

**Mosaica Consumer LINC Project
Program Models and Strategies
Strategy #4: Integrated Clinical Care Team**

1. **Type of Model/Strategy:** This strategy includes models in which PLWH serve as members of an integrated clinical care team and often maintain an ongoing relationship (six months to several years) with client PLWH, helping first to connect them to care and then to keep them in care and adherent to prescribed treatments.

2. **Purpose or Goals:** To reduce unmet need through use of peers (PLWH who are themselves in care) to:
 - Identify and build trust with PLWH who are not receiving HIV-related primary medical care or are not fully connected to care, and may distrust or know little about the system of care
 - Provide information about available services, living with HIV, and the benefits of entering and remaining in care
 - Help PLWH to enter care, navigate the system of care, and connect to needed services, directly or through medical or non-medical case management
 - Enhance retention in care and positive clinical outcomes by facilitating service coordination, referrals, and adherence, and providing ongoing emotional support

3. **Brief Description of Model/Strategy:** This strategy includes the use of peers as part of an integrated clinical care team. Peers are typically tasked with many of the same responsibilities as in strategies designed to link PLWH into care, as well as additional, ongoing care support roles. They provide outreach to identify PLWH not in care, follow up for people who have frequently missed appointments or are in danger of dropping out of care, health education about the disease and the system of care, system navigation, and mentoring and other support to help PLWH enter and become fully connected to care. Unlike the models for linking people into care, however, the relationship with the client in this strategy is typically long-term, lasting at least six months and often several years, and the peer works closely with clinical care providers such as physicians, nurse practitioners, physician assistants, and medical case managers.

As in other peer strategies, PLWH function as peer community health workers (CHWs), responsible for providing important information and support and building trust through the shared experience of dealing with HIV/AIDS. Often, the peer role begins with efforts to help a PLWH enter care. Over time, after the individual has been connected to care, the peer role shifts to assisting the client to remain in care and obtain the full range of needed services. Typically, the peer helps the client to navigate the system of HIV care, coordinating with both clinical and support service providers. When the client encounters difficult life situations, the peer provides

emotional support and shares his/her own experiences. Ongoing peer support may include clinical information on treatment adherence and managing side effects.

This strategy differs from Linking PLWH to Care not only in the overall length of time the peer spends with the client, but also in the types and intensity of services provided by peers. In this strategy, peers work closely with clinical care staff, typically have access to some clinical information about the client, provide clinical support, and offer insights used by clinicians. Because roles include adherence and other clinical support, these peers require considerable training, particularly on clinical topics.

4. **Name and Location of Models/Programs:** This strategy summary integrates approaches and experience from a number of Ryan White Part A, Part B, Part C, and Part D programs. A needs assessment conducted by the Peer Education and Evaluation (PEER) Center at the Boston University School of Public Health reported that at least 29 Part A and B programs, 106 Part C programs, and 38 Part D programs fund “peer support services.” Some engage PLWH as a part of their clinical teams, while others use peers in more limited ways. Several HRSA/HAB-funded groups of SPNS grantees have explored the use of peers in interdisciplinary clinical teams, assisting clinics to hire and successfully involve peers as clinical team members and developing a wide range of training modules and suggested forms and procedures. Programs using models reflected in this strategy summary and groups that assist such organizations (and have valuable toolkits and other model materials) include the following:

- A group of projects funded through the Minority AIDS Initiative (MAI) that hire peers as clinical team members and receive assistance through the PEER Center as part of a Ryan White Part F Special Projects of National Significance (SPNS) grant, including:
 - Peer Adherence Program (previously known as HATS - Harlem Adherence to Treatment Study) at the Harlem Hospital, New York, NY
 - Kansas City Free Clinic in Kansas City, MO
 - Truman Medical Center Hospital Hill in Kansas City, MO
 - Waterbury Hospital Infectious Disease Clinic in Waterbury, CT
- PEER Center technical assistance partners:
 - Lotus Project/WORLD (Women Organized to Respond to Life-Threatening Diseases) – Oakland, CA
 - PACT (Peer Advanced Competency Training) Project/Harlem Hospital – New York, NY
 - People to People in Kansas City, MO – a partnership between American Red Cross, Kansas City Free Health Clinic and Midwest Training and Education Center-Missouri

