

Mosaica Consumer LINC Project
Program Models and Strategies:
Strategy #3: Linking PLWH to Care

1. **Type of Model/Strategy:** This strategy includes service models in which PLWH serve as part-time or full-time community health workers, linking other PLWH into HIV-related primary medical care and other needed services. The PLWH provide these services for a relatively short period (3-6 months).

2. **Purpose or Goals:** To reduce unmet need by having peers (PLWH who are themselves in care) carry out activities designed to:
 - *Identify and build trust with PLWH* who are not receiving HIV-related primary medical care and may be unaware or distrustful of the system of care
 - *Provide information* about available services, living with HIV, and the benefits of entering and remaining in care
 - *Provide guidance* about how to enter and obtain needed services through the system of care
 - *Assist PLWH to enter and navigate the system of care*, connecting them to medical care directly or through another intake process and to medical and/or non-medical case management so other core and support needs can be assessed and met
 - *Help PLWH become fully connected to care*, so they are able to obtain needed services and are likely to remain in care

3. **Brief Description of Strategy:** PLWH perform a variety of short-term activities to identify and reach out to other PLWH who know their status but are not in care, increase their awareness of the care system, provide assistance in navigating the system, and work with those who are not in care or new to care to build trust and acceptance of the care system. These peers serve as full- or part-time provider staff (or in some cases receive stipends), playing a variety of community health worker roles, among them outreach worker, health educator, system navigator, and coach/mentor. Their period of contact with an individual PLWH is of limited duration (typically 3-6 months), but long enough to help the individual become fully connected to care. These peer services are designed to help PLWH enter the system of care and navigate their way into a number of medical and social support services that sometimes are neither co-located nor coordinated.

4. **Names and Locations of Model/Programs:** Many Part A and B areas fund peer community health workers to provide short-term services designed to bring people into care, using various service categories. Mosaica has examined several models and focused on those that include outreach services but go beyond traditional street outreach to include more intensive

involvement with an individual PLWH and more responsibility for linking individuals into care. Among the models used in preparing this summary are:

- The Phoenix EMA's revised outreach model (The protocol for the revised Phoenix outreach model is provided as Attachment B)
- Christie's Place (<http://www.christiesplace.org>) in San Diego, CA, which uses peer family case workers to identify HIV-positive women and children out of care and bring them into care. Christie's Place peers conduct outreach activities and provide case management to their peers.
- OASIS Clinic at Charles Drew Medical Center, which has a long history of employing HIV-infected peers to identify PLWH and bring them into care and/or prevention interventions and was part of a SPNS-funded outreach initiative focusing on young African American and Latino MSM
- Several Minority AIDS Initiative (MAI) funded outreach models. Part B MAI funds must be used for services including outreach and early intervention services, and a number of States have developed programs using peers. For example, Georgia has implemented a Peer Advocacy Program that goes beyond outreach and is linked to case management.
- Projects funded under the Ryan White Part F, Special Projects of National Significance (SPNS), especially the Targeted HIV Outreach and Intervention Initiative that began October 2001. Its focus was on implementing and evaluating interventions designed to connect underserved vulnerable populations living with HIV who knew their HIV status with HIV primary care. Only a small number of programs used peer outreach workers. Particularly relevant to this strategy are the following projects:
 - The Fenway Institute of Fenway Community Health and its community-based partners in Boston, which targeted people of color, transgender individuals, active drug users and individuals in recent recovery, ex-offenders, homeless individuals, and women who were "not stable in care." The Institute provided and evaluated Health Systems Navigation (HSN) training.
 - The Horizons Project in Detroit, affiliated with Wayne State University Medical School and the Detroit Medical Center, which employed peers to reach out to low-income African Americans aged 13-24, both male and female, to help these young PLWH enter and stay in care. The project continues to use peer advocates for one-on-one mentoring and peer-led HIV prevention education, among other roles.
 - Montefiore Medical Center and CitiWide Harm Reduction in New York, which did door-to-door peer outreach in single room occupancy hotels (SROs) to provide support, inform people about available services, provide harm reduction supplies, arrange some limited home-based medical care, and engage people in a variety of care and prevention services.
 - Konnect II, a peer support and advocacy program operated by the People of Color Against AIDS Network (POCAAN) in Seattle, which targeted PLWH of color who

were either out of care or received sporadic primary care. The project is ongoing, but its focus has changed to newly diagnosed PLWH.

