The Utilization and Role of Peers in HIV Interdisciplinary Teams

Consultation Meeting Proceedings

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**U.S. Department of Health and Human Services
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I. Welcome and Introductions

On February 23, 2009, a consultation meeting was held to examine the use of peers[1] in HIV interdisciplinary care settings. The meeting was convened by the U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIVAIDS Bureau (HAB). Participants included HRSA representatives, Ryan White HIV/AIDS Program grantees, researchers, technical assistance providers, health care professionals, program managers and HIV positive peers. Participants heard about the ways in which peers were being used in the fields of HIV, cancer and diabetes to facilitate access to care, treatment and health-related services.

The purpose of the meeting, explained **Steven Young**, HAB's Director of Training and Technical Assistance, was to gain greater insight into the benefits and challenges of having peers on health care teams, to identify the major components of an ideal peer program, and to make recommendations regarding ways in which peer interventions could be funded and sustained within HIV systems of care.

Young explained that in the Ryan White HIV/AIDS Program, peers are HIV positive individuals who share identifying characteristics with individuals or population groups receiving care or services. Peers and clients share similar experiences and challenges related to class, race, age, gender, language, culture and recovery from substance abuse and/or trauma. These common characteristics often provide peers with deep insight into the feelings and behaviors of clients, and help them forge both personal credibility and trusting relationship with clients. In the field, said Young, peers are also called coaches, community health workers and patient navigators, among other titles. HAB's particular interest is in examining the role of peers on interdisciplinary health care teams, whose focus in the Ryan White HIV/AIDS Program is to engage and retain clients in high quality, HIV care.

II. Brief History of Consumer Involvement in Ryan White

Young emphasized the important role that peers (also called consumers) have played in the Ryan White HIV/AIDS Program since its inception. Peers participate in program planning activities, serve as grant reviewers, participate on program advisory committees and boards, and hold positions as volunteers and staff at local health clinics and community-based organizations (CBOs). They serve as faculty of the AIDS Education and Training Centers program. HAB cooperative agreements and grants have supported leadership development for peers to promote their involvement in HIV/AIDS programs.

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[1] Peers were defined by meeting presenters and participants as individuals who are living with HIV/AIDS, and/or come from the same neighborhoods and communities and share cultural characteristics with clients.

"On an individual level, we have heard from peers that involvement in our programs helps them feel less isolated and gives them an increased sense of purpose," said Young. He added that peers can help improve HIV health care delivery and assessment of client needs, as well as reduce cultural and linguistic barriers, and stigma.

Despite widespread acknowledgement within Ryan White that peers play a beneficial role, their function has not been well documented or codified. As a result, HAB is seeking guidance on:

- Training and support needs of peers;
- Ideal roles for peers (i.e., staff, volunteers, etc);
- Financial support for the peer role (grants, reimbursement, etc.);
- Identification of reasonable client and organizational outcomes related to the use of peers; and
- Suggestions on how peers might be integrated into specific, legislatively identified core services, such as medical case management and adherence support.

III. Plenary: Expert Presentation on Utilizing Peers

Presenters

Judith Bradford, Virginia Commonwealth University
Kevin Fiscella, University of Rochester
Carol Brownson, Washington University School of Medicine

Moderator: Lynn Wegman, Division of Training and Technical Assistance, HAB

Judith Bradford of Virginia Commonwealth University reported on an HIV System Navigation Model implemented from 2001-2006 at the Fenway Institute in Boston, in conjunction with the Boston University School of Public Health. The project was funded by the Ryan White Special Projects of National Significance (SPNS) program, as part of a multi-site outreach initiative designed to increase access to and retention in care for underserved populations.

In Boston, the Fenway Institute, along with the Multicultural AIDS Institute, had begun to explore health system navigation as way to integrate services for clients with HIV and those at risk for the disease who did not know their status. For the purposes of the SPNS study, the group adapted Dr. Harold Freeman's patient navigation model designed for use in cancer care. Four local sites participated in the study.

Bradford likened health system navigators to "personal coaches, who help [individuals] develop the skills, knowledge and connections necessary to stay in care." They hail from the communities they serve, receive specific training, and are able to work effectively in the field doing outreach, as well as in health care settings.

In Boston, health system navigators attended a multi-day academy that covered topics such as motivational interviewing, the stages of change theoretical model, the strengths perspective, HIV disease and its management, and how to build local system resources to integrate care. The goal of health system navigators was to identify individuals with HIV who were not in care and facilitate their entry into quality treatment for their HIV.

The four phases of navigation included: 1) Client engagement; 2) Client assessment; 3) Implementation of client action plans; and 4) Monitoring of client progress. During the study's implementation, health system navigators received continuous supervision and support, considered critical to their success. The impact of the intervention was assessed based on whether it was able to reduce client barriers to care and improve health outcomes.

Baseline data was collected on 437 clients. Most were male (77 percent), half were African-American, a quarter were Hispanic, and a third had less than a high-school education. The majority were unstably housed, and one in five were uninsured. Half had no case manager.

Follow-up data on clients was collected at 6 and 12 months. During the follow-up period, researchers found client reductions in structural, financial and personal barriers to HIV care, as well as increased utilization of case management services. Whereas slightly more than half of clients had case managers at baseline, 72 percent of clients had case managers at both 6 and 12 months post-intervention. There were also improvements in provider engagement, which resulted in better health outcomes; the number of clients with undetectable viral loads at 12 months was 50 percent greater than at baseline. Participants who received nine or more contacts from health system navigators in the first 3 months of the intervention were half as likely to experience gaps in care at follow up. In addition, a more intense intervention in the early part of the study was positively correlated with greater client independence later in the study.

In conclusion, the project found that health system navigation programs help clients overcome barriers to HIV care, and build skills, knowledge and self-confidence that facilitate their retention in care.