- The Fenway Institute in Boston, which implemented an HIV System Navigation Model from 2001-2006 in conjunction with the Boston University School of Public Health. The group adapted Dr. Harold Freeman's patient navigation model designed for use in cancer care. The project was funded by SPNS as part of a multi-site HIV Outreach and Intervention initiative designed to increase access to and retention in care for underserved populations.
 - Cicatelli Associates' work through a cooperative agreement from HRSA/HAB, focusing on "integrating peer advocates as essential members of multidisciplinary clinical teams," which was coordinated out of New York and included work with programs in New York, Georgia, California, Illinois, Texas, and Florida.
 - A SPNS project that supported work in eight sites to test innovative models of outreach and care for young male African American and Latino MSM. One grantee was the Los Angeles County Department of Public Health, and one of its sites was the Altamed Clinic in Los Angeles County. This Latino clinic provided a clinic-based, peer-delivered, youth-focused 24-month case management intervention. Peers were supervised by a licensed clinical social worker (LCSW) as they engaged these PLWH in "consistent" HIV care and coordinated both core medical and supportive services. Another site, the OASIS (Outpatient Alternative Services Intervention System) Clinic at King-Drew Medical Center in Los Angeles also used a peer-delivered case management model.
 - The University of Tennessee Medical Group Part D Program in Memphis, which uses Consumer Advocates as part of the clinical care team. In this model they are partnered with a social worker and an outreach worker and stationed at key points of entry to help ensure that expectant mothers and their partners have successful assessments and referrals to other services. Key points of entry to the program include food pantries, GED and life skills classes, and other places where expectant mothers go for services other than medical care.
 - Numerous Latino-focused health programs – such as diabetes, mental health, and maternal and child health – that use community health workers called *promotoras* (community health "promoters"). *Promotoras* are typically bilingual CHWs who recruit people to programs, provide individual assistance, teach or help practice skills, make people aware of their rights, make referrals, and monitor progress. They can be peers – individuals living with the disease. A number of successful promotoras programs operate in California and are members of the California Community Health Worker/Promotoras Network, *Vision y Compromiso*, in El Cerrito, California.
5. **Target Populations:** These strategies can be used to target any subpopulation of PLWH that needs help in entering and remaining in care. As with the Linking PLWH to Care models, focus is typically on populations with high rates of unmet need and significant barriers to care – groups that often have limited experience with the health care system. Frequent target populations include the following sometimes overlapping groups:

- Pregnant women and women of child-bearing age, especially African Americans and Latinas
- Communities of color, particularly African Americans and Latinos – male and female
- Men who have sex with men, particularly MSM of color and young MSM
- Immigrants, such as African refugees and immigrants, Haitian immigrants, non-English-proficient PLWH, undocumented immigrants, and migrant workers
- PLWH with co-morbidities such as Intravenous Drug Use (IDUs) or other substance abuse issues, mental illness, and homelessness
- Transgenders
- People living in rural areas or the outlying counties of an EMA or TGA
- Formerly incarcerated

6. **Components/Activities:** The Integrated Clinical Care Team Strategy involves many components and complex relationships. A sound process is likely to include the following steps and activities, though many diverse models fall within this broad strategy (Attachment A provides a flow chart summarizing them).

a. **Assign development of this model to a committee or task force.** This might be the committee of a Part A planning council that is most engaged in care strategies and the system of care – or it might be a special task force chosen by a Part B grantee. The task force should include PLWH (including individuals with some peer community health worker experience), clinicians, grantee representatives, provider personnel with clinical backgrounds and/or experience with peers, and an AIDS Education and Training Center (AETC) or other academic representative. Task this group with developing a program model and possible implementation steps. Contact some of the programs described in this document and/or review some of the resources provided so the group gets a sense of the components of program models using this strategy.