- Models for the use of peer community health workers focusing on other diseases such as diabetes and cancer.

5. **Target Populations:** These strategies can be used to target a number of different subpopulations of PLWH. Target populations are most often PLWH who feel marginalized and disenfranchised, and are over-represented among people out of care. They may have trouble navigating the HIV/AIDS service system because they have never had a “medical home” and have limited experience with the health care system. Important populations vary by State and locality, but often include the following sometimes-overlapping groups: racial and ethnic minorities (especially African Americans and Latinos), women of color, young MSM of color, migrant and seasonal workers, refugees and immigrants with limited English proficiency, undocumented PLWH, Intravenous Drug Users (IDUs) and other substance users, the homeless, the recently incarcerated, and residents of outlying counties of an EMA or TGA or rural or exurban counties. Another frequent target group is individuals who were recently diagnosed with HIV or AIDS, particularly individuals that are also members of underserved or disproportionately affected subpopulations.

6. **Components/Activities:** Several components and activities are central to this strategy, as described below. In planning and implementing models that fit this strategy, consider the following tasks and focus areas:

a. **Identify populations of PLWH that are especially likely to be out of care and encounter serious barriers to care.** This information can often be found in needs assessment and comprehensive planning documents, including any assessments of unmet need. Work closely with the local planning body’s needs assessment committee to identify useful information to help shape the model. Understanding the barriers faced by specific groups can help you determine both an appropriate approach for reaching them and possible target locations for your work. Also explore available information and information gaps about services and eligibility requirements, looking at what is available to PLWH generally and to specific groups. Ask PLWH who are members of the target populations to use their own experience and knowledge base to help identify barriers to care for such PLWH groups, to supplement the information you receive from the needs assessment committee.

b. **Consider the roles peers should play.** Typically, linking to care involves a mix of activities, including many or all of the following:

- **Outreach** to identify PLWH who know their status but are not in care – and perhaps also individuals who do not know their status but have engaged in behavior that puts them at high risk for HIV, so they need to be tested; this may involve street outreach or contacts made at potential points of entry into care such as homeless shelters and substance abuse treatment programs

- **Health education** about living with HIV and AIDS, prevention for positives, the importance of regular medical monitoring, and the local system of care and how to enter it
- **Trust-building activities** designed to create a positive relationship with PLWH who are not in care
- **Provider relationship building** that enables the peer to assist PLWH in accessing services from these entities
- **Referral and assistance in entering care**, often including accompanying PLWH to a provider that does intake as well as helping them identify needed documents for determining eligibility
- **System navigation** to help new clients learn how to move about the system of care, request and obtain needed care, and avoid unnecessary frustrations
- **Coaching and mentoring**, including advice and emotional support, to help PLWH make the decision to enter care and become fully connected to care
- **Follow up** to help ensure that PLWH keep appointments during the first 2-4 months of care, until they feel comfortable within the care system

c. **Consider how your preferred activities can be funded within your Ryan White system.** The types of activities you choose and the focus of your community outreach help you decide what service categories are good fits for your program model. Short-term peer services that focus on linking an individual into care are most often a part of *outreach* and *early intervention services (EIS)*, but can also fit under a number of other service categories, depending on the roles peers will play. The 2006 legislation identified 13 allowable core medical service categories and 16 allowable supportive service categories. Your program needs to fit least one of them, depending on desired peer roles. For example:

- Outreach that targets points of entry into care – HIV testing sites, homeless shelters, substance abuse treatment programs, programs for the recently incarcerated, hospital emergency rooms, etc. – fits the requirements for *EIS* – an advantage, since this is a core medical service.
- Street outreach that targets individuals with a high probability of being HIV-positive is an allowable activity under the *outreach* category, but not under *EIS*.
- Community education about HIV transmission and available services fits the support service categories of *health education/risk reduction* and *outreach*.
- Referral and system navigation services, such as “the act of directing a client to a service in person or through telephone, written, or other type of communication,” are allowable under the support service categories of *referral for health care/supportive services*, *non-medical case management*, and *outreach*.
- *Client advocacy* involving the search for appropriate services is an allowable activity under *housing*, but client advocacy is no longer allowable as a separate service category.