Kevin Fiscella of the University of Rochester noted similarities between HIV and cancer: 1) Both are life changing; 2) Both involve complex medical management; 3) There are effective treatment options for both; and 4) Coordination of care is critical. There are differences in the demographics of affected populations, said

Fiscella, and medication adherence barriers for individuals with HIV/AIDS are more prevalent than in individuals with cancer.   In addition, those with cancer do not experience the stigma that confronts individuals with HIV/AIDS.

Fiscella defined peer navigation as a "complex adaptive system," in which good navigators adapt how "they respond to the particular context, client needs and health care system needs." He suggested that the question was not whether navigation works, rather under what circumstances and with what tools to make it most effective.

Key elements of the peer navigator role, said Fiscella, include:

- Achieving rapport with patients;
- Identifying and addressing barriers to care;
- Anticipating and preempting potential problems;
- Promoting patient self-efficacy through teaching and coaching; and
- Providing emotional support.

Fiscella described the 5 year peer navigation study, implemented in 2005 by the University of Rochester Medical Center with funding from the National Cancer Institute (NCI). The NCI study focused on care to underserved populations with four specific cancers: breast, cervical, prostate and colorectal. The Rochester program targeted individuals with breast and colorectal cancer.

The university implemented a 90-day peer navigator training that involved seminars and presentations by speakers from multiple disciplines within health care. The training also featured peer navigator interactions with standardized patients, actors who portray people with cancer and provide navigators with the opportunity to practice their skills and receive feedback. Navigators also enrolled in the Cornell Family Development Credential Program, which provided them with 90 hours of additional training.

Key features of the study included the use of paraprofessionals, selection of navigators based largely on personal characteristics, clear policies and guidelines, strong supervision and mutual support among navigators. Skills development highlighted active listening, attention to boundaries, motivational interviewing techniques, knowledge and understanding of cancer and the ability to teach problem solving and adherence strategies. Peer navigators learned strategies for supporting patients in sharing important information during oncology appointments. Evaluation of the approach focused on the impact of navigation services on client satisfaction, quality of cancer care and client functional status.

Fiscella said that effective peer navigation requires the right combination of skills and personality, as well as adequate training, guidance and supervision around roles and responsibilities. Further, peer navigators need to be able to build bridges

between clinicians and clients, instilling confidence in both about the navigator's ability to be helpful. On the clinician side, said Fiscella, his study found that when navigators do their jobs well, medical staff begin to rely on them. On the client side, navigators can influence healthy client choices around care and wellness when the relationship is strong and involves trust.

Carol Brownson spoke about the use of peers, or community health workers, in the Diabetes Initiative, a demonstration project to improve self-management support of diabetes in primary care and community sites across the country. The initiative, funded by the Robert Wood Johnson Foundation, ran from 2003-2006.

Brownson explained that self-management is a critical component of diabetes care, and is developed through building client knowledge and skills for addressing the impact of the disease on physical health, daily activities, relationships and emotional well-being. Inherent in the process is the provision of self-management support, the use of educational and other strategies to increase client confidence in managing diabetes and related problems.

The Diabetes Initiative identified six core resources and supports for self-management:

- Individual assessment, including identification of information and skills needed by clients to effectively manage their condition;
- Patient-centered, collaborative goal setting, including the establishment of short-term, achievable goals;
- Attainment of self-management skills including healthy coping strategies, especially important given evidence of high levels of depression among those with diabetes;
- Ongoing follow up and support;
- Access to community resources; and
- Regular, high-quality clinical care.

Brownson noted that sites across the initiative used different terms to refer to individuals who served in peer roles. As such, the initiative became interested in learning about similarities and differences among roles and activities across sites, irrespective of the person's title or status within a program as either a volunteer or paid staff person.

At the Gateway Community Health Center in Laredo, Texas, said Brownson, peers known as *promotores de salud* (Spanish for "health promoter" or more commonly, "community health worker") were used at the clinic prior to implementation of the demonstration. However, she explained, they were not integrated into the health care team and tended to work alongside, but not necessarily with, health center clinicians. With implementation of the demonstration, the clinic redesigned their system of care to integrate *promotora* services. Protocols now include routine

referral into the *promotora*-run program, beginning with a 10-week diabetes self-management course. In addition to these group classes, the *promotora* program features individual counseling, follow up, client support groups and phone support.

The *promotores* also screened clients for depression, which helped inform development of the care plan. They regularly participated in client case conferences and tracked key diabetes indicators used to assess client progress in self-management.

The demonstration project resulted in more efficient use of provider time, improved diabetes control, reinforcement of treatment plans, improved assessment of client social needs, and client utilization of additional clinic services and referrals. Clients benefited from improved health outcomes and greater access to quality care. Additionally, clients received more individualized care and exhibited greater adherence to treatment. As a result, Gateway developed the infrastructure and protocols necessary to support the ongoing integration of *promotores* into its system of care for chronic illnesses.

The Diabetes Initiative studied the types of interactions between peers and clients across sites. Data showed that phone contact was the most common method of contact, usually followed by a face-to-face meeting. Peer navigators spent most of their time teaching or practicing self-management skills with clients, providing assistance and monitoring progress. Assistance consisted primarily of providing encouragement, motivation, emotional support and help with goal setting.

An important lesson learned from the initiative, said Brownson, is that while peers may perform tasks previously carried out by other team members, they play a unique role in health care systems and complement, rather than replace, the roles of other professionals.

Question and Answer Session

Rodney VanDerwarker of Fenway Community Health asked the panelists about peer access to client health records in their individual programs. Kevin Fiscella explained that in Rochester, navigators had access to medical information that supported their work. Further, he added, all providers involved in the initiative knew that the navigators had undergone HIPAA training. Carol Brownson said sites within the Diabetes Initiative recognized the value of having all members of the care team working from the same medical record and reinforcing the same goals for client self-management.

Sharen Duke of the AIDS Service Center in New York City asked Brownson and Fiscella if the peer navigators in their programs were family members or survivors and if the work had the same positive effects on them as HIV peers have experienced. Brownson said many peers saw improvements in their own lives as a

result of their work, and those who supervised them emphasized the importance of balancing work and personal life. In many cases, she said, peers are caregivers or have diabetes themselves, but in some instances the disease restricts their ability to fulfill peer responsibilities.

