. The Relational Outreach and Engagement Model TOOLS

<b>TOOLS:</b>	<b>PAGE</b>
Tool #1: An Overview of ROEM	8
Tool #2: ROEM Worksheet	9



**An Overview of ROEM**  
Relational Outreach and Engagement Model

Phase	Predominant Quality	Characteristic Activities	Role/Relational Stance of Worker
<b>Approach</b>	Spontaneous, unplanned meetings  Random  Brief	Minimal specific activities  Examples: A smile, a nod, an inquiry, a brief offer to help	Like a neighbor, a caring observer  Like a passerby willing to stop and listen
<b>Companionship</b>	Providing a reliable presence	Having an agreed upon, regular meeting place  Small shared tasks  Examples: Sharing a cup of coffee or a meal; Walking or riding together	Worker is recognized, greeted, welcomed and experienced as a reliable presence  Empathetic listener
<b>Partnership</b>	Increasing trust in relationship to the worker  Willingness and capacity to open a trusting relationship with a third party	Extended from companionship phase  Trusting relationship now includes primary care or another provider	Trustworthy presence  Providing information and encouragement
<b>Mutuality</b>	Fruition of relationship  Participant has a healthy sense of self and place	Celebrating milestones and accomplishments together  Multiplicity of relationships	Supportive other  Worker prepares for appropriate termination of relationship

**ROEM WORKSHEET**

*Use this worksheet to help you develop an outreach plan for the population you will be working with. Describe what you would do or say for each of the phases in ROEM, ask other Peer Advocates for feedback, and then share your work with your supervisor.*

	Street-based sex workers who can't be seen with outreach workers	People injecting substances in a "shooting gallery"	Recent immigrants staying with family	Street based youth who never visit the clinic	Other:	Other:
Approach						
Companionship						
Partnership						
Mutuality						

## 2. PREPARING FOR OUTREACH

The Peer Advocate needs to prepare before going out into the community to conduct outreach.

The more you know about your population, the better prepared you will be. You can gather information such as:

- description of your target population
- where the target population can be found
- what their interests and concerns are
- their behaviors
- their special needs
- the gatekeepers who can help you access the population.

You can gather this information from:

- other Peer Advocates or outreach workers in your agency
- your supervisor
- your direct observations

**Refer to:**

Tool # 3: “What I need to know about my Target Population”

**PAGE**

12

In preparing for outreach, it is also important to think about your safety.

**Refer to:**

Tool #4: “Outreach Safety Planning”

**PAGE**

13

## 2. Preparing for Outreach TOOLS

<b>TOOLS:</b>	<b>PAGE</b>
Tool #3: “What I need to know about my Target Population”	12
Tool #4: “Outreach Safety Planning”	13

**What I Need to Know about My Target Population**

*Directions: Write in your target population(s) and complete the worksheet for each population. Ask other Peer Advocates or your supervisor for help in identifying all the information.*

<b>Outreach Population &amp; Situation</b>	<b>Where do they gather?</b>	<b>What are their interests and concerns?</b>	<b>What are their behaviors?</b>	<b>What are their special needs?</b>	<b>Who are the gatekeepers?</b>
Example: People injecting substances in a “shooting gallery”					

# Outreach Safety Planning

Some things to consider in safety planning include:

**Know the history of your area.** Are there racial or ethnic tensions? Has the population changed? Is there a history of gangs? Are there colors you shouldn't wear? What do you know about from newspapers or television news? Are there trouble spots? What do the people of the area say about it?

**Be familiar with the streets.** Know where you're going. Learn your way around and note the landmarks. Don't look confused or lost.

**Work in pairs, when possible, and communicate with the office.** If you're going someplace new, go in pairs or groups. Let your office or supervisor know where you're going and when to expect your return. Develop signals with your fellow outreach workers, to let one another know when you're in danger.

**Dress and carry yourself appropriately.** The way you dress, act and talk will affect how people interact with you. What behaviors, dress and activities might offend this community or population? Wear a visible ID badge. Don't wear expensive jewelry. Carry your outreach materials in clear plastic bags. Behave in a non-threatening way.

**Get to know store owners, safe houses and pay phones.** Develop a relationship with store owners; they may be able to help you if you're in danger. Carry change for a pay phone.

**Get to know the police who work in the area.** Let them know who you are, where you work and what you're doing.

**Trust your "gut"** If it doesn't feel safe, it probably isn't.

### Outreach Safety Planning

*Use this worksheet to help you plan for a safe outreach experience. Be sure to discuss your safety plan with your supervisor.*

**1. Know the history of your area.**

What do people say about the area?

Are there racial or ethnic tensions?  
What are they?

Are there trouble spots?  
Where?

How has the area changed in the past few years, if at all?

**2. Be familiar with the streets.**

What are the major landmarks?

Where will you do most of your outreach?

<b>3. Work in pairs and communicate with the office.</b>	
Who's your contact at the office?	
Who is your outreach partner?	
How will you signal your partner if you are in danger or need help?	
<b>4. Dress and carry yourself appropriately.</b>	
What kinds of clothes are inappropriate?	
What kinds of clothes are inappropriate?	
Where will you carry your ID badge?	
What words or phrases would be offensive?	



<b>5. Get to know store owners, safe houses and pay phones.</b>			
Store owners	Store name	Owner/Manager name	Address/Intersection/#
	1.		
	2.		
Safe houses	Safe house name	Contact	Address/Intersection/#
	1.		
	2.		
Pay phones	Address/Intersection	Near what business	Phone number
	1.		
	2.		
<b>6. Get to know the police who work in the area.</b>			
Police	Name	Badge #	Precinct/Phone Number
	1.		
	2.		

### 3. CONDUCTING OUTREACH

When conducting outreach, it is important to plan how you will meet your clients, and how you will introduce yourself.

The first step when meeting with a potential client is your introduction.

The introduction sets the tone for your relationship with the client, so it's helpful to consider what to say and how to say it. Check with your supervisor or other peers for help in identifying ways to introduce yourself to clients you meet through outreach.

**Refer to:**

	<b>PAGE</b>
Tool #5: Three Easy Ways to Introduce Yourself	19

The more you understand the clients you will be working with, the better able you will be to work effectively with them.

**Refer to:**

	<b>PAGE</b>
Tool #6: Tips on Outreach	20

There will always be some situations that are difficult to know how to respond to. Try to think of questions or situations that you might be difficult for you. Practice what you could say in those situations with other Peer Advocates.

**Refer to:**

	<b>PAGE</b>
Tool #7: How to Respond in Difficult Outreach Situations	24

*It is very important to know how to respond appropriately in situations where a person talks about hurting themselves or someone else.* Consult with your supervisor about how to respond in those situations, and be sure you are able to contact your supervisor when such a situation occurs.

### 3. Conducting Outreach TOOLS

<b>TOOLS:</b>	<b>PAGE</b>
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Tool #7: How to Respond in Difficult Outreach Situations	24

<b>Three Easy Ways to Introduce Yourself</b>	
Here are three examples of ways to introduce yourself. In the blanks on the right, write down three introductions of your own. Ask coworkers and your supervisor for suggestions and feedback.	
1. “Hi, I’m Juan. I came by because...”	
2. “Hi. I work with ABCD clinic. I’d like to share some information with HIV/AIDS with you. . . “	
3. “Hi. My name is Rose and I’m a Peer Advocate at XYZ clinic. Do you have a few minutes to talk? I’d like to share some information with you about the services that you might benefit from”	

**Tips on Outreach with People Using Alcohol and Other Substances**

<b>Recognize:</b>	<b>And in response...</b>
<p><b>Potential for guilt and shame.</b> People who struggle with their use may feel that they should stop using, and ashamed that they cannot stop.</p>	<p>Avoid “should” and questions that point in the direction of abstinence, unless that is the client’s goal. Focus on the client’s sense of well-being, instead of an end-goal.</p>
<p><b>Fear of “tests” and authority.</b> Sometimes people feel that no news is better than bad news, or may feel paranoid about what will happen to their results. Some people may want to avoid tests that might confirm their fears.</p>	<p>Be clear about who sees test results and why they are important. Explain confidentiality and patient rights. Explore what test results would mean for the client.</p>
<p><b>Denial.</b> Everyone experiences difficulty facing the harm and, sometimes, the pleasure of their behavior. Drug use also carries a stigma, so some clients may want to hide their concerns by denying their real experiences.</p>	<p>Be safe, neutral and open. Avoid the words “good” or “bad”, so clients can share the gray areas that concern them. Instead of “consequences” talk about “what happens when...” and how to help clients get what they want while reducing negative outcomes.</p>
<p><b>Money.</b> If a client needs a certain amount of money to support a habit, costs of services and time or money spent getting to services may be a barrier to health care.</p>	<p>Know the financial options for care, and provide an easy, accessible way to get there.</p>
<p><b>Questions.</b> Some people who have been through the “system” get tired of answering questions about their history, especially when it’s unclear how it will be used and who will see it.</p>	<p>Build a relationship with the rest of your team, so you can confidently describe how doctors or other medical providers will treat your clients. Validate your clients concerns and their right not to answer questions; build rapport first.</p>

**Tips on Outreach with Adolescents**

<b><i>Recognize:</i></b>	<b><i>And in response...</i></b>
<p><b>They will test you.</b> Adolescents will want to determine how to trust you. To figure you out, they'll likely try to "push your buttons".</p>	<p>The more calm and unruffled you can be, the more likely adolescents will learn to trust what they can and cannot expect of you. Be consistently positive, supportive, repetitive and reassuring.</p>
<p><b>Lack of trust is self-protection.</b> When people feel alone, isolated and afraid, they protect themselves.</p>	<p>Be respectful of your clients' feelings. Build trust at the client's pace, and follow through on what you say you'll do for the client.</p>
<p><b>Adolescents are developing into adults.</b> At some point during growth from childhood to adulthood, adolescents begin to learn the outcomes of their actions.</p>	<p>Don't get angry with clients when they don't see outcomes. Try to let them see the connections themselves, with you as a consultant to their process of discovery.</p>
<p><b>Confidentiality is key.</b> Young people are extremely conscious of other people "knowing their business".</p>	<p>Build familiarity with people and the process of HIV care by explaining confidentiality and patient rights.</p>
<p><b>Experimentation is part of learning.</b> Taking risks and learning about oneself and others in the process is key to developing into an adult. Even harmful behavior is a learning experience, despite how we might feel about the possible outcomes.</p>	<p>Frame risk-taking in terms of what your clients are learning about themselves. Most adolescents are given a slap on the hand for their sex lives and drug use. Being neutral about their behavior lets them share more of their lives, and opens the door for you to talk about real harms, instead of imagined ones.</p>