Once you have decided the most appropriate service category for your program, you can more fully develop the model so it meets target population needs and service category requirements.

- d. **Explore funding potential.** The final decisions about what service categories are funded and how much money is to be allocated to them are made during priority setting and resource allocation (PSRA). However, if you are designing a new or revised service model, you should consider such issues as the following:
- **Current priorities and allocations** -- whether your program is currently prioritizing and funding programs in the service category(ies) of interest.
 - **The procurement schedule for service categories of interest.** For example, if your program uses a three-year contracting cycle, you need your new model to be ready for the next competition. If that isn't for almost three years, you may want to consider another service category or a different approach.
 - **Potential for inclusion under the Minority AIDS Initiative (MAI).** Depending on reauthorization, MAI funding will probably be competed in 2010, so a new outreach or EIS model would need to be ready for inclusion in the application submitted in the spring of 2010.
 - **The potential for refining service models under existing contracts,** through changes in Standards of Care (SOC), use of directives, or slightly revised service models. Some programs allow for at least limited changes to be made when contracts are signed at the beginning of each program year.
 - **Level of flexible resources.** If your program has enough funds to meet core medical service needs and be able to explore new service models, funding of a new model is likely to be a practical possibility. If funds are very tight, then refinement of a currently funded model may be the most feasible approach.
 - **Priority on addressing unmet need.** The potential for action is highest if your jurisdiction has a high rate of unmet need and/or if addressing that is a priority – for example, a goal under your comprehensive plan.
 - **Experiences with peer models.** If providers are running other successful programs that involve PLWH as staff, they are likely to be especially open to new peer models. If provider capacity to provide appropriate training and supervision is limited, there may be fears about taking on such a model – which may be reflected in negative planning body responses to proposed models.
- e. **Implement – after you have determined and planned for development of peer community health worker core competencies necessary for carrying out defined roles and activities -- and ensure ongoing training and supervision.** Peers under this strategy must have certain baseline knowledge on specific topics that are key to helping clients learn about, enter, and navigate the system of care. These should include orientation and training for PLWH new to the peer role, as well as refresher and advanced sessions for current peer workers. While much of this training is usually done by

providers, the grantee and planning body can provide training that prepares consumers for both informal and formal roles in linking PLWH into care. In addition, the program model and funding level must make possible a high level of ongoing supervision for peers, to make them effective and valued members of the project team.

f. **Ensure that the program model as implemented addresses topics and roles that are closely linked to peer program success.** Research indicates that the following are particularly important considerations:

- **Establish collaboration agreements and/or Memoranda of Understanding (MOUs) with key entities as quickly as possible.** Information and communication are the keys to building trust among PLWH who are not in care. To do this effectively, peer community health workers must work with the entire network of providers. Some providers require MOUs or collaboration agreements in order to share information with, or accept referrals from, peer community health workers that work for another provider. The peer needs to stay client centered and to act as a bridge to care. If written agreements are needed, it is worth the time and effort of the peer and his/her provider to make sure everyone is working together to help the client enter and stay in care.
- **Promote patient understanding of the system of care and how to navigate it.** This strategy is time limited, which means the peer community health worker often has 3-6 months to work with a client. During that time, it is imperative that the peer work to increase the client's understanding of certain key concepts, primarily self management of HIV disease and the need to work with the HIV health care system and remain in care. Clear communication that is informative and culturally appropriate is vital. With some target populations, materials in languages other than English may be required.
- **Anticipate problems and assist in mitigating their impact.** This requires both peer knowledge of the HIV care delivery system and a careful assessment of the client and his/her situation. Many PLWH face complicating factors that create crisis situations that result in disconnection from HIV care. Large numbers of PLWH are dually and multiply diagnosed with mental illness and substance abuse. Problems such as housing and transportation can negatively influence access to care. Peers can help by proactively raising and addressing these challenges and helping clients navigate the system to obtain needed services – and connect them with case managers and other providers who also understand and are prepared to deal with client issues.
- **Strengthen service coordination and referrals.** While it may not be the responsibility of the peer to refer a client for services, often a peer will accompany a client to a referral or work to ensure a smooth referral. In this model, the peer acts as a bridge to care – an additional support that helps break down barriers that may lead to a denial or interruption in care. As part of service coordination, peers under this model must prepare clients and their ongoing caregivers to interact successfully, helping them build trust. The intent is to ensure that at the end of the 3-6 month period, when the peer service ends, the client is genuinely connected to care.