b. **Identify populations of PLWH that would benefit from intensive peer support, and consider the kinds of support they need.** Have the task force begin by considering these issues to gain an understanding of what is most needed in your jurisdiction. Generally, you will be targeting PLWH that encounter serious barriers to entering and remaining in care. Review available needs assessment data, including any data assessing unmet need and identifying key barriers keeping PLWH out of care or leading them to miss appointments and be non-adherent, as well as your comprehensive plan and the Statewide Coordinated Statement of Need (SCSN). Ask the needs assessment committee to identify useful information for targeting your work, and consult with your PLWH committee. Understanding the barriers faced by specific PLWH groups can help you target the model, selecting specific population groups and locations. Ask

PLWH from these target populations to use their own experience and knowledge base to help identify barriers to care, including factors that cause PLWH who have entered care to miss appointments, fail to take their medications, and drop out of care. Based on this information, the task force can agree on suggested target populations and on the kinds of barriers that will need to be addressed.

- c. Learn about provider experiences, needs, and interests.** If PLWH are to become members of clinical care teams, the support of clinical personnel and key administrators is essential. This model calls for providers to go beyond the use of peers as outreach workers and integrate PLWH into their multidisciplinary clinical care teams, involving peers in case conferences, assigning them important adherence and consumer support tasks, giving them access to some clinical records, and making them valued members of their clinical teams. Sometimes past provider experiences – positive or negative – color the way they view peer models. Talk to providers who are members of your planning body or its committees to learn about their experiences with peers. Provide information from evaluations referenced here that demonstrate that health-related and monetary benefits of these models. Explore provider views and experiences, and discuss with them ways in which peers can add value – for example, by providing individual attention to clients when clinical staff are pressured to serve as many clients as possible in a single day. Ensure an understanding of local provider perspectives and the kinds of models most likely to address the needs they identify.
- d. Agree on needed peer roles.** Once you understand community needs and provider perspectives, you can agree on roles you would like to see peers play in an integrated clinical team. Some peer roles help link PLWH into care, while others help keep clients adherent and fully connected to care and increase their disease self management skills. Consider the following roles:
- **Outreach** to identify PLWH who know their status but are not in care and clients identified by providers as not fully connected to care (i.e., they frequently miss appointments and may have adherence issues)
 - **Health education** about living with HIV and AIDS, prevention for positives, the importance of regular medical monitoring, the local system of care and how to enter it, and self management training and education.
 - **Trust-building activities** designed to create a positive relationship with PLWH who are not in care or are loosely connected to care.
 - **Referral and assistance in entering care**, often including accompanying PLWH to intake, helping them identify needed documents for determining eligibility, and helping them move from intake to their first clinical appointments.
 - **System navigation** to help new clients learn how to move about the system of care, requesting and obtaining needed care, and avoid unnecessary

frustrations, and to assist more experienced clients in obtaining needed services and working with new providers.

- **Linkage with community resources** to ensure positive relationships with core and support service providers, within or outside the Ryan White system, and sharing of information with clients about available resources.
- **Coaching and mentoring**, including advice and social support and encouragement – initially to help PLWH make the decision to enter and become fully connected to care, and later to keep them connected.
- **Treatment education**, including information on HIV/AIDS medications and their side effects, and how to live with the disease and the medications.
- **Adherence counseling**, to help clients adhere to treatment including medications, and ensure that problems are reported to the clinical team.
- **Interpretation services**, often provided as part of the task of accompanying PLWH to intake and new clients to various services. While Ryan White programs should offer core medical services in several languages, some provider staff will speak only English. Bilingual, bicultural peers can play a valuable role in interpreting for PLWH as they seek to enter the system of care, and in translating forms that are available only in English.
- **Ongoing follow up and support**, accompanying new clients to their first appointments and helping to ensure that they keep appointments during the first few months in care, then contacting them periodically to identify and address problems that may cause them to miss appointments or become lost to care.