<b>Tips on Outreach with Marginally Housed or Homeless Populations</b>	
<b><i>Recognize:</i></b>	<b><i>And in response...</i></b>
<p><b>Financial and time concerns.</b> Even if services are free or low-cost, street-based clients may prefer to spend their time making money.</p>	<p>Know the financial options for care. Be very clear about what the fees will be, and the benefits of the services offered.</p>
<p><b>People get asked a lot of questions.</b> Homeless clients who have been in the system already may be tired of being asked about their personal history.</p>	<p>Acknowledge that they have been approached by others before; Identify what is unique about what you are offering.</p>
<p><b>Filling out forms may be scary.</b> Most medical settings require a permanent address for their records. This can be intimidating and embarrassing for someone who can't fill a form out completely, either because no address is permanent or because the client can't read or write.</p>	<p>Offer a permanent address that clients can use on forms. Offer to read or fill out forms for your clients, rather than assume they can fill forms out on their own.</p>
<p><b>Immediate concerns can outweigh long-term concerns.</b> People meet their needs in the order that is the most important to them. Basic human needs like food, shelter, and social contact may be more important than making appointments.</p>	<p>Identify what you can and can't do for them to meet their immediate needs. Help them find sources to get immediate needs met.</p>
<p><b>Concern over judgments.</b> Homelessness can be a humbling experience. It can also be a source of pride for some people, to have survived on the streets. Some people respond by being defensive and rejecting help.</p>	<p>Roll with the client's resistance and at the client's pace. Remember to praise the client's strengths and resilience. Reframe 'failure' in terms of how the client had survived despite being homeless.</p>
<p><b>People move.</b> Homeless people may be on the move, and may not be able to access the same services at the same site.</p>	<p>Provide options for care locations, since a client's personal location may change.</p>

**Tips on Outreach with Immigrants**

<b>Recognize:</b>	<b>And in response...</b>
<p><b>Language may be a barrier.</b> Immigrants are sometimes treated as though they are not capable of understanding, when the real issue is the difference between English and their native tongue.</p>	<p>Either know the language or find a suitable interpreter, possibly through a local immigrant organization. Never make fun of or underestimate your client’s ability to understand what you are trying to communicate.</p>
<p><b>Responses to authority and immigration.</b> Some immigrants may be suspicious of the authority you represent. Others might respond by agreeing with you and saying “yes” to everything, and then not taking any action.</p>	<p>Let clients know you are not with immigration and you will not report information on them to legal authorities. Describe what your role is, and how you can be of service.</p>
<p><b>Culture.</b> Cultures approach health and wellness differently. What might seem perfectly reasonable in one culture may be the opposite in another.</p>	<p>Explore the medical approaches to health of your clients’ cultures. Do not assume every client from the same country has the same perspective. Offer services that will enhance the medical experience of HIV care, rather than pit one approach against another.</p>
<p><b>Gender.</b> Some cultures strictly define women’s roles and one must approach women through their male partners, who make major decisions in the household.</p>	<p>Respect the gender roles of different cultures, even if you do not agree with them. You might have to talk to the man first, in order to reach a woman consumer.</p>
<p><b>Lack of materials and resources.</b> Brochures and referrals are usually limited to only a few languages. While translation is always possible, not seeing one’s own language may cause a client to feel isolated and unseen.</p>	<p>Make attempts to find brochures and pamphlets in the common languages in your outreach area.</p>
<p><b>Fear of the unknown.</b> Social and medical services may not be offered the same way as they are—if they are at all—in someone’s home country. Services may seem scary or intimidating at first.</p>	<p>Be ready to explain in detail what the services are and why they’re offered. Walk your clients through the process, and leave the door open for questions. Explain things more than once to assure understanding.</p>



**How to Respond in Difficult Outreach Situations**

*Directions: Think of how to respond in each of the situations described below. Write your response in the space provided. Ask coworkers for suggestions. Share your worksheet with your supervisor for feedback.*

<i>When a client says...</i>	<i>You can say or do...</i>
"I don't want to talk to you."	
"Why should I trust you? I don't even know you!"	
"I think you sold me bad dope two years ago!"	
"I don't understand why you're here. What do you want from me?"	
"I don't trust you."	
"Please don't tell this to anyone else, but I..."	
Other:	

# Section II: Referral and Navigation

Navigation corresponds to the partnership phase of the ROEM. During navigation, the Peer Advocate not only connects the client with services and agencies, but accompanies the client to the service provider in order to:

- assure that client can access the service;
- help with keeping appointments;
- assist client with keeping appointments and adherence to treatment;
- help explain educational points and answer questions; and
- provide support whenever possible.

To navigate clients, you need to have referral sources for services at your agency and at other agencies, and know how to access those services.

Before helping clients get the services they need, the Peer Advocate needs to know what services the client might need and what service providers meet those needs.

- List out all possible needs your clients might have.
- Check with other Peer Advocates or your supervisors for referral agencies you can use if your agency doesn't provide the service.
- Develop a list of referral agencies you can use for clients.

Also, ask clients for service agencies they know of and have used in the past. Check with your supervisor to see if you can add these agencies to your referral list.

## Refer to:

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Talk with your supervisor about how to find referrals for services if you don't already have the referral available. Find out everything you can about the referral service including:

- hours of operation
- specific services offered
- languages spoken
- if childcare is available
- what documentation or papers clients will need to have
- financial or payment information
- how to get to the service
- the target population of the service
- typical 'waiting time'
- whether they accept walk-ins or appointments
- how long it takes to get an appointment.

Try to find the ‘best’ referral source for a client, based on what he or she needs and what the referral agency has to offer. Once you have referred or navigated a client to a service, ask clients for feed back on agencies they have used, and share that feedback with your supervisor, so you can decide how to proceed.

**Refer to:**

Tool #9: Tips on How to Make a Good Referral

**PAGE**

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Many clients will need help in accessing services. In this case, your job is to navigate the client to the service agency. For instance, a client at your agency may have missed an appointment for follow-up care. You may want to meet with the client, discuss the need for care, and then accompany the client to your agency so they can receive important medical care and other services. Depending on the particular client’s needs, you may be more or less intensively involved in navigating a client to services.

**Refer to:**

Tool #10: Navigating Clients to Services

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# Section II: Referral and Navigation TOOLS

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**Referral Agencies**

Talk with your supervisor about any referrals you do not have a source for, or any referral sources clients have not been satisfied with. Be sure your supervisor has approved all referral sources you are using.

	<b>Agency or agencies you can use as a referral</b>	<b>What kind of feedback have clients given you about this referral?</b>
<b>Medical services</b>		
<b>Health education</b>		
<b>Case management</b>		
<b>Nutrition</b>		
<b>Immunizations</b>		
<b>Vision</b>		
<b>Dental and oral health</b>		
<b>Reproductive health</b>		
<b>Mental health</b>		
<b>Physical therapy</b>		
<b>Complementary therapy (like acupuncture)</b>		
<b>Chemical dependency</b>		
<b>Spiritual care</b>		
<b>Family-related care, childcare</b>		
<b>Legal</b>		
<b>Housing</b>		
<b>Formal education &amp; training</b>		
<b>Job training</b>		
<b>Clothing</b>		
<b>Food</b>		
<b>Needle exchange</b>		
<b>Other:</b>		
<b>Other:</b>		
<b>Other:</b>		

## Tips on How to Make a Good Referral<sup>2</sup>

### 1. Make sure the client wants a referral.

Referrals don't solve problems unless a client has an interest in working on a problem in the first place, and sees how a referral will help. Be sure you find out what the client thinks, feels, and wants out of a referral— before you offer one.

### 2. Ask questions to find out the client's past experience.

People drop referrals all the time, sometimes because they don't know what to expect and other times because they've had bad experiences in the past. Ask, "Have you seen a social worker before? What did you think about the experience? Would it help if I described how it all works?"

### 3. Give a contact name.

Offering a name personalizes the referral. For example, "I know a really cool nutritionist named Luna. She's very open-minded, and a lot of my clients like her."

### 4. Make sure the referral is culturally relevant.

Find referrals that match the client's interest in terms of language, gender, sexual identity, relationship to drug use, ethnic background, racial identity, or whatever other cultural identities your client would want reflected in a referral.

### 5. Referrals should be easily accessible and affordable.

Make sure you offer a referral that your client can get to and can afford.

### 6. Explore obstacles and allow room for resistance.

Sometimes clients nod and say "Yes" to a referral, just because they think that's what you want. Find out how realistic this referral is for the client by asking, "Sounds like you want help with your meds, so we've talked about seeing a nurse I know named Oliver. Really, though, how does that sound to you?"

### 7. Invite feedback, and don't force the referral.

Clients are the best source for knowing how well a referral has met their needs. Be curious and ask directly, "I'm wondering how you felt about that referral. If you were able to go, what was it like? Would you recommend I send other people there?"

<sup>2</sup> Adapted from the University of California San Francisco AIDS Health Project, *Ensuring Quality HIV Prevention Counseling* (training manual), September 2006.

**Note: Clients may need more or less help in accessing services. Personalize this plan to meet the needs of the particular client with whom you are working and go over the plan with your supervisor.**

<b>Navigating Clients to Services</b>	
<b>Step One: Initial contact</b>	<p>Make contact with the client (in person or on the phone) and explain your role as a Peer Advocate, why you're calling (e.g., to schedule an appointment or to discuss the importance of follow up care.)</p> <p>Gather basic information during the encounter, such as whether or not the client lives alone, if the client would like to have others with him or her (family or friends) at the time of the meeting, and basic demographic information if such information is not already known.</p>
<b>Step Two: Meet with the client</b>	<p>Discuss the importance of follow-up care and explore why the client has not yet returned for follow-up care:</p> <ul style="list-style-type: none"> <li>• “What has prevented you from seeking follow-up care?”</li> <li>• “If you schedule an appointment now, what might stop you from keeping the appointment later?”</li> </ul> <p>If client has missed a previous appointment for care, explore why the client did not follow through on her appointment. “I’m concerned that you didn’t keep your scheduled appointment, and I’d like to talk with you about this. Last time I was here, you said you wanted to go for follow-up care, so I want to understand what made it difficult for you to do that.”</p>
<b>Step Three: Offer basic information</b>	<p>Provide basic information on the provider and visit, such as what the appointment is for, where to go, what the client can expect at the appointment, how long the appointment should take, when test results will be available, etc.</p>
<b>Step Four: Assess needs</b>	<p>In a non-judgmental and respectful manner, conduct a comprehensive needs assessment. Explore with the client her barriers to follow-up care. Barriers could include:</p> <ul style="list-style-type: none"> <li>• A need for child care</li> <li>• Lack of English proficiency</li> <li>• Fear</li> <li>• Low level of literacy</li> <li>• Family obligations</li> <li>• Lack of carfare or transportation</li> <li>• Current drug use</li> <li>• Eligibility requirements</li> <li>• Restrictive agency regulations and policies</li> <li>• Cost</li> </ul>