- **Teach self efficacy (disease self management) through leading by example, coaching, and building self confidence and understanding.** The use of peers under this model is designed to empower individuals to enter and stay in care. Peers are taught to coach, gently or harshly scold, and cheer when things go well. The communication and information they share is designed to help build the PLWH's confidence, trust, and understanding of the HIV care system.
 - **Provide emotional support as needed.** Clients will need emotional support – which is especially important for those who lack the support of family or friends. Issues of stigma, disclosure, and the strain of making difficult health care decisions all combine to test the emotional stability of even the most stable PLWH. Sharing personal experiences and discussing what helped the peer during similar trying moments is important information for clients. At the same time, boundaries must be established, so that peers share only what is appropriate, respect confidentiality, and maintain professional ethics. Peers need to know how to maintain boundaries between their professional and personal lives, and avoid the kinds of emotional involvement that lead to inappropriate PLWH dependence and rapid peer burnout.
7. **PLWH Titles, Roles, and Responsibilities:** The linking to care strategy most often involves consumers as peer community health workers. They may have many other job titles – among them outreach worker, system navigator, peer advocate, peer mentor, and peer coach. These reflect some of the many roles a peer may play in this strategy. As described earlier, roles typically include identifying PLWH who are not in care, building trusting relationships with them, providing information about available services and about living with HIV/AIDS, providing guidance about how to enter the system of care and obtain needed services, and helping PLWH enter and become attached to care, which involves multiple roles such as system navigation, coaching, and mentoring.
8. **PLWH Qualifications:** Models within this strategy require a range of skills, all combined to help engage PLWH in the HIV care system. It is generally beneficial to have peers who are indigenous to your target populations. Some programs feel that race/ethnicity may be more important than age or gender. One Los Angeles outreach program targeting young Latino male MSM found that the peer needed to be Hispanic, but that an older Latina was sometimes more effective than a young Latino – the older sister/mother role proved beneficial. There are other exceptions to the matching, particularly in some African immigrant communities. Due to stigma and confidentiality concerns, this population may prefer to interact with someone outside the African immigrant community. In general, peers should reflect the target population as much as possible. For example, similar life experiences are very helpful. A peer who did not receive regular medical care until s/he became HIV-positive is more likely to understand the challenges of navigating the health care system than someone who comes from a higher-income background. One group of outreach programs compared their experiences and concluded that the peer team should where possible be diverse in such characteristics as race/ethnicity, language skills, gender, age, sexual orientation, and community of residence. This provides opportunities for various

types of matching between peers and PLWH. Shared background and shared experiences are generally helpful in building trust and modeling health care-seeking behaviors.

In addition to their characteristics and personal experience, peers need to have or acquire the following skills

- **Familiarity with the current system of HIV/AIDS care in the service area** – ideally as a consumer, but also as a PLWH staff member or volunteer
- **Detailed knowledge of one or more specific PLWH subgroups**, through membership in that group and/or significant work or personal experience with it
- **Detailed knowledge of a particular geographic area** (e.g., central city, specific neighborhood, suburb, exurb, rural county or region of a State)
- **Understanding of how Ryan White programs work**, and the points in the continuum of care where individuals are likely to encounter problems or certain population groups will face access barriers
- **Culturally appropriate communication skills** enabling the peer to convey necessary information in a manner that is easy for the client to understand
- **A good understanding of professional and personal boundaries** that can protect the client and the peer. Many peer programs struggle to define and enforce confidentiality
- **Ability to empathize** – to put him/herself in the shoes of a PLWH from the same or a different background, in order to understand that PLWH’s needs and service barriers
- **Skills in working with providers, including clinical staff** – to be able to build trust, establish credibility, and use provider relationships to assist a PLWH in entering care and help ensure responsive services

9. **Supervision/Staff Support:** This strategy and the models in this category all require a high degree of supervision of and support for peer community health workers, particularly during their first year in the role. The provider’s organizational infrastructure and organizational culture have to be able to attract and retain peer staff. This means establishing and implementing policies, procedures, and training and treating peers as valued employees, while providing clear guidance and expectations to peers and to other agency staff. Supervisors need to ensure regular training, communications, and joint problem solving around challenging cases, as well as appropriate MOAs with providers and facilitation of peer relationships with providers.