Fiscella echoed Brownson's comments and said that in his program many navigators are family members or survivors who benefit from working as peers.

Amy Wohl of the Los Angeles County Health Department asked Fiscella about the 90-day peer training at the University of Rochester. Wohl wanted to know how the training was funded and whether peer navigators completed it all at once or over a period of time. Fiscella said the funding was provided by NCI and that most of the training was up front, with ongoing supervision providing additional opportunities for learning. Fiscella noted that the training was perhaps more intensive than in other programs because the intent was to develop paraprofessional staff, rather than volunteers.

Chester Kelly of the Racial Equality Center in Chicago asked the panelists what criteria they used to recruit peers, saying he believed it was important for peer navigators to share life experiences with their clients. Brownson said the *promotora* model uses peers with social and cultural similarities from the same neighborhoods and with similar life experiences as clients. She emphasized the importance of having peers with whom clients could relate, and trust. Bradford felt it was less important for peers to share all characteristics of clients if there was appropriate diversity on the health care team.

Linda Scruggs of AIDS Alliance for Children, Youth and Families asked panelists what percentage of peers in their programs were paid employees versus volunteers. In the Diabetes Initiative, said Brownson, it varied from site to site, but she noted that volunteers generally had less program responsibility than paid community health workers. She advocated arrangements in which peers are compensated appropriately for the roles they fill and integrated into the care team.

Bradford said all peer navigators in the Boston study held paid positions and had client loads of 20-40, depending on the client's stage of involvement in the project. She stressed the importance of having flexibility within programs so that peers and clients have options when a relationship is not working out.

IV. Grantee Panel: Benefits & Challenges of Utilizing Peers

Presenters

Carol Tobias, Boston University School of Public Health
Cornell Wrisby, Cicatelli Associates, Inc.
Amy Wohl, Los Angeles County Department of Public Health

Moderator: Helen Rovito, Division of Training and Technical Assistance, HAB

Carol Tobias of the Boston University School of Public Health reported on activities of The PEER Center, a Research and Evaluation Center (REC) that coordinates the Peer Education Training Sites (PETS), an initiative to develop organizational capacity for implementing peer training for HIV positive individuals. Organizations involved in the initiative include the People to People program in Kansas City, The PACT program in New York City and the Lotus Project in Oakland.

Upon receiving its funding in 2005, the PEER Center conducted a national needs assessment of Ryan White programs to determine how and to what extent peers were being used in HIV care. Results showed that peer support services were being funded in 29 Part A and B programs. Another 25 indicated they planned to fund peer services in the future. When asked about the support needed to develop and sustain peer programs, grantees requested information on program models, start-up activities, and adherence strategies, as well as technical assistance and funding.

The needs assessment also found that, in Fiscal Year 2005, 106 of 360 Part C grantees (29.4 percent of the total) and 38 of 91 Part D grantees (41.7 percent of the total) provided peer-related services. Their requests for support included information on how to generate proposals for funding, implement peer interventions, provide adequate supervision to peers, ensure program continuity, and facilitate communication among interdisciplinary team members.

Concerns raised by grantees regarding the use of peer navigators included how to maintain client confidentiality and ensure appropriate client-peer boundaries.

In response to the needs assessment, the PETS and The PEER Center have begun providing support and guidance to grantees through telephone and onsite technical assistance and Webinars. The Center is planning regional workshops designed to aid grantees in developing peer programs. Also in the works is a toolkit that will provide guidance on topics such as how to gain organizational buy-in, define peer roles and responsibilities, recruit and train peers, supervise peers and conduct program evaluations. The toolkit is available for download at http://www.hdwg.org/peer_center/program_dev.

The PETS initiative has trained a total of 423 peers from 7 States and 10 cities. An evaluation of the training, using pre- and post-testing, has focused on 226 trainees with at least 6 months experience in the field. Preliminary results show increases in knowledge on a range of issues related to HIV/AIDS and its treatment, although many were topics on which the peers were fairly knowledgeable at baseline. Staff of the PETS initiative are concerned, said Tobias, that the training did not yield significant improvements in trainee knowledge regarding appropriate types of peer activities, interpretation of viral load measures, and the use of open-ended questions.

The evaluation also assessed the types of activities in which peers were engaging most often, and found these included providing emotional support to clients, teaching them about safer sex strategies, and helping them understand how HIV medications can help them. Only 15 percent of peers surveyed said they help clients make decisions about disclosing their HIV status, and only 25 percent indicated they help clients talk openly with their doctors. "I think these are things that as we move forward in training peers, that we may want to examine more closely," said Tobias.

The initiative is in the process of developing a peer-training guide that will address core competencies of HIV knowledge, including risk reduction, adherence approaches, and peer roles and communication skills.

Cornell Wrisby of Cicatelli Associates presented on a 3 year HRSA-funded training and technical assistance project to build the capacity of peer advocates to work effectively as members of Ryan White-funded health care teams. The project utilized a multi-dimensional approach that included: 1) A competitive application process; 2) A focused needs assessment; 3) Curriculum development; 4) Training; 5) Comprehensive technical assistance; and 5) Evaluation and dissemination of best practices.

Regional trainings involved 191 peers, clinicians and peer supervisors from all Parts of the Ryan White HIV/AIDS Program. Utilizing a team approach, the trainings addressed peer roles and responsibilities, skills building, and development of individual plans for peer program implementation at participating agencies. Each training consisted of 4 days of activities: 2 days were dedicated exclusively to peers, 1 day brought peers and clinic managers together, and a final day focused on managers only.