	<ul style="list-style-type: none"> <li>• Lack of culturally competent service provision</li> <li>• Other or conflicting priorities</li> <li>• Disbelief in the importance of follow-up care</li> <li>• Mental illness, including depression and anxiety</li> </ul>
<p><b>Step Five: Anticipate and problem solve barriers</b></p>	<p>Help the client anticipate any problems that might interfere with keeping her appointment, and help the client strategize around these problems:</p> <ul style="list-style-type: none"> <li>• “Who will take care of your children?”</li> <li>• “Who could you ask to come with you to the appointment?”</li> <li>• “How will you get there?”</li> <li>• “Will you go from work, or from home?”</li> <li>• “Are you asking for time off from work?”</li> <li>• “Who provides emotional support for you?”</li> <li>• “If you get anxious about this appointment, is there someone you can call to talk to?”</li> </ul> <p>Depending on the barrier, interventions will vary. For instance, the tasks might include:</p> <ul style="list-style-type: none"> <li>• Listening empathetically to the client’s fears and concerns</li> <li>• Talking with family members with the client to explain the service and the importance of follow-up care</li> <li>• Helping the client develop coping strategies to manage anxiety</li> <li>• Making referrals for other services, such as mental health care; food stamps; legal services</li> <li>• Explaining eligibility and cost requirement</li> <li>• Listening to the client’s health beliefs, and helping the client see follow-up care as an additional service, rather than a competing service</li> </ul> <p><u>Walking into the provider’s office with the client, just so the client can see what it is, who is there, what will happen, etc</u></p>
<p><b>Step Six: Help client with appointment</b></p>	<p>You can help the client call for an appointment, or, if it is a ‘walk-in’ determine time when client would like to go. Help client with issues such as getting to the service agency:</p> <ul style="list-style-type: none"> <li>• Help the client call the provider</li> <li>• Write questions for the client to ask the provider</li> <li>• Indicate that you will remind the client of the upcoming appointment</li> <li>• Let the client know that you will maintain contact between now and the appointment with phone calls or in-person visits</li> <li>• Offer to meet the client at the provider’s office</li> <li>• Offer to accompany the client to the provider’s office from the client’s home</li> </ul>



<p><b>Step Seven: Follow-up</b></p>	<p>Get permission to call the client back or return to visit the client in a week or sooner to see if the client was able to schedule the appointment, or needs any assistance in doing so. Continue with follow-up phone calls or in-person visits until the date of the appointment. During this time, explore ongoing services needed, as well as barriers and fears of the client, and address them, as may be appropriate. Other tasks might include:</p> <ul style="list-style-type: none"> <li>• Helping the client figure out transportation issues (e.g., how to use public transportation, parking issues, etc.)</li> <li>• Agreeing to meet the client at the provider’s office for the appointment</li> <li>• Helping the client problem-solve concerns regarding child care, or offering to meet the client at the provider’s office and watching the children during the client’s appointment with the provider</li> <li>• Helping the client explore possible coping strategies and naming possible people for support who can help the client if she becomes anxious about her upcoming appointment</li> </ul>
<p><b>Step Eight: Accompany client to appointment</b></p>	<p>Accompany the client to the provider’s office, unless the client has said she does not want you to go with her. In that case, call the client after the time of the appointment, to inquire as to whether the client kept the scheduled appointment.</p>
<p><b>Step Nine: Keep in touch</b></p>	<p>If the client kept the appointment, keep in touch as necessary. For instance, you might call back when the client gets his/her test results; or ask if the client wants you to accompany him/her to the provider for the test results. If the client did not keep the scheduled appointment, then the barriers addressed were not the barriers keeping the client from follow-up care. In this case, continue to meet with the client and attempt to uncover the barriers keeping the client from attending follow-up care.</p>
<p><b>Step Ten: Next steps</b></p>	<p>Work with your supervisor to problem-solve and determine strategies for next steps.</p>

# Section III: Patient Education

An essential part of the Peer Advocate’s job is patient education. To be effective as an educator, the Peer Advocate needs to have good communication skills, and to be knowledgeable about the information they want to share with others.

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It is also important to be clear about what you know and don’t know, and to be comfortable saying “I don’t know, but I’ll find out for you” when appropriate. Another key skill is knowing how to respond to questions that ask for your opinion, rather than factual information.

**Refer to:**

	<b>PAGE</b>
Tool #15: Responding to Questions	47

Some questions or topics may be easier for you to respond to, and some more difficult. Identify what topics you are less comfortable talking about, and check with your supervisor and other peer advocates about how to increase your comfort level in discussing those topics.

**Refer to:**

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Tool # 16: Assessing Your Comfort Level	48

## Section III: Patient Education TOOLS

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**Frequently Asked Questions about HIV and AIDS**

*Below are some frequently asked questions. What other questions might you clients ask? Write the questions in the boxes provided, and ask your supervisor for help in determining how to answer them.*

<p><b>1. What is HIV?</b></p>	<p><b>Human Immunodeficiency Virus.</b> It is the virus that causes AIDS. There are two main types of the virus, HIV-1 and HIV-2</p>
<p><b>2. What's the difference between HIV-1 and HIV-2</b></p>	<p>HIV-1 is the most common type of HIV in the U.S.</p> <p>HIV-2 is primarily found in West Africa</p> <p>HIV-1 and HIV-2 are transmitted the same way; both cause immune system damage</p> <p>Very few cases of HIV-2 in the U.S.</p> <p>Most of the cases of HIV-2 in the U.S. are associated with people who are from West Africa, or have sexual or injection partners from West Africa</p>
<p><b>3. What is AIDS?</b></p>	<p><b>Acquired Immuno-deficiency Syndrome</b></p> <p>AIDS = HIV and a T-cell count below 200 or at least one opportunistic infection(s)</p> <p>Opportunistic infections are listed in the current CDC case definition</p>
<p><b>4. What is the immune system?</b></p>	<p>The body's method of protecting itself from germs</p> <p>Immune system develops antibodies in response to germs</p> <p>Antibodies attempt to eliminate germs</p>
<p><b>5. What are T-cells?</b></p>	<p>Also called CD4 cells, these are part of the immune system</p> <p>Recognize germs and tells the immune system to fight them</p> <p>HIV destroys T-cells as HIV reproduces</p> <p>Without T-cells, the immune system no longer recognizes germs, and therefore does not fight them off</p>

<p><b>6. HIV is a retrovirus. What is a retrovirus?</b></p>	<p>Retroviruses cannot reproduce on their own; instead they invade T-cells and then use T-cells to produce more virus</p> <p>As new HIV breaks out of the T-cell, the T-cell is destroyed; new HIV particles find more T-cells, make more HIV, and destroy more T-cells</p>
<p><b>7. How does HIV make people sick?</b></p>	<p>HIV weakens the immune system by destroying T-cells (CD4 cells)</p> <p>As the immune system is weakened, it cannot protect the person from other germs it comes in contact with</p> <p>Germs that normally would not harm a person can have a major impact because the immune system is impaired</p>
<p><b>8. What are the major characteristics of HIV?</b></p>	<p>Lifelong infection; once infected, always infected</p> <p>HIV mutates as it reproduces, making it difficult to develop medications that work over long periods of time</p> <p>Damages the immune system</p> <p>Easily destroyed when outside of the body; HIV is no longer infectious after contact with air for several seconds</p>
<p><b>Question:</b></p>	<p><b>Response:</b></p>
<p><b>Question:</b></p>	<p><b>Response:</b></p>
<p>For more information, please visit one of the following:          NYSDOH: <a href="http://www.health.state.ny.us/diseases/aids/facts/index.htm">http://www.health.state.ny.us/diseases/aids/facts/index.htm</a>          NYCDOH: <a href="http://www.nyc.gov/html/doh/html/ah/ah.shtml">http://www.nyc.gov/html/doh/html/ah/ah.shtml</a>          CDC: <a href="http://www.cdc.gov/hiv/">http://www.cdc.gov/hiv/</a></p>	

**Frequently Asked Questions about HIV Transmission**

*Below are some frequently asked questions. What other questions might your clients ask? Write the questions in the boxes provided, and ask your supervisor for help in determining how to answer them.*

<p><b>1. How is HIV transmitted from person to person?</b></p>	<p>Body fluids from a person living with HIV must enter the blood stream or contact a mucous membrane of an uninfected person. This is called “exposure”</p> <p>Infection happens once HIV enters a cell and starts to reproduce</p> <p>Not every exposure to HIV leads to infection, which is why some people may not contract HIV even after unprotected sex or sharing injection equipment</p>
<p><b>2. What body fluids transmit HIV?</b></p>	<p>Blood, semen (and possibly precum), vaginal and cervical secretions, and breast milk contain enough virus to be able to transmit HIV from person to person</p> <p>Internal body fluids, found in the lungs, heart, joints, brain and spinal cord, are also infectious; people rarely come in contact with these fluids</p> <p>HIV is also present in saliva, tears, perspiration, urine, and feces, but in the amount of HIV present is not enough to transmit the virus through casual contact</p>
<p><b>3. How can sex transmit HIV?</b></p>	<p>Sexual transmission can happen when body fluids carrying HIV come in contact with a mucous membrane or torn skin</p> <ul style="list-style-type: none"> <li>• Anal intercourse (penis to rectum)</li> <li>• Vaginal intercourse (penis to vagina)</li> <li>• Oral sex (mouth to penis or vagina)—this is considered low to very low risk for HIV</li> <li>• Blood, semen, vaginal secretions directly on broken skin or mucous membrane</li> </ul>
<p><b>4. What does “the hierarchy of risk” mean?</b></p>	<p>Some forms of sex transmit HIV more easily than other. For example:</p> <ul style="list-style-type: none"> <li>▪ The rectum has one layer of very absorbent skin and very little natural lubrication</li> <li>▪ The vagina has two layers of skin and can produce natural lubrication</li> <li>▪ The mouth has three layers of skin and saliva (which may offer some protection against HIV)</li> </ul> <p>HIV is more easily transmitted through unprotected anal sex than vaginal sex, and oral sex is considered low to very low risk for HIV.</p>