Capable and knowledgeable supervision is also necessary because many of the services that can support this strategy require careful monitoring. One concern is ensuring that only allowable activities are being implemented with Ryan White funds. This includes, for example, an understanding of how outreach or EIS should link to but not overlap with prevention outreach and CDC-sponsored testing.

10. **Training for PLWH:** As emphasized throughout this summary, this strategy requires peers to have a number of generic and jurisdiction-specific skills. Some need to be provided

through training provided right after the peer is hired, while others are developed through periodic staff development sessions and in-service training. Topics include but are not limited to the following:

- Understanding HIV disease, including HIV 101, disease progression, and disease management
- Ryan White legislation, allowable services, policies, and guidelines
- Navigating the system of HIV care – understanding the system and points of entry, barriers to care, and building and maintaining relationships with providers
- Techniques for developing trust with PLWH who are not in care
- Problem solving and crisis management
- Confidentiality
- Self care and self disclosure
- Maintaining professional boundaries
- Communication skills including active listening, motivational interviewing, and responding to emotion, as well as culturally competent communication

11. **Important Linkages:** This strategy requires the peer to identify PLWH who are not in care and connect them solidly to care within 3-6 months, including medical case management, primary medical care, and referral to other necessary core and support services. This process is greatly facilitated by a wide range of provider-focused professional linkages through MOUs or collaboration agreements, and through professional relationships with specific personnel in those organizations. To find and engage PLWH who are not in care, the peer needs linkages to providers that serve as points of entry into care – from counseling and testing staff at HIV and STD clinics to emergency room nurses and homeless shelter staff. To ensure that these PLWH get the services they need, the peer needs positive linkages with intake personnel at every access point to the system of care, including staff who serve as initial points of contact for new referrals. The assessment of client need is typically a case management function, and thus the linkage between the peer and medical case management is especially important to ensure a smooth transition into care.

12. **Resources Required:** This strategy can be developed at many different resource levels, dependent upon available resources. A typical model includes several peers working full- or half-time, plus supervisory personnel. Some small TGAs and low-incidence States have used consumers who are on disability and therefore can work a limited number of hours per week. This may work best where the program needs to reach and engage PLWH from a variety of backgrounds, and having a number of peers each working 12-15 hours a week provides valuable diversity.

Peer community health worker salaries vary by jurisdiction, but the *Community Health Workers National Workforce Study* found that most CHWs made more than the minimum wage (now \$7.25 per hour), and that the typical range for new hires was \$9 to \$14.99 per

hour (\$18,750 to \$31,180 for full-time work). Half of experienced community health workers (CHWs) earned a full-time equivalent wage of \$15 per hour or more (\$31,200 for full-time work). A 2004 study found that the average yearly income for CHWs in Massachusetts was \$23,000 (a little over \$11 per hour); the mean in Florida in 2003 was slightly lower, at \$22,376 (about \$10.75 per hour). The *Workforce Study* found that most employers provide benefits to CHW, most often mileage reimbursement (76% of employers), health insurance (71%), sick leave (71%), vacation (68%), personal leave (56%), and some form of retirement plan (54%). The level of benefits depends on hours worked.

Some programs employ peers who are living with AIDS and are on disability. Such individuals remain eligible for benefits only if their pre-tax earnings are less than the “substantial gainful activity” (SGA) limit. The SGA amount for non-blind people on disability for 2009 is \$980 per month gross income, which means less than \$11,760 per year. If you want to hire PLWH on disability, they will probably be able to work 35-50% time. If you pay \$11 per hour, the individual can work about 20 hours a week; if you pay \$15, s/he can work about 15 hours a week.