Cicatelli provided follow-up technical assistance, without which the training "could have been hit or miss," said Wrisby. The organization held conference calls to review training information and address issues related to peer program implementation at individual sites, conducted virtual classroom sessions for which participants submitted questions in advance, provided onsite assistance, and distributed a toolkit containing information and instruments to support peer program implementation. An online discussion board was established and enabled

trainees to post questions to each other and to Cicatelli staff. Trainees also were provided with access to field experts, individuals with experience in implementing peer programs and who agreed to provide them with guidance and information.

Lessons learned from the program include:

- The importance of institutionalizing peer activities so that their existence is assured when key staff leave an organization;
- Having a champion with the authority and ability to gain organizational buy-in;
- Having clear expectations for peer responsibilities so that providers, staff and patients understand their roles;
- Ensuring that peers are aware of confidentiality policies and regulations;
- Ensuring clear communication between peers and other staff; and
- Establishing policies that address boundary issues.

Amy Wohl of the Los Angeles County Department of Health reported on two clinic-based peer interventions conducted by the agency's Office of AIDS Programs and Policy in collaboration with its HIV Epidemiology Program. The first, funded in 2004 under the Ryan White SPNS program, used peers to identify Latino and African-American young men who have sex with men (YMSM) and connect them to care. The project utilized a peer-delivered case management model combining psychosocial, clinical and adherence services. Peer case managers met regularly with clients, worked with them to develop individualized care plans, and coordinated their medical and support services. Each was given a cell phone to make communication with clients as easy as possible.

The intervention reduced client wait times for appointments at the county's public health clinics and aided the flow of information between clients and providers, in part because clients felt more comfortable divulging relevant information to peer case managers and asking them questions about treatment. YMSM clinic attendance and case management utilization rates were also increased as a result of the intervention. Clients surveyed about the program indicated that peers helped them gain access to health care services, provided helpful referrals and made it easier for them to interact with their doctors.

The second project, a randomized trial comparing three adherence support interventions, was funded by the Centers for Disease Control and Prevention (CDC). The first intervention involved the Direct Administration of Antiretroviral Therapy (DAART) by Latino bilingual peers to African-American and Latino clients 5 days per week for 6 months. The second involved clients in weekly contact with trained adherence case managers. In the standard care control arm of the study, clients received counseling from primary care providers and pharmacists.

The study found that clients in the DAART arm of the study, which enrolled 82 participants, attended significantly more outpatient appointments than clients in the other two arms of the study. Latinos were more likely to complete DAART than African-Americans, and foreign-born clients were more likely to complete DAART than U.S.-born clients. Wohl surmised that Latino clients likely felt more comfortable working with the peers, given the fact that they had similar ethnic and cultural backgrounds.

A 6 month follow up with study participants revealed no significant differences in adherence, viral load or CD4 counts between the DAART participants and those in the standard care arm. However, a satisfaction survey completed by 42 clients who had participated in the DAART arm showed that 76 percent felt the peers had helped them better manage their disease, and 43 percent indicated that the support, attention and friendship they received from peers was valuable.

The study also found that a warm and non-judgmental approach, experience working with HIV positive persons, shared cultural experiences with clients, and the ability to work effectively with clinicians were all key characteristics of effective peers. Challenges related to the use of peers included the potential for overlap in their social and work lives, issues around client confidentiality, difficulties in retaining peers in programs, and the need for training that specifically models appropriate professional conduct.

Peer workers, said Wohl, can serve as a critical bridge between clients and providers. "Successful peer workers are those who can relate to, understand and advocate for their clients," she said.

Question and Answer Session

Emily Gantz McKay of Mosaica asked how many peers in the DAART program were HIV positive. Wohl responded that only one peer was HIV positive, but that all peers had friends or family members with HIV.

Laura Cheever of HAB asked Tobias and Wrisby how much of the information in their toolkits was HIV specific. Tobias responded that the organizational capacity building tool kit included a mix of information. For example, the peer roles and responsibilities section was HIV specific, whereas the supervision and evaluation components were more general. Since the training tool kit has been designed for HIV peers, one third of it specifically referenced HIV but could be used by peer navigators working with other disease groups. Wrisby said Cicatelli's supervisor toolkit was more general, while the peer advocate toolkit was HIV specific.

Sharen Duke asked the panelists for information on best practices around maintaining client confidentiality. Wohl explained that peer access to patient records was important because providers often sought their assistance in

addressing issues recorded in client medical charts.   As such, confidentiality issues were addressed in weekly health care team meetings, which included peers. Wrisby said her project found that many agencies with electronic medical records systems had established "peer-only" sections of client charts where peers could enter information. Those with paper records had devised encounter forms for peers to complete and include in client files.

V. Peer Panel: Benefits and Challenges of Utilizing Peers from a Personal and Professional Perspective

Presenters

Dan Aguilar, Fenway Community Health, Boston, Massachusetts
La Trischa Miles, Kansas City Free Clinic, Kansas City, Missouri
Diane Williams, AIDS Service Center, New York City, New York
De'Vallion Linzy, Brother Jeff's Community Health Initiative, Denver, Colorado

Moderator: Sera Morgan, Division of Training and Technical Assistance, HAB

La Trischa Miles of the Kansas City Free Clinic in Kansas City, Missouri said her interest in becoming a peer was born of her "own personal pain." She explained that prior to her diagnosis in 1999, she considered HIV to be something that affected other people; As someone who had been married for many years she did not perceive herself as being at risk. Her HIV diagnosis proved devastating, said Miles, and resulted in the breakup of her marriage, after which she went into a period of deep depression and isolated herself from others. A turning point for her was meeting a peer coordinator who "gave her hope."

"From that experience, I did not want anyone else to go through what I did, and that developed my passion for being a peer," said Miles. "I felt at that time that I could either be bitter, or get better, and I chose the latter."

Miles said being a peer requires tremendous commitment, good listening skills, compassion for others, and a willingness to learn about HIV as a disease. Also key is the ability to model healthy, positive behaviors for clients.

"Knowing your limitations is important," Miles said, adding that sometimes clients are not ready to move at a pace or make a decision that you, as a peer, would deem optimal. Peers must be able to both support clients while empowering them to take charge of their own health care. "Building [client] capacity is critical and you have to be careful not to undermine that process," said Miles.