- e. **Outline a program model that calls for appropriate roles and targets priority populations.** This includes considering the most appropriate service category for the model – usually primary care or medical case management, but possibly another core service area. For example, some programs are using early intervention services (EIS) not only for initial outreach and links to care, but also to assist with adherence and retaining people in care. Discussions with your Project Officer may be required.

In outlining the model, the task force should remember that peers need to be integrated into a clinical care team, but do not need to be located in a clinic. Sometimes peers work out of a community-based organization but come to the clinic site certain days or when their clients have appointments. They typically do much of their work in the community.

Be sure to build appropriate expectations and requirements into your model, to encourage effective use of peers. For example:

- **Recruitment and hiring of peers with the characteristics and experiences that can help reach the target population(s).** These may include current patients of the provider who have progressed in managing their own disease and feel comfortable working with other PLWH. Because peers are expected

to use their experience and knowledge base to help identify and address care barriers, they should be comfortable sharing their own experiences and have the capacity to serve as a bridge between medical care and the patient. The group of peers hired by a provider should together reflect key target populations. (See #7, Qualifications, below.)

- **Plans to ensure core competencies.** Peers under this strategy must have certain baseline knowledge and skills as well as opportunities to continue building their capacity over time. Providers need to allocate resources for intensive initial training as well as regular in-service sessions. This includes not only the kinds of training needed for linking PLWH into care, but also more technical knowledge such as an understanding of medications, side effects, and the dangers of non-adherence. They also need an understanding of various co-morbid factors such as mental health and substance abuse. Because the peers will be working in a clinical setting, they need training in areas like Confidentiality/HIPAA (the Health Insurance Portability and Accountability Act) requirements, and on how to work effectively with clinicians. Some models call for up to 90 days of pre-service training for peers, as well as regular continuing education sessions. (See #9, PLWH Training, below.)
- **Attention to PLWH concerns about medical care.** A provider may want to hire peers full- or part-time, or to pay stipends to PLWH who are on disability. It is important to adopt procedures that either provide health insurance or enable the peers to maintain eligibility for current medical care, through Ryan White or other sources.
- **Staffing needed to ensure active, ongoing supervision.** Studies have clearly demonstrated the importance of regular, hands-on supervision for peers, to ensure that they get the direction and support needed to interact successfully with both clients and the clinical team. (See #8, Supervision/Staff Support, below.)
- **Training for clinicians on how to work with peers.** In some instances, the use of peers in clinical settings represents a new model for clinical staff. Just as peers need training in how to interact effectively with clinicians, clinical staff need awareness and skill training that addresses how to integrate and work effectively with peers as part of an ongoing clinical team. In addition, some peers may also be patients. Training can assist clinicians in differentiating and shifting between these two peer roles – colleagues and patients.
- **Collaboration agreements and/or Memoranda of Understanding (MOUs) with points of entry into care and with the range of service providers with whom the peers will need to interact.** Information and communication are the keys to building trust among PLWH. To do this effectively, peers must work with many points of entry – from emergency rooms and testing sites to homeless shelters – and 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. It is worth the time and effort of the peer and his/her provider to make sure agreements are in place and everyone is working together to help PLWH enter and stay in care.

Some agencies may use the Health Insurance Portability and Accountability Act (HIPAA) as an excuse not to collaborate or provide information to a community health worker who is an employee of an outside agency. It is important that peers and their supervisors understand what HIPAA does and does not require, so it is not used to prevent peer integration and access to appropriate client information.

f. Explore funding potential and timing. The task force needs to consider how and when the model could be implemented. In a Part A program, the planning council will probably need to approve the program model, take action during priority setting and resource allocation to ensure funding for the model, and perhaps provide a directive to the grantee or work with the grantee on when and how the model can best be implemented. In a Part B program, the task force might make its recommendation to the grantee and planning body. In considering how best to implement a new or refined program model that will probably be implemented within core medical services such as primary care or medical case management, consider such issues as the following:

- **The procurement schedule for service categories of interest.** For example, if your program uses a three-year cycle, you need your new model to be ready for the next competition of that service category.
- **Potential for inclusion under the Minority AIDS Initiative (MAI).** Depending on reauthorization, MAI funding will probably be competed in 2010, so a new model that helps bring PLWH of color into care and keep them in care through an integrated clinical care team model would need to be developed, approved, and ready for inclusion in the application 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.
- **Availability of 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 – or refinement in a current model to add PLWH to your clinical care teams – may be relatively easy. If funds are very tight, it will be important to be able to discuss data from similar programs that suggest that this type of model brings PLWH into care and contributes to positive health outcomes.

g. Once procurement and contracting are in place, support the implementation of the model. Training and supervision of peers is the providers' responsibility.