13. **Service Categories:** Peers who function as community health workers and focus on bringing PLWH into care fit into a number of Ryan White core medical and support services. The approaches work particularly well within Early Intervention Services (EIS) and Outreach service categories.

- **EIS:** EIS has the benefit of being a core medical service, and fits this strategy since the relationship with the client is deliberately short- to medium-term and focused on linking PLWH to care and ensuring that they become fully connected to care, rather than providing ongoing client support. For Parts A and B, as specified in the 2006 Ryan White legislation, EIS focuses on reaching PLWH at points of entry through communication and information sharing, testing, and referral, and provision of related services designed to speed entry into care and a solid connection to primary care. EIS must incorporate an HIV testing component, but should not fund this component if sufficient testing resources are already available. It can provide the wraparound services needed to get people tested and link people to primary medical care and other needed services.
- **Outreach:** Ryan White outreach services “target and identify individuals who may or may not know their HIV status and are not in care, have not returned for treatment services or do not adhere with treatment requirements,” according to the policy guidance on outreach. The goal is to link them into primary care and encourage adherence to treatments. Ryan White-funded outreach should target populations at disproportionate risk for HIV/AIDS, and funds must not be used for broad HIV prevention education. Programs must coordinate with more broadly targeted prevention outreach funded by the Centers for Disease Control and Prevention (CDC).
- **Other supportive services:** Depending on the roles the peers will play, the models may also fit into several other supportive service categories, such as **Non-Medical Case Management, Health Education/Risk Reduction** and **Referral for Health Care and Supportive Services**. These services might use peer community health workers for client education, referrals, and/or counseling/support. Following are the definitions of these service categories provided by HRSA/HAB:

- **Non-Medical Case Management** is “the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services.” It “does not involve coordination and follow-up of medical treatments, as medical case management does.”
- **Health Education/Risk Reduction** is “the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.”
- **Referral for Health Care and Supportive Services** is “the act of directing a client to a service in person or through telephone, written, or other type of communication.” The category is to include referrals for all service categories except primary medical care and case management; referrals to those two services are to be reported under primary care and case management categories.

14. **Attached Materials:** Attached are:

- Attachment A: a flow chart of the strategy documented here
- Attachment B: a protocol for the Phoenix EMA’s redesigned outreach program, including the HRSA/HAB guidance on outreach services, Policy Notice 02-01, The Use of Ryan White CARE Act Funds for Outreach Services and Q & A
- Attachment C: several sample tools on outreach to specific populations and on referrals and patient navigation, excerpts from Cicatelli Associates’ *Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates* and the companion Supervisors toolkit.

15. **Benefits:** This model offers many benefits. Employers report hiring community health workers because their use is cost-effective: they are able to find hard-to-reach populations and assist them in obtaining care, and they cost less than staff with more formal training. Peer CHWs chosen to “look like” their target population use their own experiences to establish rapport with other PLWH, are able to build trust with other PLWH, and when appropriately trained and supported make effective system navigators and mentors for other PLWH.

The CHW *Workforce Study* found that providers who hire community health workers view them as able to improve the delivery of health-related services because they are:

- “Effective in gaining access to hard-to-reach populations that had been avoided by other health workers;
- “Able to patiently coach clients in culturally appropriate terms and induce behavioral changes;
- “Able to successfully communicate with clients, after developing trusting and caring relationships, to impart or gather information and motivate key decisions such as participating in immunization programs; and

- “Able to address certain client needs such as adapting health regimens to family and community dynamics.” (*Community Health Workers National Workforce Study*, March 2007, Chapter 5).

16. **Challenges:** The main challenges associated with this model involve the hiring, training, supervising, and support of peer community health workers, and the need to ensure that providers and partners value and work effectively with these workers.