She explained that the peer program at Kansas City Free Clinic is structured and involves facilitation of weekly support groups, direct contact with doctors and pharmacists, and participation on multidisciplinary teams. Peers at the clinic are

fully integrated into the program, work as part-time staff and earn vacation and sick leave.

De'Vallion Linzy of Brother Jeff's Community Health Initiative in Denver, Colorado, said the foundation for his involvement in peer work was established during high school. Linzy was enrolled in a *Big Picture* school where he attended classes 3 days a week and interned the other 2 at a domestic violence program for lesbian, gay, bisexual, and transgender youth. After concluding his internship, Linzy became the mid-western region co-chair of the Gay, Lesbian and Straight Education Network (GLSEN). In his senior year of high school, he was diagnosed with HIV.

"I went into a black hole for 6 months," he said, describing how he stopped calling friends and family, dropped out of school and ceased going to work at GLSEN. One day the principal of his school showed up at his house to offer support, and that started Linzy on a path to re-engagement with the world. His principal helped him get a fellowship at Brother Jeff's, where he was trained to be an HIV peer navigator.

Linzy echoed Miles' comments about the skills needed to be a peer, and added that being nonjudgmental is also important. He emphasized the importance of being realistic about what clients are capable of at any given time, realizing that what works for one may not work for another. Linzy also said that for him, being a peer means accepting that his job does not end at 5:00 pm. "I give out my cell phone number to clients because you never know when things might come up for them," he said.

"My story is a lot like La Trischa's," said **Diane Williams** of the AIDS Service Center in New York. "I became infected in 2000 because of love." Williams explained that she had been in a relationship for 9 months and was working as a substance abuse counselor when she was diagnosed with HIV. At that point, she said, it seemed as if her "whole life stopped."

Williams said she went into a deep depression for 2 years following her diagnosis. A friend who was a peer educator at AIDS Service Center was finally able to convince her to give the agency a try. "[AIDS Service Center] opened up possibilities for me and everyone embraced me and made me feel safe," she said.

She participated in a peer training, and at the same time learned how to take care of herself and stay healthy. Being a peer, she said, helped her "get [her] life back." Clients began to think of her as a role model.   She then became a trainer for the peer recovery education program, and in 2008 was hired as a full-time training coordinator for the organization's HIV and Hepatitis C prevention program.

Williams said one challenge of being a peer is figuring out how to help clients who are engaging in risky behavior. She starts with trying to meet their basic needs. "I

give them a shirt, a toothbrush, a hug, or whatever it is they need at the time and will get them to come back to [our program]." As an example of how this approach has worked, she shared that one of her clients who had taken 2 years "to get sober" is now a peer educator for the organization.

Williams explained that AIDS Service Center peer educators meet regularly with supervisors and receive monthly evaluations. "Supervisors are very accessible to us so that we can address any issues that come up," she said.

Dan Aguilar of Fenway Community Health Center in Boston, Massachusetts, became a peer after doing HIV prevention and youth development work in the city for many years. As a peer interventionist, Aguilar worked as part of a research team charged with developing a peer program for men who have sex with men (MSM) who are HIV positive. He provided input on the program's development and helped ensure the inclusion of culturally competent services for people of color.

As a peer, Aguilar said he sometimes shares information with clients about his own experiences living with HIV/AIDS. This is done on a case-by-case basis, and only if he perceives it will be helpful to the client. He stressed the importance of boundaries in enabling peer effectiveness.

Aguilar said one of his most gratifying moments as a peer came when he was able to convince Fenway to translate peer program materials into Spanish, which helped support him in providing culturally competent outreach and services to Spanish-speaking clients. It also enabled him to successfully advocate for a salary increase based on the fact that he had a "unique language skill that benefited the program."

He concluded his comments by saying that peers perform a critical role on health care teams, one that should be valued and compensated appropriately.

Question and Answer Session

Rodney VanDerwarker of Fenway Community Health acknowledged the breadth of expertise on the peer panel. Linzy suggested that it is an expertise that has to be subtly expressed so that clients still feel a connection to peers as someone who is "like them."

Shalini Eddens of Women Organized to Respond to Life-Threatening Diseases said one factor that distinguishes HIV peers from those working with other disease groups is their need to address the ways in which client stigma and disclosure affect access to quality HIV care.

Williams and Miles voiced different perspectives on disclosing HIV status to clients. Williams felt strongly that clients' knowledge of her HIV status would lead them to assume an intimacy with her that might hinder her role as a professional. Miles, on

the other hand, felt the bond created by disclosing her status to clients helped advance her goals as a peer.

Fiscella asked the peers about their experiences working with medical providers. They acknowledged that while it can take time to develop good relationships with physicians, overall their experiences had been very positive. Aguilar noted that doctors at Fenway recognize peers as extenders of medical services and appreciate the fact that peers often elicit important information from clients that they are less inclined to share with their clinicians.

VI. Design an Ideal Peer Program

The first session of the afternoon involved participants in a small-group exercise. HAB's Sonya Hunt Gray, the session facilitator, told participants to imagine they had access to unlimited resources and could develop the peer program "of their dreams." To help guide their discussions, participants were asked to specifically identify the characteristics of their client populations, major staff of their programs, the client and organizational outcomes their programs would produce, major components of their peer training efforts and top challenges for peers and managers in their programs.

Each group was given a target population for their program. These included:
1) MSM; 2) Youth; 3) Homeless individuals; 4) Transgender individuals;
5) Incarcerated individuals or those transitioning from prison; 6) Immigrants/refugees/undocumented individuals; 7) Injection drug and/or other substance users; and 8) Seniors.

Following the exercise each group presented on the specifics of their individual programs, which are detailed below.