<p><b>5. How can injection drug use transmit HIV?</b></p>	<p>HIV is found in blood and blood can be passed from person to person through shared injection equipment.</p> <ul style="list-style-type: none"> <li>• Blood caught in the needle point or syringe barrel</li> <li>• Blood can also collect near the plunger</li> <li>• Tourniquets used to “tie off” may also carry blood</li> <li>• Cookers used to prepare drugs</li> <li>• Filters (also called “cotton”)</li> </ul> <p>Hepatitis C Virus (HCV) lives outside the body longer than HIV and so is an even greater risk when injection equipment is shared</p>
<p><b>6. How is HIV transmitted from mother-to-child?</b></p>	<p>HIV transmission can happen from a pregnant mother living with HIV to her child before birth, during delivery, and after birth while breastfeeding (mostly through chapped, cracked nipples that leak blood)</p> <p>With medical care and medications, an HIV+ woman has less than a 1% chance of passing the virus on to her child; that number rises to 25% without medical treatment</p>
<p><b>7. What other ways is HIV transmitted?</b></p>	<p>Donor products: blood products, semen, donated body organs or tissues</p> <p>Tattooing, piercing, injecting steroids</p> <p>Occupational injury: needlesticks, recapping needles, blood splashes, risk of transmission is low</p>
<p><b>8. What is reinfection?</b></p>	<p>This is commonly used to refer to when people who are already infected with HIV come in contact with HIV again. For example, someone who is HIV positive may have unprotected sex with another person who is HIV positive.</p>
<p><b>Question</b></p>	<p>Response:</p>
<p><b>Question</b></p>	<p>Response:</p>
<p>For more information, please visit one of the following:          NYSDOH: <a href="http://www.health.state.ny.us/diseases/aids/facts/index.htm">http://www.health.state.ny.us/diseases/aids/facts/index.htm</a>          NYCDOH: <a href="http://www.nyc.gov/html/doh/html/ah/ah.shtml">http://www.nyc.gov/html/doh/html/ah/ah.shtml</a>          CDC: <a href="http://www.cdc.gov/hiv/">http://www.cdc.gov/hiv/</a></p>	

<b>What is Hepatitis C?<sup>3</sup></b>	
<p>“Hepatitis” is a general term that means inflammation of the liver. Hepatitis A, B and C are all viruses that can cause this inflammation. Each one is very different in the ways they are transmitted and the ways your body deals with them. None of the viruses is spread through casual contact (holding hands, hugging, sneezing, sharing food, etc.)</p>	
<b>Transmission</b>	<p>Hepatitis C (HCV) is a blood-borne virus that is largely transmitted through sharing injection equipment (including cookers, cotton, water and syringes), or needles for piercing or tattooing. Sexual transmission ranges from 5-15% and mother-to-child transmission during birth from (5%). There is also a small risk from occupational exposure for health care workers.</p>
<b>Symptoms</b>	<p>Jaundice (yellowing of the skin and whites of the eyes), fever, loss of appetite, diarrhea, vomiting, exhaustion. 75% of people infected with HCV report no symptoms and symptoms, when they do appear, may not be felt for as long as 30 years.</p>
<b>What’s the connection with HIV?</b>	<p>In the United States, about 1 in 3 people living with HIV are also co-infected with HCV. The rate varies from 50-90% based on the area. Risk of mother-to-child transmission of HCV is higher if the mother is HIV-positive (from 6% to 25%).</p>
<b>Treatment</b>	<p>There is no vaccine for Hepatitis C but treatment can help slow the virus and, for some people, clear the virus from the body. Side effects can be very challenging and may interfere with HIV medications. Early diagnosis and treatment by a specialist is important.</p>
<b>Prevention</b>	<p>HCV can live outside the body for several days. It is suggested not to share toothbrushes, razors or any item that could have blood on it, even if you can’t see blood with your eyes. For drug injectors, HCV can be prevented by not sharing needles, tourniquets, cotton, cookers or anything that could come in contact with blood. Sharing straws for snorting or pipes for smoking drugs (because of cracked or bleeding lips) is best avoided.</p>

<sup>3</sup> Information gathered from ACRIA (AIDS Community Research Initiative of America), as cited in *Peer Training Institute Adult Curriculum*, Cicatelli Associates, Inc.



## Syringe Disinfection for Injection Drug Users

**NOTE: This document is from: <http://www.cdc.gov/idu/>**

For 20 years, syringe disinfection has been a part of HIV prevention efforts for injection drug users (IDUs). Questions about it persist, however, because of limited scientific studies, varying recommendations on the right way to disinfect, and evidence suggesting that IDUs do not use this approach very much. This fact sheet presents basic information on disinfection, especially bleach disinfection. The central message is that disinfection is a back-up prevention strategy if the user cannot stop injecting; does not have a new, sterile syringe; and is about to inject with a syringe that has been used before.

### How Did Disinfection Become a Widely-used HIV Prevention Strategy?

The strategy of disinfecting syringes to prevent HIV emerged in California in the 1980s. East Coast epidemics among IDUs (especially in New York) made public health officials fear that HIV would be a major threat to California IDUs.

California IDUs, like those in other parts of the country, shared and reused syringes, in part because it was hard for them to get new, sterile ones. This greatly increased their [risk of HIV transmission](#). State law made it illegal for drug users to buy syringes from pharmacies and a crime to possess them. Restricted access to sterile syringes, combined with limited capacity of substance abuse treatment programs, forced prevention programs to focus on reducing injection-related risks among IDUs who would not or could not stop injecting. Field research in California showed that IDUs would act to reduce their risks if acceptable measures were available to them. One such measure was syringe disinfection with household bleach. (Disinfection means using something to kill viruses and bacteria that cause infection.) Laboratory tests had shown that bleach killed HIV. Bleach also was cheap, quick, and available everywhere.

Substance abuse treatment and access to sterile syringes through pharmacies, physician prescription, and syringe exchange programs are essential components of HIV prevention efforts among injection drug users. See “To Learn More About This Topic” at the end of this fact sheet for information on how to get fact sheets on these topics as well as other materials on HIV prevention among IDUs.

This led community programs to train outreach workers to teach IDUs how they could reduce the risk of infection by disinfecting their syringes and needles.

Distribution of bleach kits — small (usually 1-oz. size) bottles of full strength household bleach with instructions on how to disinfect syringes — quickly became a standard component of IDU prevention in San Francisco. Other U.S. cities then rapidly adopted this strategy.

### How Disinfection Can Reduce Transmission Risk: It Reduces the Number of Viruses and It Kills Them

Current disinfection recommendations are based on the following steps:

- Flush out blood, drugs, and other organic matter from the syringe. These can contain viruses and do interfere with the disinfection process.
- Disinfect the syringe.
- Rinse out the disinfectant.

The idea behind these steps is to reduce the risk of HIV transmission in two ways. First, flushing removes blood and drugs from the syringe, which reduces the number of viral particles. Second, using a disinfectant can kill remaining viruses so they can't infect anyone else. Instructions for disinfecting syringes usually include ways to make sure that viruses are removed and killed:

- Fill the syringe with clean water (such as water right from a tap or a new bottle of water).
- Shake or tap the syringe containing water or disinfectant (this dislodges particles and thoroughly mixes the water or disinfectant with material in the syringe); then squirt out and throw away the water; repeat until no more blood can be seen.
- Leave the water or disinfectant, especially the disinfectant, in the syringe for a while (in principle, the longer the better; for example, 30 seconds is better than 15 seconds); then squirt out the disinfectant.
- Rinse out the syringe with clean water (fill syringe, shake or tap, squirt out and throw away water); rinsing is done to get rid of disinfectant and any viruses left in the syringe.

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### **Does Disinfection Work Against Viral Hepatitis?**

Hepatitis B virus (HBV) and hepatitis C virus (HCV) cause serious illness among millions of people. They also are closely connected with HIV, injection drug use, and high-risk sexual behaviors. Many people think that disinfection doesn't work against HBV or HCV, but laboratory studies on HBV show that disinfection works against this bloodborne virus in the same ways that it does against HIV.

An important thing to remember about HBV and HCV is that the numbers of viruses in blood are much higher for HBV and HCV than they are for HIV. As a result, getting rid of as much blood as possible by flushing out and rinsing is especially important in reducing the risk of becoming infected with viral hepatitis.

### **The Link Between Preparing Injection Drugs and the Risk of Transmission**

The drugs used by IDUs (heroin, cocaine, amphetamines) usually are sold as a powder that must be dissolved in water before they can be injected. Some injection drugs, such as black-tar heroin, which is a gummy solid not a powder, must be heated in a spoon or bottle cap (a “cooker”) to speed up the dissolving. Once dissolved, the drug is drawn into a syringe through a filter (a “cotton”) that prevents small particles in the solution from clogging the needle. The drug is then injected into a vein. Sometimes, two or more IDUs will draw up drugs from the same cooker.

Before injecting, a user must be sure that the needle is in a vein. He or she does this by pulling back on the plunger after pushing the needle through the skin in a likely spot. Blood entering the syringe (“registering”) shows that the needle is in a vein. Once the drug has been injected, the IDU may pull back the plunger, drawing blood back into the syringe, and then re-inject it into the vein (“booting” or “jacking”). After injecting, the user rinses out the syringe with water to prevent any remaining blood from clogging the needle. Users often dissolve drug powder and rinse their syringes with water from the same container.

HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV) can be transmitted when IDUs share the same syringe. These viruses also can be transmitted when users divide drug solution among several syringes, share rinse water or a cotton or cooker, or mix the drug solution with a used syringe. Transmission can occur when any element — syringe, water, cotton, cooker, drug solution — becomes contaminated with blood that is infected with HIV, HBV, or HCV because that element can contaminate any other element it touches. Even if an IDU is careful to always use a new, sterile syringe to inject drugs, the process of sharing contaminated equipment, drug solution, or water can increase his or her risk of acquiring or transmitting HIV, HBV, or HCV. (For more information about drug preparation and viral transmission, see Koester, 1998.)

### **Disinfection Seems to Make Sense. What’s the Problem?**

#### *A Disinfected Syringe is NOT a Sterile Syringe*

If it is done carefully and thoroughly, disinfection can reduce the amount of live HIV, HBV, and HCV in a syringe. However, even the best disinfection procedure cannot guarantee that all viruses have been killed. The plastic syringes usually used by IDUs are designed for one-time use. They are not designed to be cleaned and used again.

Disinfected syringes do NOT meet the standards that are applied in all other settings in which people use syringes (such as hospitals, other health care settings, and insulin injections by people with diabetes). In these settings, people must use a new, sterile syringe for every injection.

For these reasons, a disinfected syringe is NOT as safe as a new, sterile syringe. Recommendations about disinfecting syringes with bleach or other agents apply ONLY to situations in which IDUs do not have sterile syringes.

#### *Scientists Have Limited Laboratory Evidence that Disinfection Works Against HIV in Syringes and Other Injection Equipment*

Scientists have published a small number of laboratory studies on the ability of bleach and other agents to kill HIV. These experiments try to mimic conditions faced by IDUs and usually test the impact of disinfection on blood to which HIV grown in a test tube has been added.