- *Orientation and training:* PLWH hired as peer CHWs need orientation and training both to ensure appropriate knowledge and skills and to prepare them for working effectively within provider organizations and with partner entities. It is often challenging for a provider to ensure both sufficient initial orientation and training and regular, ongoing staff development. This is particularly true if the provider has a small number of PLWH in these roles – the group may seem too small to justify formal training sessions, and providing the same level of training on the job can be very difficult. The peers may lack related job experience, which can make the adjustment to the position challenging. In addition, peers have a serious health condition, and maintaining good health must be a continuing concern. Health problems may lead to high absenteeism and reduce productivity.
- *Provider and partner attitudes:* A related challenge is the varying attitudes of provider and partner staff about the use of peers, their ability to maintain confidentiality, and their overall value. Research supports the value of peers in both HIV/AIDS and other chronic diseases, but introducing a changed program model involving the use of peers can meet with resistance. Other staff need to be educated about the value of peers and expectations for including them in communications and in discussions about clients.
- *Outreach challenges:* Apart from challenges in effectively using peers, outreach has historically been a difficult service category to implement successfully. Many Part A and Part B grantees have limited experience with EIS, the service category definition has proven confusing, and detailed guidance from HAB is just becoming available. Grantees should carefully monitor EIS or outreach models implemented under this strategy, requiring documentation of levels of activity and evidence of success. In addition, monitoring is needed to ensure that guidance from HRSA/HAB is followed and unallowable activities are avoided. Despite these challenges, outreach and EIS are extremely valuable approaches for reducing unmet need, and use of peers can increase their effectiveness.

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

- Increased understanding of the care system among targeted PLWH
- Number of out-of-care PLWH (a) identified, (b) served, and (c) linked into care (e.g., completing program intake) – and the percent of those identified and served who enter care
- Levels of engagement in care for those served – e.g., percent of appointments kept

- Percent retention in care among clients who used linking to care services, after 3, 6, and 12 months

There have been only a few evaluations of the use of peer CHWs to bring PLWH into care, but the literature includes a number of evaluations of the use of CHWs in areas such as diabetes management, infant mortality reduction, asthma management, and primary care utilization. There is considerable evidence that peer outreach helps to improve access to health care for hard-to-reach populations, promotes client knowledge about the health care system and about specific diseases, contributes to behavior change in terms of seeking care, healthy behaviors, and disease self-management, and contributes to improved health status. While methodologies and outcome vary, the CHW *Workforce Study* analyzed literature reviews of such studies (See Chapter 6, CHW Workforce Research and Evaluations) and found evidence of a variety of positive results. For example, CHWs working with ethnic minority women were “effective in increasing access to health services, increasing knowledge and promoting behavior change....” A study of outreach by community health workers employed by Denver Health Community Voices found that their efforts had positive financial impacts as well; peer outreach led to “increased primary and specialty care visits and reduced urgent care, inpatient, and outpatient behavioral health visits,” providing a return on investment of 2:28 to 1 due to a reduction in uncompensated care costs. (See reference to journal article in Section #20 below.)

18. Helpful Hints and Lessons: Experience with programs using this strategy suggests the following:

- In determining what service category your program best fits, carefully consider your key target populations, and where they are most likely to be found. If you feel they are likely to be reachable in settings like homeless shelters or emergency rooms, you probably want to design an Early Intervention Services program, since such programs typically focus on settings that provide points of entry. If you feel street outreach is needed, your program will probably fit Outreach. Be sure the design is appropriate for the service category, and enables you to meet HRSA expectations for components and activities.
- Develop clear job descriptions and expectations for peer community health workers and be sure you communicate them clearly. If the program is new, you may test and refine tasks, but don’t start off with vague or loosely defined tasks or roles. It can be very difficult to gain support for the program if it is viewed as poorly defined or ineffective.
- This strategy requires high peer continuity and retention. The PLWH identified and assisted needs to work with the same peer over a period of 3-6 months. Some programs use PLWH volunteers or provide small stipends. This helps to control costs and provides for a diverse group of peer community health workers. However, such peers tend to be involved for fewer hours, have more limited roles, receive less orientation and training, and may have lower retention. Some programs have been successful using PLWA on disability who are able to work only limited hours, providing a high level of orientation, training, and supervision to these part-time personnel.

- Prepare provider staff to work with peers – don't leave it to the peers to establish these relationships. The extent of acceptance and support for peer CHWs among co-workers and partner staff is a major factor in determining peer retention and program success.
- Build into your program a significant period of orientation and training before services begin, so that peers have needed knowledge and skills before they begin providing services.
- Once basic training has been completed, build in regular, scheduled in-service training at least once a month, preferably twice a month. Many existing curriculum materials exist, so you can usually find rather than develop them – but be sure you provide structured training that includes a chance to practice new skills and apply new knowledge.
- If you expect to have several providers, each with a small number of peers, consider supporting joint orientation and training for these peers so they receive sufficient and effective orientation and in-service sessions. Some grantees are considering a centralized entity that hires, orients, and then outstations peer CHWs so they work with various providers, but retain responsibility for staff development and some level of supervision.