1. Transgender Populations

This program would utilize an integrated medical facility/CBO model, where the CBO would recruit and train HIV positive transgender peers. A core training would cover topics including HIV/AIDS, client-peer boundaries, confidentiality, sexuality, engagement strategies, transgender issues, treatment adherence, and how to work with medical practitioners. Ongoing skills training would be provided.

The medical facility and CBO would be located no more than 30 minutes from each other. The facility would hire a nurse practitioner to work at the CBO as the program director. This director would be responsible for peer training and education, and would also provide some on-site medical services. Peers would perform case finding to identify HIV positive transgender individuals not in care. Staff at the medical facility would monitor client attendance at medical appointments and identify those who were sub-optimally in care. The director

would be informed and would dispatch peers, possibly accompanied by case managers, to find clients and bring them into the facility.

The facility also would identify newly diagnosed individuals through its on-site HIV testing program. The director would be notified and would assign peers to accompany these new clients to their medical appointments. The peers would orient the clients to the medical facility and escort them to follow-up appointments.

The peers' work would be supplemented through educational services, support groups, and mental health services, among others. HIV specialty services would also be offered at the medical facility in coordination with the necessary hormone treatments. Program staff would include the full-time director, a full-time mental health clinician, full-time peer coordinator to supervise the peers, one half-time peer and two peers at 25 percent. The program would also have a data and evaluation person and administrative support person, both working half time.

2. Youth and Young Adults

This integrated peer model would be based at a CBO in St. Louis, Missouri and would be affiliated with a health center. Primary risks in this client population would include having unprotected sex and substance use. The program would target African-American males and females and some transgender individuals. The main barriers to care would include the tendency for youth not to seek medical care, lack of transportation, stigma and fear of disclosure, prevalence of other STDs, and the likelihood that many in this target population would not know their HIV status.

Peers in this program would accompany clients to appointments, send appointment reminders by text or email, provide primary and secondary prevention education to the newly diagnosed and collaborate with testing sites for referral into care. Peers also would conduct follow-up on client care, adherence, treatment, mental health, and other forms of support.

The program would be expected to help reduce the time between client diagnosis and treatment, reduce the number of missed appointments among clients, increase client use of safe sex practices, and increase the number of clients following prescribed medical protocols. Organizational improvements would include the provision of higher quality medical care for youth, and better staff morale due to the support received from the peer program.

Peer training would address topics such as client confidentiality, orientation to health care systems, adolescent developmental and health stages, communication skills, motivational interviewing, available community resources, and harm and risk reduction approaches. Health center and CBO staff would also receive training on the role and use of peers.

Peers would likely face challenges with regard to gaining acceptance from fellow staff and learning how to work within a bureaucracy. Challenges confronting the Program Manager would include establishing the training, creating policies and procedures to ensure client confidentiality within the context of the peer program, providing peer access to medical records, and recruiting and retaining youth peers given the somewhat transient nature of the population. These issues could be addressed through the target population's ongoing involvement in program development and planning, supervision, and implementation of a clear evaluation plan.

Staff of the program would include a full-time peer coordinator, three half-time peers, a consultant (licensed clinical social worker or psychologist) to help with peer training and supervision, and a full-time clinic or nurse manager who would serve as a peer supervisor.

3. Heterosexually Active Adults

This peer program would be located in a primary care clinic with specialty services. The main clinic would be situated in an urban setting with rural satellite sites. The peer program would be two-tiered. The first tier would involve peers in doing client outreach, counseling and testing, and engaging newly diagnosed clients in care. The second would involve peers in the delivery of HIV, Hepatitis C and adherence education, the provision of emotional support and client coaching services, provision of health system navigation and facilitation of client relationship building with members of the health care team.

Client indicators used to assess the effectiveness of the peer program would include reduction in viral loads, improved quality of life and better client mental health. Organizational benefits would include the provision of more culturally competent services, better client retention in care and a reduction in the number of missed appointments. It is also anticipated the client volume at the clinic would increase due to word of mouth about the benefits of the peer program.

A peer training would cover all aspects of HIV disease, including information on medical treatment and resistance. Peers would receive instruction on how to read medical lab reports, provide clients with adherence and community support, educate family and caretakers about HIV, and how to do coaching with clients. Peers would learn about workplace expectations and ethics governing their conduct and activities.

Challenges for peers would include getting clients to engage in care and in healthy behaviors. Challenges for management would include getting buy-in from other clinic staff, providing mentorship to peers, and monitoring the quality of peer activities.

Program staff would include a quarter-time clinical supervisor, a full-time peer program manager, a full-time outreach/re-engagement peer and a half-time outreach/re-engagement peer, two full-time education and support peers, a nurse/ trainer and pharmacist/trainer, both at 10 percent.

4. Men Who Have Sex With Men (MSM)

This peer program would be located in a one-stop shop and would target its services to gay-identified males of color over 18. The primary risk factor for this population would be unprotected sex with other males.

Major peer activities would include identifying newly diagnosed individuals, engaging them in care, and retaining them in care by escorting them to medical appointments, orienting them to available medical and support services, making referrals for support services, working in partnership with them to develop individualized care plans and meeting with them regularly to chart progress in achieving goals. The program would highlight the use of peers as a bridge to all staff, not just clinicians.

The program would be expected to reduce the time between client diagnosis and engagement in care, increase the number of clients in high quality HIV care, improve client retention in care, increase client adherence to prescribed medications and bolster client satisfaction with care. It is also envisioned that the program would accrue benefit to peers, and a method would be devised for measuring peer outcomes.

Top challenges facing peers would include gaining the trust of physicians, maintaining boundaries and determining whether to disclose HIV status to clients. Challenges to senior managers would include preventing staff burnout, hiring and training staff and ensuring program sustainability. A challenge to the organization as a whole, as well as to clients, would be how to address the homophobia, poverty, racism and other problems routinely faced by this population.

Staff of this program would include a full-time licensed clinical social worker to serve as the peer supervisor, a half-time clinic supervisor, three full-time peer educators and a counselor at 25 percent time.