However, these conditions are not the same as those faced by IDUs, and findings are not definitive. In laboratory studies, fresh undiluted household bleach (5.25% sodium hypochlorite) appears to kill HIV pretty well. Scientists

also have tested whether other liquids can disinfect syringes. These liquids, which are sometimes used by IDUs, include dish detergent, rubbing alcohol, hydrogen peroxide, and fortified wine. Results of these few studies are limited.

Some research has found that even several vigorous rinses with clean water may be as effective as undiluted household bleach because they do a good job of reducing the number of infectious viruses.

Results of these studies depend on many things, including the strength of the agent, whether the HIV is in whole blood or by itself, and the steps used. Because few laboratory studies have been published, we have only limited data on disinfection as it is done by IDUs. As a result, we don't have clear answers to questions about which agents work best, the best disinfection procedures, or the time necessary for adequate disinfection.

Laboratory studies of the effect of disinfection on HBV and HCV are difficult because these viruses cannot be grown in a test tube. Studies with animals have shown that disinfection can prevent HBV transmission. Because HBV and HCV are similar, these findings may also be true for HCV. However, it's important to note that conditions in animal studies are not the same as those faced by IDUs.

#### *Studies of IDUs Do Not Prove That Bleach Disinfection Protects them Against HIV or Viral Hepatitis*

Studies have looked for differences in the number of new infections between injectors who say they always disinfect and injectors who say they do not disinfect. They have found no significant difference in new infections among IDUs in the two groups. Several factors may help explain these findings.

- Studies don't measure risk behaviors completely. Studies don't always collect detailed risk information and may focus only on an IDU's risky drug practices. As a result, a study focusing on disinfection may not show anything if the infection is due to something else, such as having unprotected sex with infected partners.
- Some studies have technical limitations. For example, sometimes it is hard for a scientist to know whether a person is really a "disinfector" or a "non-disinfector." IDUs in the study may not remember correctly whether or how many times they used bleach during a certain period in the past. Or, they may think that saying they used bleach is the answer the scientists want to hear. As a result, IDUs who say they disinfect may seem to be at the same risk of infection as those who say they don't disinfect.

#### *Barriers Make it Hard for IDUs to Disinfect Correctly and Can Prevent Them from Doing It At All*

IDUs may agree that disinfection is a good idea if they cannot get new, sterile syringes. However, some investigators have found that few IDUs actually use bleach to disinfect syringes or they don't go through all the recommended steps if they do use it. Many factors make it hard for IDUs to disinfect:

- Current instructions involve a lot of steps and IDUs may think it is impossible to do correctly.
- IDUs may not be able to get clean water.
- They may not want to carry bleach or other disinfectants because it marks them as drug users.
- Withdrawal symptoms (being "drug sick") and the overpowering need to inject as soon as possible also may drive an IDU to inject without disinfecting.
- Some IDUs need help to inject and other people give them the injection. The person doing the injecting may not disinfect thoroughly.

- Drug users may not have time to disinfect carefully because they must prepare the drug solution and inject quickly (for example, police are nearby).
- Once the IDU has injected, the effects of the drug may prevent him or her from disinfecting carefully before the next injection (this may be especially true with cocaine, which is commonly injected multiple times in a drug use session).

### **Bleach has Advantages and Disadvantages as a Disinfectant**

#### **Advantages:**

- It can reduce the amount of infectious HIV, HBV, and HCV in a used syringe.
- It is readily available.
- It is inexpensive.

#### **Disadvantages:**

- IDUs, outreach workers, and policymakers may mistakenly believe that disinfecting with bleach is as safe as using a new, sterile syringe.
- It does not sterilize the syringe, so the syringe may still carry infectious organisms after disinfection.
- Studies have not shown that bleach disinfection prevents HIV or HCV transmission among IDUs.
- If a person carries small bottles of bleach, police may assume he or she is a drug user.
- Sunlight, warm temperatures, and exposure to air gradually weaken bleach so that it doesn't work anymore; IDUs have to be sure to use fresh, full-strength bleach.
- It damages the syringe.

### **What are the Take-Home Messages?**

- The way that an IDU prepares and injects drugs is important in determining the risk of that person getting or transmitting HIV, HBV, and HCV:
  - Any item — syringe, water, drug solution, cooker, cotton — that is contaminated with blood containing these viruses can contaminate all the other items.
  - Even if an IDU uses a sterile syringe each time, he or she can become infected if the drug solution or preparation equipment is shared with others who are infected.
- Disinfection will not make injecting drugs “safe.” It may make injecting “less risky” because it can reduce the number of and kill some of the HIV, HBV, or HCV in a syringe. As a result, disinfection can be a useful back-up strategy for IDUs.
- We don't have clear, consistent laboratory evidence about the best disinfection procedure and we don't know how effective this strategy is. So, we suggest steps that seem logical.
- Disinfection should be used only when an IDU has no safe options for preventing transmission.
  - Disinfection is not as good as stopping injecting, getting into substance abuse treatment, using a new sterile syringe, and not sharing drug solution and equipment.
  - Bleach and other disinfectants do NOT sterilize the syringe.

**Keeping Everything Clean is an Important Part of Reducing HIV and Viral Hepatitis Risk**

More and more, health workers are realizing that cleanliness and good hygiene can help reduce an IDU’s risk of getting or transmitting HIV or viral hepatitis. Good hygiene can also help prevent sores and bacterial infections in the skin where IDUs inject. The following tips are an important part of the prevention message to IDUs who cannot or will not stop injecting:

- Wash your hands and arms before preparing to inject.
- Use a clean surface to prepare drugs for injection, or spread out a piece of clean paper.
- Use an alcohol pad to clean the skin where you’re going to inject.
- After injecting, use a gauze pad to stop the bleeding.
- Put a bandage on the place where you injected.
- Throw away the used alcohol pad and gauze and all the other drug preparation equipment.
- Clean anything else blood might have touched (such as the tourniquet, your injecting space, or your clothes).
- Safely dispose of the syringe.
- Wash your hands again to clean off dirt, blood, and viruses.

Sources: Marcia Bisgyer of SafetyWorks, Inc., Mamaroneck NY, and Allen [Clear of Harm Reduction Coalition](#), New York, NY

**What Should We Tell IDUs?**

Education and outreach workers should stress the following messages when they talk to IDUs:

Disinfection should be used ONLY when an IDU has no safe options for preventing transmission.

- The best way for you to prevent HIV, HBV, and HCV transmission is to NOT inject drugs.
- Entering substance abuse treatment can help you reduce or stop injecting. This will lower your chances of infection.
- Get vaccinated against hepatitis A and hepatitis B. You can prevent these kinds of viral hepatitis if you get vaccinated.
- If you cannot or will not stop injecting, you should:
  - Use a new, sterile syringe obtained from a reliable source to prepare and divide drugs for each injection.
  - Never reuse or share syringes, water, cookers, or cottons.
  - Use sterile water to prepare drugs each time, or at least clean water from a reliable source.
  - [Keep everything as clean as possible](#) when injecting .

If you can’t use a new, sterile syringe and clean equipment each time, then disinfecting with bleach may be better than doing nothing at all:

- Fill the syringe with clean water and shake or tap.
- Squirt out the water and throw it away. Repeat until you don’t see any blood in the syringe.
- Completely fill the syringe with fresh, full-strength household bleach.
- Keep it in the syringe for 30 seconds or more.
- Squirt it out and throw the bleach away.
- Fill the syringe with clean water and shake or tap.
- Squirt out the water and throw it away.
- If you don’t have any bleach, use clean water to vigorously flush out the syringe:
  - Fill the syringe with water and shake or tap it.
  - Squirt out the water and throw it away.
  - Do this several times.

## To Learn More about This Topic

Visit websites of the [Centers for Disease Control and Prevention](#) and the [Academy for Educational Development](#) ■ for these and related materials:

- Preventing Blood-borne Infections Among Injection Drug Users: A Comprehensive Approach, which provides extensive background information on HIV and viral hepatitis infection in IDUs and the legal, social, and policy environment, and describes strategies and principles of a comprehensive approach to addressing these issues.
- Interventions to Increase IDUs' Access to Sterile Syringes, a series of six fact sheets.
- Drug Use, HIV, and the Criminal Justice System, a series of eight fact sheets.
- Substance Abuse Treatment and Injection Drug Users, a series of six fact sheets.
- Viral Hepatitis and Injection Drug Users, a series of five fact sheets.
- Small numbers of these publications can be ordered at no charge from [www.cdc.gov/idu](http://www.cdc.gov/idu).

**See the July 1994 issue of the *Journal of Acquired Immune Deficiency Syndromes*.** This issue of the Journal includes seven papers from a workshop on the use of bleach to disinfect drug injection equipment. The papers provide an historical perspective on the use of bleach in HIV/AIDS prevention activities, review results of laboratory studies on the effectiveness of various agents in inactivating HIV, and describe the results of field studies on the disinfection practices of IDUs. (*Journal of Acquired Immune Deficiency Syndromes* 1994;7(7):741-776.)

**See the April 1993 CDC/CSAT/NIDA HIV/AIDS Prevention Bulletin.** This publication reviews the topic of disinfection and concludes that stopping injection or using new, sterile syringes is superior to disinfection. (Curran JC, Scheckel LW, Millstein RA. HIV/AIDS prevention bulletin. Centers for Disease Control, Center for Substance Abuse Treatment, and National Institute on Drug Abuse, April 19, 1993.) [www.cdc.gov/idu/pubs/bleach\\_letter.htm](http://www.cdc.gov/idu/pubs/bleach_letter.htm)

### Check out these sources of information:

Abdala N, Crowe M, Tolstov Y, Heimer R. Survival of human immunodeficiency virus type 1 after rinsing injection syringes with different cleaning solutions. *Substance Use & Misuse* 2004;39(4):581-600.

Abdala N, Gleghorn AA, Carney JM, Heimer R. Can HIV-1-contaminated syringes be disinfected? Implications for transmission among injection drug users. *Journal of Acquired Immune Deficiency Syndromes* 2001;28(5):487-494.

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Centers for Disease Control and Prevention. [Recommendations for prevention and control of hepatitis C virus \(HCV\) infection and HCV-related chronic disease](#). *Morbidity and Mortality Weekly Report* 1998;47(RR 19):1-39.

Ciccarone D, Bourgois P. Explaining the geographical variation of HIV among injection drug users in the United States. *Substance Use & Misuse* 2003;38(14):2049-2063.