To be successful, providers should be supported in efforts to ensure that peers are prepared to fulfill key roles, with particular emphasis on the following:

- **Promoting patient understanding of the system of care and how to navigate it.** Especially right after entry into care, the peer needs to increase the client's understanding of certain key concepts, primarily the need to work with the HIV health care system and remain in care, and the importance of learning successful self management of their HIV disease. Clear communication that is informative and culturally appropriate is vital to this effort. Peers are often called upon to translate medical jargon into plain language for clients. Often they are asked questions that patients feel uncomfortable asking their physician. For some clients, peers will need to be able to communicate these concepts in a language other than English.
- **Anticipating problems and helping to mitigate their impact.** This requires in-depth knowledge of the HIV service system and a careful assessment of the client and his/her situation. Many PLWH face complicating factors that create crisis situations that could lead them to drop out of HIV care. For example, many PLWH are multiply diagnosed with mental illness and/or substance abuse. Homelessness and lack of transportation can also negatively affect access to care. Peers can help by proactively helping clients navigate the care system and obtain needed services. As part of a clinical care team, the peer should be trained and prepared to help assess clients needs and to work with the medical case manager or other team members to address client needs and solve problems.
- **Facilitating service coordination and referral.** Sometimes a peer is responsible for referring a PLWH for services. More often, a peer accompanies the PLWH to a referral. The peer acts as a bridge to care, and helps ensure that the client receives needed services at the appropriate time. This is an importance and sometimes complicated role, sometimes involving client advocacy.
- **Teaching 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 PLWH to enter and stay in care. Peers are taught to coach, gently or more harshly scold as appropriate, and cheer when things go well. The communication and information they share is designed to help build client confidence, trust, and understanding of the HIV care system.
- **Providing emotional support, while maintaining professional boundaries.** Clients need emotional support – especially those with few family or friends to provide such support. 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 for clients. At the same time boundaries must be established so that peers share only what

is appropriate, while maintaining respect and confidentiality as well as professional ethics.

h. Evaluate the model as implemented. Require providers to collect data needed to assess the quality and value of peer activities, including whether it contributes to the number of PLWH entering and remaining in care.

7. **PLWH Titles, Roles, and Responsibilities:** Peers working in integrated clinical team models have many different titles – peers, peer advocates, system navigators, peer case manager. Peers can play a wide range of roles, from outreach to adherence counseling, and typically play multiple roles in working with a client over a period of months or years. Some of the roles are similar to those of peer community health workers engaged in helping get PLWH into care (See Strategy #3), while others are clinical. Speaking at the HIV/AIDS Bureau’s Consultation on the use of peers in interdisciplinary teams, Dr. Judith Bradford of Virginia Commonwealth University described peers in this strategy as “personal coaches, who help [individuals] develop the skills, knowledge and connections necessary to stay in care.” Typical roles include outreach worker, health educator, system navigator, client advocate, adherence counselor, coach, and mentor.