19. Sources of Information: This summary is based on review of:

- A number of existing outreach programs and several relatively new Early Intervention Service programs, including the Nashville TGA EIS program
- The HRSA/HAB guidance and other HAB materials on outreach, and a discussion with HAB Division of Service Systems Management Team regarding EIS programs and guidance
- The revised Phoenix EMA outreach protocol
- Several SPNS projects with an outreach focus or component, including the young African American and Latino male MSM projects
- PowerPoint presentations from a February 2009 HRSA/HAB consultation on the use of peers in interdisciplinary clinical care teams – since many of these models include a significant outreach component
- Information included in a major report on Community Health Workers published in 2007, the *Community Health Workers National Workforce Study*, conducted with support from HRSA's Bureau of Health Professions.
- The experience of members of the Mosaica Consumer LINC team in helping grantees and planning bodies develop and implement outreach and early intervention services, much of it through work under the Ryan White Technical Assistance Contract

20. References and Resources:

- *Community Health Workers National Workforce Study*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, March 2007. Conducted by the Regional Center for Health

Workforce Studies, University of Texas Health Science Center, San Antonio. Available online at <http://bhpr.hrsa.gov/healthworkforce/chw/>.

- *Building Blocks to Peer Success: A Toolkit for Training HIV-positive Peers to Engage PLWHA in Care.* Peer Education and Evaluation Resource (PEER) Center, Boston, MA, April 2009. This toolkit was funded through a cooperative agreement from HAB's Division of Training and Technical Assistance (DTTA). It provides resources to support the training of PLWH who work as peer community health workers to engage and retain people living with HIV in health care. The toolkit is designed for use by experienced trainers and by providers that employ peers, to develop pre- or in-service training programs and individual sessions. The PEER Center has other resources related to peer programs. Toolkit is available at http://www.hdwg.org/peer_center/training_toolkit.
- *Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates and Integrating Peers into Multidisciplinary Teams: A Toolkit for Peer Advocates – Supervisor's Guide.* Cicatelli Associates, New York, 2007. The advocates toolkit provides extremely useful and practical tools that can be used for peer training. The toolkit covers such varied topics as outreach, referrals and system navigation, how to talk to PLWH about HIV/AIDS, treatment adherence, peer safety, and client confidentiality, as well as working effectively with provider staff. The supervisor toolkit provides guidance and sample tools in such areas as policies and procedures, confidentiality, job descriptions, and orientation. Both toolkits available online at <http://careacttarget.org/library/peers/ToolkitForPeerAdvocateSupervisors.pdf>.
- *User Name: Outreach Worker.* An update from the RWCA SPNS Program, HRSA HIV/AIDS Bureau, "What's Going on @ SPNS." Describes two demonstration projects in the Young MSM of Color Initiative that use peer outreach methods that include the Internet. See <http://careacttarget.org/Library/SPNSBulletin/spnsbulletin.aug06.pdf>.
- "SPNS Outreach Initiative Program Descriptions." Describes the projects funded under the Outreach initiative, including several that fit this strategy. Available online at: http://www.bu.edu/hdwg/pdf/projects/corephaseII/SPNS_Program_Descriptions.pdf.
- HRSA/HAB Policy Guidance 07-06, "Use of Ryan White HIV/AIDS Program Funds for Outreach Services." This policy guidance clarifies expectations and requirements for outreach services funded under Ryan White. See <http://hab.hrsa.gov/law/0706.htm>.
- "Measuring Return on Investment of Outreach by Community Health Workers," in *Journal of Health Care for the Poor and Underserved*, Volume 17, No. 1 Supplement, Feb. 2006. This article documents the positive financial impact of outreach by community health workers employed by Denver Health Community Voices. The study documents the economic contributions of peer CHWs to the safety net system. See http://muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/toc/hpu17.1S.html.