Clatts MC, Heimer R, Abdala N, et al. HIV-1 transmission in injection paraphernalia: heating drug solutions may inactivate HIV-1. *Journal of Acquired Immune Deficiency Syndromes* 1999;22(2):194-199.

Hagan H, Thiede H. Does bleach disinfection of syringes help prevent hepatitis C virus transmission? [letter] *Epidemiology* 2003;14(5):628-629.

Hagan H, Thiede H, Weiss NS, et al. Sharing of drug preparation equipment as a risk factor for hepatitis C. *American Journal of Public Health* 2001;91(1):42-46.

Hughes RA. Drug injectors and the cleaning of needles and syringes. *European Addiction Research* 2000;6(1):20-30.

Kapadia F, Vlahov D, Des Jarlais DC, et al. Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users? *Epidemiology* 2002;13(6):738-741.

Koester SK. Following the blood: syringe reuse leads to blood borne virus transmission among injection drug users. [letter] *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology* 1998;18(Suppl 1):S139-S140.

Normand J, Vlahov D, Moses LE, eds. [Preventing HIV transmission: the role of sterile needles and bleach](#). ■ Washington, DC: National Academy Press, 1995. Chapter 6, The effectiveness of bleach as a disinfectant of injection drug equipment.

Sattar SA, Tetro J, Springthorpe VS, Giulivi A. Preventing the spread of hepatitis B and C viruses: Where are germicides relevant? *American Journal of Infection Control* 2001;29(3):187-197.

Thorpe LE, Ouellet LJ, Hershow R, et al. Risk of hepatitis C virus infection among young adult injection drug users who share injection equipment. *American Journal of Epidemiology* 2002;155(7):645- 653.

United States Public Health Service (USPHS). [HIV prevention bulletin: medical advice for persons who inject illicit drugs](#). Atlanta (GA) and Rockville (MD): USPHS, May 9, 1997.

<b>Responding to Questions</b>	
<b>Type of Question</b>	<b>Tips on how to respond</b>
Personal (information about the Peer Advocate):	You should decide what information about yourself you are willing to share, and what you are not willing to share. As a Peer Advocate, you may want to share some information about yourself with the client. However, you should share information only if it in some way is helpful to the client or your professional relationship with the client.
Challenging (challenging the authority or right of the Peer Advocate to be presenting information):	Don't get in arguments with clients; acknowledge the client and his or her concerns. Recognize that not all people will agree with you, or want the information you have to share. Be sure to identify where your information comes from.
Don't Know (fact-based questions that Peer Advocate doesn't know answer to)	Never make up an answer to a question. It is always better not to know than to guess. It is okay to say "I don't know." Tell the person you will find out the information, and get back to them with it.
Opinion questions (questions that don't have a specific, fact-based answer)	Opinion questions can often be turned back to the client: for example, if someone asks, "What's the best way to do that?" the Peer Advocate can respond by asking, "What has worked best for you?" or "What have you tried?" Emphasize that there are many different ideas about that issue and each person must choose what is best for him or herself.





# Section IV: Adherence Support

Another important task of the Peer Advocate is to help clients with adherence to medical treatments and other issues, such as attending appointments. It is important to realize that improving adherence to a new behavior is a behavior change process. Your clients may need different types of support from you depending on where they are in this process.

When a client is trying to adjust to a medical regimen, they will need to address numerous issues before they can adhere consistently. The “Nine Steps to Adherence” indicates tasks the Peer Advocate can do that can help the client adjust to their medical regimen and adhere to treatment.

**Refer to:**

	<b>PAGE</b>
Tool # 17: Nine Steps	52

Taking HIV medications is difficult, and to be successful, the client must have significant knowledge and skills to aid them in this venture. The Peer Advocate can use the Assessment Readiness Checklist to identify in which areas the client may need additional support in order to successfully manage HIV medications.

**Refer to:**

	<b>PAGE</b>
Tool #18: Assessing Readiness for Treatment	53

After assessing client readiness, the Peer Advocate can share this assessment with the clinic team to determine how each member of the team will proceed to improve the client’s readiness for treatment.

**Refer to:**

	<b>PAGE</b>
Tool #19: Readiness for Treatment Adherence	55

When client is ready to begin treatment, Peer Advocates can complete the “Adherence Counselor’s Checklist” to assure that they have prepared the client for taking medications. This tool can also be used to indicate what additional supports the client might need, and can be shared with the team.

**Refer to:**

	<b>PAGE</b>
Tool #20: Adherence Counselor’s Checklist	56

Many different issues can impact on a client’s ability to adhere to medical treatments. These include: the complexity of the treatment regimen, the duration of the treatment, the costs

associated with treatment, the need for behavioral or lifestyle changes in order to manage the medication, and side effects of the medication.

Peer Advocates can play an important role in assisting their HIV positive clients with side effects. Peer Advocates can advise clients of possible side effects, can serve as an important "bridge" between the patient and the physician, and, most importantly encouraging the patient to discuss any side effects with the physician.

**Refer to:**

Tool #21: Managing Side Effects

**PAGE**  
57

Taking medications involves significant behavioral changes on the part of the client. Behavior change can be difficult, and the Peer Advocate can help motivate the client by remaining supportive, and affirming the client's work. Affirmations can help keep the client motivated.

**Refer to:**

Tool # 22: Affirmations

**PAGE**  
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# Section IV: Adherence Support TOOLS









<b>TOOLS:</b>	<b>PAGE</b>
Tool # 17: Nine Steps	52
Tool # 18: Assessing Readiness for Treatment	53
Tool #19: Readiness for Treatment Adherence	55
Tool #20: Adherence Counselor's Checklist	56
Tool #21: Managing Side Effects	57
Tool #22: Affirmations	60

**Nine Steps Toward Adherence**

*Each of the Nine Steps listed below indicate tasks the Peer Advocate can accomplish to help clients with adherence. Think of what you can do at each of the Nine Steps and write it in the space indicated. Ask other Peer Advocates for suggestions, and share your work with your supervisor. NOTE: The first step is completed as an example.*

Step	You can ...
Establish Trust	Communicate clearly, build rapport, develop an open relationship, assure confidentiality, maintain a safe relationship
Identify & Respect Beliefs	
Assess Current Situation	
Provide Treatment Education	
Facilitate Motivation and Readiness	
Identify & Enhance Self-Efficacy	
Facilitate Decision Making	
Establish an Action Plan	
Support & Maintenance	

<b>Assessing Readiness for Treatment</b>				
<i>Is the client aware of . . . ?</i>	<i>Yes</i>	<i>No</i>	<i>Some what</i>	<i>Not Sure</i>
<p><b>1. Treatment for HIV/AIDS infection</b></p> <ul style="list-style-type: none"> <li> <i>Understand the illness itself</i></li> <li> <i>Understand the goals of treatment</i></li> <li> <i>Recommended T-Cell Count</i></li> <li> <i>Recommended Viral Load Count</i></li> <li> <i>Drugs that are available for treatment</i></li> </ul>				
<p><b>2. Adherence to treatment for HIV/AIDS</b></p> <ul style="list-style-type: none"> <li> <i>Definition “What is adherence?”</i></li> <li> <i>How strict adherence is important to treatment success</i></li> <li> <i>Range of Non-adherent behaviors</i> <ul style="list-style-type: none"> <li><i>a. Failure to take medications</i></li> <li><i>b. Delay in seeking care</i></li> <li><i>c. Failure to accept treatment</i></li> <li><i>d. Missing appointments</i></li> <li><i>e. Premature termination of treatment</i></li> <li><i>f. Failure to take recommended preventive measures</i></li> <li><i>g. Substituting own treatment programs</i></li> <li><i>h. Other. . .</i></li> </ul> </li> <li> <b>Common Causes of Non-Adherence</b> <ul style="list-style-type: none"> <li><i>a. Not believing treatment will work</i></li> <li><i>b. Not wanting to get better</i></li> <li><i>c. Secondary gains from illness</i></li> <li><i>d. Lack of feelings of self-efficacy</i></li> <li><i>e. Denial of medical situation</i></li> <li><i>f. Shame and concealment of illness</i></li> <li><i>g. Need to not feel different from others</i></li> <li><i>h. Not feeling ill or feeling better</i></li> <li><i>i. Unskilled or required technique</i></li> <li><i>j. Misunderstanding directions</i></li> <li><i>k. Unpleasant side effects</i></li> <li><i>l. Forgetting</i></li> <li><i>m. Substance use</i></li> <li><i>n. Medication procedure is a trigger for SA</i></li> </ul> </li> </ul>				

<p>O. <i>Cultural values</i>  p. <i>Mental illness</i>  q. <i>Financial problems</i>  r. <i>Other. .</i></p>				
<b>3. Aware of what behavior change(s) will be needed?</b>				
<b>4. Willing or able to change specific behaviors?</b>				
<b>5. Aware of the relationship of side effects to adherence?</b>				
<p><b>6. Does the client. . .</b>   <i>Live alone</i>   <i>Have supportive family</i>   <i>Have supportive friends</i>   <i>Have supportive providers</i>   <i>Have a mental illness</i></p>				
<b>7. Knowledgeable of his/her history of adherent behavior</b>				
<b>8. Has the client been on a treatment regimen before?</b>				
<b>9. Able to afford the medications needed for treatment?</b>				
<p><b>10. Able to fit treatment in to present lifestyle?</b>   <i>Major adjustments needed</i>   <i>Minor adjustments needed</i>   <i>No adjustments needed</i></p>				