5. Seniors

This program would serve individuals over 55 from a range of backgrounds. The primary risks for this group include intergenerational relationships, increased sexual activity from the use of Viagra, and bartering for sex. Other risks would include client difficulties in adjusting to medication schedules, memory gaps, lack of knowledge regarding HIV and effective management of co-occurring health conditions.

Major peer activities would include condom distribution, HIV education and HIV testing. Peers would be trained on the fundamentals of HIV and the aging process, and would receive instruction on self-care and development of effective coping skills. The program also would investigate the possibility of training peers to do rapid testing in senior centers, assisted living facilities, churches, and other places where seniors congregate or live. Staff of the program would receive training on the use and role of peers as members of the care team.

The program would be expected to lower client risk of sexually transmitted diseases and HIV, improve client social contacts and decrease client isolation. In addition, the program would enhance the organization's capacity to care for seniors with HIV and expand its ability to recruit new clients.

Main challenges for peers would include financial issues, mobility, their own health issues and lack of trust among senior clients regarding efforts to engage them in HIV testing and care. Challenges to management would include finding healthy, active seniors to serve as peers and finding subgroups within the senior population to match client demographics. These issues could be addressed through ongoing training and supervision, as well as the provision of emotional and mental health support to peers.

Staff of this program would include a full-time program coordinator, a full-time licensed clinical social worker, a full-time driver, four half-time peer navigators, two of which would be retired nurses/physicians/physician assistants, and one volunteer evaluator.

6. Runaway Homeless Youth (12-26)

This peer program would utilize a mobile health clinic to conduct outreach to homeless youth ages 12-26. The primary HIV risks for this population would include unprotected sex, injection drug use, selling sex for money, and interaction with the criminal justice system.

The clinic would deliver primary care and HIV services. Clients would be identified through street and shelter outreach activities. Peers would conduct outreach, provide linkages to care and referrals to other services, perform client intakes, and educate clients on risk reduction and safe sex practices.

Peers would be trained on confidentiality guidelines, privacy regulations, sexual health, risk reduction techniques, effective communication skills and clinic orientation procedures. In addition, peers would participate in cross-training with law enforcement personnel, and would also train clinic staff on how to use their services to better meet client needs. Peers would receive ongoing supervision and support.

The program would anticipate improvements in access to care and resources for homeless youth, which would lead to better health outcomes. It also would generate potential employment opportunities for homeless youth interested in becoming peers.

Challenges for peers would include difficulties in connecting with clients given the transient nature of the target population. Peers might also find it hard to adjust to their new lives as professionals.

Challenges for other program staff would include grappling with the broad spectrum of needs for this population and ensuring their retention in care. It is also expected that staff would have varying levels of comfort in working with this client population. These issues could be addressed through training and supervision of peers, collaboration with other agencies serving homeless youth, and establishment of accountability measures that reflect realistic expectations of peer performance.

Staff of this program would include a peer supervisor at 80 percent, two full-time peers, two half-time peers, a clinician at 60 percent and a mental health professional at 60 percent.

7. Injection drug users and other active substance users

This program would be based in a clinic and focus on all substance users over 18. Major peer activities would include street outreach, one-on-one contact with clients, support group facilitation, provision of practical or emotional support, and referral to support services. The program would establish separate services for men and women and employ a harm-reduction approach.

The program would be expected to increase client functioning, decrease risky behaviors and social isolation, and improve client health maintenance in part through increased use of available primary care services. It is also envisioned that there would be increased client adherence to mental health and substance abuse treatment, in part due to sustained client relationships with peers. The clinic would expand its caseload of substance-using clients and strengthen its relationship with the client community, providing it with more opportunities to reduce HIV stigma and improve client access and adherence to care.

Peer training would address harm-reduction techniques, communication skills, establishment of boundaries, client confidentiality, group facilitation, and basic knowledge of HIV and its treatment. In addition, one peer would be certified in substance abuse treatment.

Top challenges for peers would include burnout and substance abuse relapse. These issues could be addressed through the provision of effective supervision and support.

Staff of the program would include a full-time program manager, a clinical supervisor working quarter time, and three full-time peer slots with half-time options.

8. Immigrants/undocumented individuals

This peer program would focus on Latino MSM who do not identify as gay. Barriers for this population would include lack of education, fear of deportation, isolation from family networks, limited English proficiency, different cultural norms, stigma, lack of employment and co-morbidity with tuberculosis.

Peer activities would include linkage to care, community support, assistance in gaining documentation and provision of translation services. It is anticipated the program would help lower client viral loads, increase client CD4 counts, decrease client depression and stress, improve client adherence to HIV medications, and decrease the number of appointments that clients miss.

Peers would be trained in motivational interviewing techniques, community asset mapping to help them orient to available resources in the community, HIV-101, client coaching, confidentiality, and delivery of culturally competent services.

Top challenges for peers in this program would include burnout, gaining buy-in from other staff, and building relationships within the organization. The organization would need to consider how best to avoid potential legal risks while recruiting peers who reflect the target client population.

Staff for this program would include a half-time HIV test provider, a full-time program coordinator, a full-time lead peer, two half-time peers and a half-time clerical support person.

VII. Recommendations to HRSA for Future Peer Programs

In the final session of the day, Steven Young asked participants for their recommendations regarding future use of peers in HIV care and treatment programs. Young invited input on program models, methods for sharing them, strategies for funding them and the types of technical assistance needed to help grantees implement them.

There was uniform consensus among the participants of the HRSA/HAB Peer Consultation Meeting that peer education programs work. An array of peer education models have proven effective in helping people living with HIV/AIDS overcome barriers to accessing HIV care, and enabling them to build the skills, knowledge and self-confidence necessary to facilitate their retention in care. Everyone—patient, clinician, funder—benefits from the improved health outcomes and greater access to quality care.

Next steps for incorporating peer educators into HIV interdisciplinary teams will include the creation of policy guidelines and funding opportunities that help guide Ryan White programs in designing, implementing and evaluating program models to connect and retain people living with HIV/AIDS in quality HIV care.