<b>Readiness for Treatment Adherence</b>		
<i>Readiness Category</i>	<i>Sources of nonadherence (risk factors)</i>	<i>Selected Strategies</i>
<b>Low Readiness Low Motivation to use Medications</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Misperceptions, misunderstandings, and/or uncertainties about the significance of the presenting problem</li> <li><input type="checkbox"/> Fears about unintended consequences of change</li> <li><input type="checkbox"/> Doubts about whether change is possible or within reach</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Ask open questions to encourage client to talk about their concerns</li> <li><input type="checkbox"/> Be empathetic</li> <li><input type="checkbox"/> Provide feedback</li> <li><input type="checkbox"/> Correct misconceptions of inaccurate information</li> <li><input type="checkbox"/> Normalize anxiety about change</li> <li><input type="checkbox"/> Encourage client to talk about their fears</li> <li><input type="checkbox"/> Reviewing past successes</li> <li><input type="checkbox"/> Affirming small steps</li> </ul>
<b>Some Readiness Motivated, but still ambivalent</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Uncertainty or ambivalence about change</li> <li><input type="checkbox"/> Concerns about the suitability of the treatment modality offered</li> <li><input type="checkbox"/> Misperceptions about treatment</li> <li><input type="checkbox"/> Previous negative treatment experiences</li> <li><input type="checkbox"/> Negative therapist or treatment outcome expectancies</li> <li><input type="checkbox"/> Negative general relationship expectancies</li> <li><input type="checkbox"/> Culture-specific differences</li> <li><input type="checkbox"/> Stigma</li> <li><input type="checkbox"/> Mandated treatment; coercion</li> <li><input type="checkbox"/> High barriers to care (financial problems, family hardships)</li> <li><input type="checkbox"/> Low self-efficacy in handling treatment demands</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Assure for rapport and open communication</li> <li><input type="checkbox"/> Be empathetic</li> <li><input type="checkbox"/> Explore understandings of how treatment works</li> <li><input type="checkbox"/> Provide information about how treatment works</li> <li><input type="checkbox"/> Elicit perceptions of treatment</li> <li><input type="checkbox"/> Providing information of treatment</li> <li><input type="checkbox"/> Explore pros and cons of taking medication with client</li> <li><input type="checkbox"/> Discuss benefits of treatment</li> <li><input type="checkbox"/> Reviewing past treatment experiences</li> <li><input type="checkbox"/> Negotiating short term goals</li> <li><input type="checkbox"/> Acknowledge the difficulties of adherence</li> <li><input type="checkbox"/> Identifying positive experiences of receiving help</li> <li><input type="checkbox"/> Identify barriers to adherence and work with client to develop strategies to address these barriers</li> <li><input type="checkbox"/> Display optimism about treatment effectiveness</li> <li><input type="checkbox"/> Identify skills needed for adherence and help client develop these skills</li> </ul>
<b>Ready and Willing to adopt new behaviors</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> May already be doing new behavior</li> <li><input type="checkbox"/> Specific problems or situations may arise that make maintaining the new behavior difficult</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Identify possible problems and provide specific problem solving strategies, and contingency planning</li> <li><input type="checkbox"/> Provide support, reassurance</li> </ul>

*Motivational Interviewing: Preparing People for Change, Miller & Rollnick, 2002*



<b>Adherence Counselor's Checklist</b>			
<i>Issue</i>	<i>Yes</i>	<i>No</i>	<i>Comment</i>
1. Have I identified any adherence barriers and made a plan on how to overcome them in collaboration with the client?			
2. Have I linked the client to identified concrete and/or other social services?			
3. Have I reviewed with the client his/her daily routines and dosing schedule(s)?			
4. Have I provided adherence and treatment education?			
5. Have I provided the client with tools to help with taking the medications?			
6. Did I have the client repeat dosing times and instructions?			
7. Did I provide the client with written and/or visual instructions?			
8. Does the client know how to contact me with questions or problems?			
9. Has a follow up appointment been scheduled and does the client know when it is?			

## Managing Side Effects

*The following is a list of side effects that HIV positive clients on medication might experience. Many side effects can be managed with other medications or adjustments to the treatment regimen. The information below is provided only to help familiarize non-physicians with side effects and possible treatments that physicians may prescribe.*

<b>Nausea &amp; Vomiting</b>	<ul style="list-style-type: none"> <li>ⓧ Can be managed with a variety of antiemetics (e.g. Compazine, Phenergan)</li> <li>ⓧ If severe (e.g. patient cannot eat or drink) holding or changing the medication may be in order</li> <li>ⓧ Diet can help with symptoms- B.R.A.T. (bananas, rice, applesauce, toast); peppermint, chamomile or ginger tea, cold carbonated drinks.</li> <li>ⓧ Avoid hot, spicy, strong- smelling and greasy foods.</li> </ul>
<b>Diarrhea</b>	<ul style="list-style-type: none"> <li>ⓧ Very common with Nelfinavir (Viracept) .</li> <li>ⓧ Usually can be controlled with Imodium</li> <li>ⓧ Calcium has also been found to be helpful</li> <li>ⓧ Diet Management- drink lots of fluids to prevent dehydration, avoid foods that are greasy, high fiber or sweet; Avoid milk products</li> <li>ⓧ May persist &amp; medication change may be necessary</li> </ul>
<b>Decreased Appetitive</b>	<ul style="list-style-type: none"> <li>ⓧ Common with many ARVs</li> <li>ⓧ Some patients respond to appetite stimulants (e.g. Magace, Marinol)</li> <li>ⓧ Nutritional support is helpful ( e.g. Ensure, Boost, Nutrivir)</li> <li>ⓧ If persistent, may require medication change</li> </ul>
<b>Rash</b>	<ul style="list-style-type: none"> <li>ⓧ Occurs most commonly with Nevirapine, Sustiva, Abacavir</li> <li>ⓧ Can be managed with Benadryl or Atarax</li> <li>ⓧ Provider MUST be made aware these symptoms because they can become life-threatening</li> <li>ⓧ Avoid hot showers or baths</li> <li>ⓧ Use mild soap or oatmeal soap</li> <li>ⓧ Protect skin from sun exposure</li> </ul>

<p><b>Insomnia &amp; Dizziness</b></p>	<ul style="list-style-type: none"> <li>ⓧ Common with Sustiva</li> <li>ⓧ Can be managed with sleep aids (e.g. Benadryl, Ambien)</li> <li>ⓧ Timing of dosing can be changed</li> </ul>
<p><b>Hepatitis or Pancreatitis</b></p>	<ul style="list-style-type: none"> <li>ⓧ Usually manifest as abdominal pain</li> <li>ⓧ Provider <b>MUST</b> be made aware</li> <li>ⓧ Evaluation with blood tests and imaging studies may be necessary</li> </ul>
<p><b>Fatigue, Muscle Aches, Headache, Malaise</b></p>	<ul style="list-style-type: none"> <li>ⓧ Non-specific complaints</li> <li>ⓧ May indicate a developing underlying process (e.g. anemia, neutropenia, thrombocytopenia, myopathy)</li> <li>ⓧ Regular follow up should uncover any serious problems</li> </ul>
<p><b>Neuropathy</b></p>	<ul style="list-style-type: none"> <li>ⓧ Commonly seen with 001 (Videx), OOC (Hivid), 04T (Zerit)</li> <li>ⓧ Usually managed with combination of analgesia (NSAIOs, narcotics), Elavil, Neurontin</li> <li>ⓧ Any symptoms of tingling, numbness and pain in the hands or feet <b>MUST</b> be reported to provider</li> <li>ⓧ Wear loose fitting shoes</li> <li>ⓧ Keep feet uncovered in bed</li> <li>ⓧ Medication change usually needed</li> </ul>
<p><b>Kidney Stones</b></p>	<ul style="list-style-type: none"> <li>ⓧ Seen with Indinavir (Crixivan)</li> <li>ⓧ Due to lack of proper hydration</li> <li>ⓧ Abdominal pain is the common manifestation</li> <li>ⓧ Blood in urine and pain with urination can be present</li> </ul>
<p><b>Lipid/fat Abnormalities</b></p>	<ul style="list-style-type: none"> <li>ⓧ Seen with long term use of antiretroviral (esp. NRTI's and PI's)</li> <li>ⓧ Manifests as fat redistribution such as: thinning of arms and legs with accumulation of central fat</li> <li>ⓧ Increases in cholesterol and triglycerides</li> <li>ⓧ Switching of medications might be helpful</li> <li>ⓧ It is important to follow up with provider for regular cholesterol/TG checks</li> <li>ⓧ If levels are high enough fat lowering drugs may be required</li> </ul>

<p><b>Glucose Abnormalities</b></p>	<ul style="list-style-type: none"> <li>⌘ Seen with long term use of antiretrovirals (NRTI's and PI's )</li> <li>⌘ Levels of glucose increase as in diabetes</li> <li>⌘ Switch to NNRTI's can be helpful</li> <li>⌘ Ultimately may require treatment for diabetes</li> </ul>
<p><b>Bone Abnormalities</b></p>	<ul style="list-style-type: none"> <li>⌘ Some correlation between use of ARV ( esp. PI's) and osteopenia (thin bones)</li> <li>⌘ Similar connection with development of avascular necrosis (hip joint destruction)</li> <li>⌘ Calcium supplementation recommended</li> <li>⌘ Development of hip pain requires thorough evaluation</li> </ul>
<p><b>Drug Interactions</b></p>	<ul style="list-style-type: none"> <li>⌘ Some HIV medications can lead to increases and decreases in the levels of other drugs that are taken concurrently (e.g. methadone)</li> <li>⌘ Some of these interactions can be life threatening or may lead to inadequate therapy</li> <li>⌘ Clients should tell their doctor all the medications they are taking, including over-the-counter medications</li> </ul>

**AFFIRMATIONS**

*Affirmations are statements of recognition of the client’s strengths. They help build the client’s confidence their ability to manage the changes. To be effective, affirmations must be genuine. When clients can’t see their own strengths or progress, the Peer Advocate’s affirmations can show the client positive aspects of their behaviors.*

*Read the situations below, and the sample affirmations that are provided. Then, in the space provided, add sample affirmations of your own.*

*Ask other Peer Advocates about other situations that you might encounter. Write those in the spaces provide and include and the affirmations you might use in those circumstances.*

<i>Situation</i>	<i>Sample Affirmation</i>	<i>Your Affirmation</i>
Client decided to begin medications, but has been having trouble keeping to the regimen	“I appreciate how hard it must have been for you to decide to take medications”	
The client has been having trouble with side effects, and says he has “tried everything” and doesn’t know what else to do except quit taking medications.	“I think it is great that you want to do something about this problem.”	
Client complains that taking medications is hard, and doesn’t know how anyone can do it.	"I must say, if I were in your position, I would find it difficult too."	
Client states that she can’t seem to manage taking care of children, trying to pay the bills and taking care of her own health. Sometimes it’s easier to just not take her meds.	”You certainly have to cope with a lot of problems right now.”	
Other:		
Other:		

# Section V: Advocating for Clients

The Peer Advocate is in a unique position to speak for the client within the multidisciplinary team. As a client advocate, you:

1. Represent your client whose needs you are seeking to meet.
2. Assess issues and information that affect clients and the services they need.
3. Bring the client's interests to your team and other decision makers.
4. Bring the client information from your team and other decision makers.
5. Represent your team to other agencies and organizations.

The first step is to understand the client's needs and develop a plan for advocating for the client.

## Refer to:

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Tool #23: Steps to an Advocacy Plan	63

A case conference is an excellent format in which to share information about the client and advocate for the client's needs and concerns. However, you will be most successful if you plan what and how to present at the case conference.

## Refer to:

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Tool #24: Case Conferencing	65
Tool #25: Case Conference Preparation	66

It is also important to review how to present information in the case conference. A successful Peer Advocate is assertive without being aggressive.