Meeting participants produced a wide range of recommendations on potential models, program development, core competencies, potential funding streams, data collection and dissemination activities, and integration of peer activities into Ryan White programs. The recommendations presented below have been organized into five broad categories: (1) Exploration of Potential Peer Models; (2) Collection and Dissemination of Information; (3) Research and Evaluation; (4) Core Components of Peer Programs and Training; (5) Integration of Peer Navigators into Ryan White Programs.

Exploration of Potential Peer Models

- Diversify the "face of AIDS" by putting "brighter" or "happier" faces on individuals featured in HRSA publications.
- Consider the HAB national cooperative agreements meeting as a venue for exploring and funding the replication of peer navigation models.
- Look at the CDC's Diffusion of Effective Behavioral Interventions (DEBI) program model as a way to evaluate and disseminate information that promotes peer navigator models.
- Consider community-based organizational models, as well as those based at clinics and medical facilities.
- Explore peer navigator models that integrate peers at the systems, rather than clinic or organizational, level as a cost-effective approach that could support development of uniform standards for peer services.
- Contact the Substance Abuse and Mental Health Services Administration (SAMHSA) to gain more information about their national effort to train former drug users to work as substance abuse counselors.
- Given that many CBOs receive CDC funding, consider models in which peers combine HIV prevention work with medical system navigation services.
- Collaborate with other disease groups in the development of programs and policies governing peer navigator involvement in HIV/AIDS programs.
- Include peers from target populations in the development of programs, policies, peer roles and competencies.
- Ensure youth involvement in program planning.
- Explore and clarify the role peers may play in direct observational therapy (DOT).

- In conjunction with health care reform efforts, promote models of care that utilize peers as an innovative way of extending health care services in a cost-effective manner.
- Consider models that professionalize the role of peers and focus on job creation. Models should highlight credentialing of peers with clearly defined core competencies and stable reimbursement streams. Peers should have access to career pathways that offer opportunities for advancement.
- Consider how Healthy People 2010's focus on eliminating health disparities can be used to bolster public support for peer programs as part of health care reform.
- Tap into other peer look-alike networks—such as those that link community health workers—for resources, assistance and collaboration.

Collection and Dissemination of Information

- Consider establishment of a database/clearinghouse with information on peer programs and related issues.
- Collect and disseminate data on the impact of peers on client health and organizational outcomes.
- Move SPNS findings into programming.
- Ensure that the various terms used interchangeably or similarly for the word "peer" are defined and searchable in the TARGET Center database and in other Ryan White-supported databases.
- Develop a common terminology for the field that aids dissemination of information about peer programs.

Research and Evaluation

- Fund research and evaluation efforts that document the positive impact of peer programs on HIV care and treatment, quality of life and other outcomes. There are very limited studies demonstrating the effectiveness of peer programs on health, social and other outcomes (like employment) with few rigorous study designs.
- Conduct a cost-benefit analysis on the use of paid peers versus other models. Such an analysis could compare the use of paid versus volunteer peers, or the use of peers in training to the use of BA- or BS-level case managers.
- Do baseline research on provider and clinician expectations regarding the roles of peers and the benefits of including them on interdisciplinary teams.

Core Components of Peer Programs and Training

- Peer programs should clearly delineate the roles and responsibilities of peer navigators versus case managers.
- Distinguish or clarify the differences between peers and case managers and where their jobs may overlap.
- Peer programs should emphasize knowledge of HIV and co-infections.
- Peers can provide DOT, especially in conjunction with home delivery of medications.
- Peers need adequate supervision, organizational support and agency structures that facilitate their use and effectiveness.
- Provide capacity building support to organizations that want to develop peer programs to complement training programs, particularly in the areas of supervision and evaluation.
- Incorporate training for supervisors and program managers around peer programs.
- Peers should be reflective of the populations they serve and deliver culturally competent services.
- Engage social workers, therapists and other health care professionals to supervise and support peers in their work.
- Peer training should address stigma as a barrier to care, teach the importance of client privacy and confidentiality, educate peers on the fundamentals of HIV disease and its treatment, provide strategies for addressing client mental health and substance abuse needs, teach techniques for establishing clear client/peer boundaries, and address the balance of power between clients and peers. Further, peer training should emphasize skills development through role-playing exercises, shadowing, ongoing supervision, mentorship and preceptorships.
- Peer training should address the knowledge gap between HIV and Hepatitis C. In general, there is a need to emphasize co-infection education.
- Explore the availability of training sources, such as universities or organizations, which can aid grantees in adapting peer training programs.

Integration of Peer Navigators into HIV Care and Treatment Programs

- Consider defining peer roles and responsibilities in program guidances.
- Standardize language and invite peer input into language development (e.g. by forming a national committee of peers).
- Develop guidelines for incorporation of peers into early intervention services, medical case management and other core services of the Ryan White Program.

- Consider legislative changes that support the use of peers in HIV/AIDS programs.
- Explore a regional approach to training peers in HIV care and treatment programs. A systems-level approach in the regions could train peers to work with clients who have different or co-occurring diseases, e.g. heart disease, diabetes, cancer and tuberculosis.
- Conduct events or trainings for the purpose of improving relationships between clinicians and peers. In general, there is a need for those in the professional clinical ranks who will champion the use peers.
- Establish partnerships with academic programs so that peers can work toward getting professional credentials while they work as peers.
- Explore preceptorships and mentorships for peers and their supervisors.
- Adopt a bilingual and linguistically competent approach to the development of peer programs that includes starting in the primary language of the client rather than translating English materials into other languages.
- Promote peer navigator programs as a way to improve client care while maximizing grantee resources and "above-the-line" spending.
- Develop training and technical assistance activities that teach grantees how to incorporate peer navigators into their programs without jeopardizing peers' receipt of public benefits.
- Consider establishment of systematic pipelines that enable recruitment of peer navigators from HIV/AIDS planning bodies.

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