## Refer to:

	<b>PAGE</b>
Tool #26: Tips on Being Assertive	67

Finally, Peer Advocates can assess their effectiveness in advocating for clients. Reviewing the self-assessment with a supervisor can lead to developing strategies to become even more successful in the future.

## Refer to:

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Tool #27: Advocacy Self-Assessment	68

# Section V: Advocating for Clients

## TOOLS

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<p><b>Steps to an Effective Advocacy Plan</b></p> <p>The advocacy plan is developed with input from clients. You can also consult with your multidisciplinary team members who have expertise in your client’s area of need, and your supervisor.</p>	
<p>Step 1.</p> <p><b>Define the Problem and Identify Solutions</b></p>	<p>A. Describe the problem</p> <ul style="list-style-type: none"> <li>• Clients present with multiple needs. It is important to define specific problems and prioritize them.</li> <li>• Write out a short statement of the problem.</li> </ul> <p>B. Describe the ideal solution and list alternate acceptable solution(s).</p> <ul style="list-style-type: none"> <li>• List the issues and the results you hope to achieve.</li> <li>• Prepare your client for compromise. Because you may not get everything you desire, identify alternatives to the ideal outcome that would also be acceptable.</li> </ul>
<p>Step 2.</p> <p><b>Identify Resources and Information Needed to Support a Solution</b></p>	<p>A. Resources/information</p> <ul style="list-style-type: none"> <li>• List the information/resources you already have and the information/sources you need to reach the desired outcome.</li> </ul> <p>B. People who can help achieve the solution</p> <ul style="list-style-type: none"> <li>• List the people who can help you achieve your solution.</li> <li>• Describe how they can help you.</li> </ul>
<p>Step 3.</p> <p><b>Advocate for your Client</b></p>	<p>A. Identify decision makers, people to talk with to advocate for your client</p> <ul style="list-style-type: none"> <li>• List the decision maker(s) who can give you what you want</li> <li>• Note: Decision Makers are always people, not agencies</li> </ul> <p>B. Develop a message to use when advocating for your client</p> <ul style="list-style-type: none"> <li>• List the 3 most important points to cover.</li> <li>• Describe why your position deserves support.</li> <li>• Provide clear, concrete information to support your position.</li> <li>• Focus on needs, and your proposed solution:</li> <li>• List the needs our position would address.</li> </ul>



	<ul style="list-style-type: none"> <li>• Explain why each need is important.</li> <li>• Explain how your position/idea will meet each need.</li> </ul> <p>C. Meet with decision makers and use your message to advocate for your client</p> <ul style="list-style-type: none"> <li>• Be direct and clear.</li> <li>• Use appropriate eye contact and other non-verbal communication skills.</li> <li>• State what you want in an assertive manner.</li> <li>• Listen for their response to your position.</li> <li>• Answer questions and clarify information. □</li> </ul>
<p>Step 4.</p> <p><b>Assess the Outcome and Identify Next Steps</b></p>	<p>A. Agreements Reached</p> <ul style="list-style-type: none"> <li>• What agreements were reached?</li> <li>• List any remaining issues and the plan to address them.</li> </ul> <p>B. Next Steps</p> <ul style="list-style-type: none"> <li>• List the tasks that must be completed, include who will do what</li> </ul>

**Case Conferencing**

Case conferencing is a gathering of providers who work with a specific client. Case conferencing can be a casual meeting between a few team members or a more formal meeting with agencies outside your own. The goal is to think together about identifying problems, coming up with solutions, and developing next steps.

When presenting a client in a case conference, you may want to answer the following questions first.

<p><b>1. What do I want to achieve with this client? What does the client want to achieve?</b></p>	
<p><b>2. What are the issues or problems in the way of this goal?</b></p>	
<p><b>3. What interventions have I tried? What worked in the past?</b></p>	
<p><b>4. What was the client's response to the interventions?</b></p>	
<p><b>5. What are possible interventions I can try now?</b></p>	
<p><b>6. How will I work in collaboration with the client, and what could get in the way of our collaboration?</b></p>	
<p><b>7. How will I work in collaboration with other staff or providers?</b></p>	
<p><b>8. Do I need help or resources in implementing this intervention?</b></p>	
<p><b>9. If the client doesn't respond to this intervention, or if the behaviors becomes more serious, what can be done?</b></p>	

**Case Conference Preparation**

**Before you meet for a case conference with someone outside of your agency, make sure to:**

- Be well rested
- Know the material
- Practice the presentation
- Know your goal
- Organize your notes
- Check all your materials
- Note the address and how to get to the case conference
- Arrive early

### **Tips on Being Assertive**

- Be prepared.
- Know what you want to say and how you want to say it.
- Be prepared for potential obstacles or resistance.
- Use body language that communicates confidence.
- Make eye contact.
- Stand or sit up straight.
- Monitor your emotions.
- Focus on the solution, not on blaming the other person.
- Be calm and open, not angry, aggressive or abrasive.
- Be concise and straightforward in your message.
- Speak clearly, firmly, and loudly enough to be easily heard.
- Use fewer words for more effect.
- Use “I-statements” to identify what you want.
- Don’t apologize, or make excuses for your position.
- Respond to your audience.
- Listen for their response to your advocacy message.
- Answer questions and clarify information when asked.
- Be firm.
- Do not back down.
- Negotiate a compromise rather than give in completely.
- Stick to your goal, and do not allow yourself to become distracted.

### **Advocacy Self-Assessment**

Complete the following to see how you are doing as an advocate. Then, discuss this self assessment with your supervisor.

- A. Recall a time when you advocated for a client.**
  
- B. What was the issue?**
  
- C. How did you determine this was a client's needs?**
  
- D. What did you want to happen?**
  
- E. What happened?**
  
- F. What could you have done differently?**
  
- G. What are three steps you can take to be a better advocate?**

# Section VI: Confidentiality and Boundaries

Confidentiality means that you can share information about the client with your supervisor or other clinic staff as needed, and in some cases you must share the information. Confidentiality also means that you and the clinic's other staff will not share client information with anyone outside of the clinic, unless the client gives you permission.

**Refer to:**

	<b>PAGE</b>
Tool #28: Explaining Confidentiality	71

Although you are bound by confidentiality, clients are *not* obligated to keep information about you confidential. You should therefore decide what personal information you are willing to share with clients.

**Refer to:**

	<b>PAGE</b>
Tool #29: Checklist on Confidentiality Issues	72

Some information you get from clients you will have to share with your supervisor and/or your team. Be clear with your client about the difference between “confidential” and “secret” and let the client know what information will be shared.

**Refer to:**

	<b>PAGE</b>
Tool #30: Sharing Information with your Team	73

As a Peer Advocate, you can probably identify with your clients more than almost anyone else on your team. Some of your clients may even be people you know: they could be family, friends, people you've had sex with or shared drugs with, or just people you could run into on the street, on a bus, or in a grocery store.

While this familiarity can be a strength to your work, it can also be problematic. Even when you identify with the experiences of the client, you do not really share the same life as your client. To be effective as a Peer Advocate, it is important to maintain professional boundaries in your work.

Boundaries refer to limits defined by a worker, a client, or the policies and procedures of an agency. Supervision reinforces boundaries by helping you see where boundaries are blurry, and then coming up with ways to set and maintain limits. Talk with your supervisor to learn how to set and maintain boundaries and how to handle difficult situations.

**Refer to:**

	<b>PAGE</b>
Tool #31: What to Do About Typical Boundary Violations	74

# Section VI: Confidentiality and Boundaries TOOLS

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<b>Explaining Confidentiality</b>	
<b>Principles</b>	<b>How to explain it to a client</b>
Laws protect information about a client that you learn about through serving that client.	<p>“Confidentiality laws mean that I cannot tell anyone outside of the clinic anything about you, unless you give me your written consent.”</p> <p>“I can’t even let someone know you get services here, or that I know you.”</p> <p>“The only time we would ever reveal information without your consent would be if you are a danger to yourself or someone else. In that case, I’d talk to my supervisor and she would contact 911 or the police, to get you help. She wouldn’t reveal any information about HIV.”</p>
The professional standard is very high for protecting HIV information.	
The agency or anyone working for the agency—including peers— <i>cannot</i> release information without the patient’s written consent.	
This rule is absolute and is not open to interpretation. However, if a client is a harm to self or others your supervisor must report that.	
No matter what your relationship is outside the clinic, you must not reveal information to anyone outside of the clinic without written consent from your client.	
Inside your clinic, you must share information with your supervisor, and other team members, on a need to know basis.	<p>“I want to make sure you can trust me with the things you want to share with me.”</p> <p>“I will not tell anything to anyone outside of the clinic, unless you give me written permission.”</p> <p>“I also don’t keep secrets from my supervisor. Whatever you share with me, you’re also sharing with my supervisor.”</p>
As a client yourself, you probably already understand that sharing information without consent would make clients less likely to trust you.	



**Checklist on Confidentiality Issues**

*Being a Peer Advocate may sometimes feel like you're more of a 'friend' than a staff person. However, setting and maintaining boundaries about what you do and do not share about your personal life is your choice. Protect your confidentiality, not just the client's. Talk with other Peer Advocates and your supervisor about how to respond in the situations described below.*

<b>Sample Question</b>	<b>Your Answer</b>	<b>Who can you talk to about this issue?</b>
Do I want my clients to know my HIV status?		
How do I protect my own confidentiality?		
Does my job 'out' me as a person living with HIV/AIDS?		
What should I do if I have trouble taking my own meds?  Do I share that with the multidisciplinary team?		
How comfortable am I sharing about...  My drug use?  My HIV status?  My medication regimen?  My sex life?  My sex work?  My experience with domestic violence?  My experience with prison?		

**Sharing Information with your Team**

*Directions: Think of how you would respond in each of the situations below, and write your responses in the space provided. Then, consider who you would tell on your team about this issue. Be sure to check your responses with your supervisor.*

Scenario	What to say to the client	Who to bring issue to
A client tells you they aren't taking medications as prescribed.		
You hear from a neighbor that one of your clients is shooting drugs, but the client denies she is using.		
Your client threatens to hurt him or herself, or someone else.		
Your client asks you not to tell anyone else that her boyfriend beats her.		

**What to Do about Typical Boundary Violations**

*Think about how you would respond in each situation below, and write your responses in the spaces provided. Then, talk with your supervisor about how to handle these situations.*

The Situation	You can respond by...
A client asks you for money...	
A client flirts with you, wants to have sex with you, or touches you sexually...	
A client asks you for information about another client...	
A client asks you about your personal health and you do not want to share...	
A client asks for your home phone number	
You see the client when you are out shopping. You wonder if you should say "Hi?"	
A client sees you when you are off work and eating at a local restaurant. You are having a few drinks with your meal (you are over 21 years old). Your client buys you a drink and comes over to chat.	