8. **PLWH Qualifications:** Typically, peers in models based on this strategy come from and have an in-depth knowledge of the geographic communities they serve and the populations they target. Programs have found that successful peer workers are those who can relate to, understand, and advocate for their clients. The many roles for peer community health workers in this strategy require a range of skills and capacities, such as the following:

- **High school diploma or high school equivalency** – usually required for this model
- **Familiarity with the 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 groups**, through membership in that group or significant work or personal experience with it.
- **Understanding of how Ryan White programs work**, and the barriers as well as the points in the system of care where individuals are especially likely to encounter problems
- **Strong communication skills**, enabling the peer to convey necessary information in a manner that is culturally appropriate and easy for the client to understand; this includes skills such as active listening and motivational interviewing
- **Ability to develop trusting relationships with PLWH**, so that the knowledge and advice provided influence PLWH behavior

- **An understanding of professional and personal boundaries**, of particular importance in situations where peer and client may encounter each other in social settings
- **A recognition of the importance of confidentiality**, including issues related to the peer's role as a member of a clinical team, often with some access to client medical records
- **An affinity for clinical issues**, including an interest in and capacity to learn skills related to a variety of issues that affect clients, from medications and their side effects to the impact of co-morbidities and the dangers of non-adherence – skills the peer will need in order to provide psychosocial support and help reinforce and reiterate clinical care instructions, assist with adherence issues, and help clients manage medication side effects
- **Personal status** – currently in care, adherent to prescribed treatments, and not engaged in substance abuse

9. **Supervision/Staff Support:** The models in this strategy all require a high degree of staff support and supervision. A provider needs the infrastructure and support to attract, train, supervise/advise, and retain peers. The peer needs supervision on a variety of levels: as an individual employee, a member of a clinical team, a member of the peer program, and as a PLWH. Meeting these needs requires policies, procedures, and training capacity, which together ensure clear guidance and expectations for peers and other agency staff. Supervisors must have the knowledge, skills, time, and authority to enforce the policies and procedures. This includes ensuring that peers are in fact treated as valued members of the clinical care team – kept informed, given appropriate access to client information, included in clinical team meetings, consulted, and listened to. One important responsibility of the supervisor and other members of the clinical team is to help the peer see that s/he is changing people's lives. As with any staff member, emphasizing the value of the work helps maintain motivation and prevent burnout.

Supervision can be complicated. Sometimes the peer has a single supervisor; sometimes s/he receives dual supervision by a peer program manager and a member of the clinical staff – which necessitates a very clear division of supervisory and staff development responsibilities.

Some successful programs also include mentorship by experienced peers. This benefits the less experienced peer in obvious ways. It also benefits the provider, especially when clinical staff are overworked and under strain, because staff can focus on training one peer very well and then empowering that person to help train and support the other peers.

10. **Training for PLWH:** This strategy requires both pre-service and ongoing training for peers, to provide ongoing opportunities for professional growth. Orientation and training systems need to be in place before the first peer is hired. Typically, peers

working as members of a clinical team need orientation and training in such areas as the following:

- Understanding of the organization, its mission and values, its policies and procedures, its “organizational culture,” the structure and operations of its HIV program, and specific job roles and expectations – all a part of initial orientation
- Understanding of HIV disease, including HIV 101, disease progression, and disease management
- Co-morbidities
- Medications, their best use and side effects
- Understanding and navigating the system of HIV care
- Confidentiality
- Outreach, making contact, and trust building
- Communication skills including active listening, motivational interviewing, and responding to emotion
- Empathy and maintaining professional boundaries
- Self-disclosure as a peer
- Problem solving and crisis management
- Working effectively with clinical staff
- Self-care for the peer

Some peer models provide extensive pre-service training. One cancer program describes a 90-day pre-service training period. Training can be a combination of orientation, pre-service training, and in-service staff development – but peers should not be assigned clinical tasks or given access to clinical data until they have completed needed training. The PEER Center partners conduct peer advocate training sessions that range from three to ten full days. Christie’s Place in San Diego, which employs PLWH as family case workers, usually hires PLWH as peers after they have volunteered for six months. However, this is rarely practical for projects using peers as members of clinical teams. The less knowledge and experience peers have before they are hired, the more extensive the pre-service training needs to be.

Programs that have been operating for several years typically need to offer training at multiple levels, from introductory to advanced, to fit each peer’s level of experience.

11. **Important Linkages:** This strategy assumes that peers will be involved in connecting PLWH to care – first to medical care and medical case management, then to a whole range of Ryan White and non-Ryan White funded core medical and support services. The peer needs positive professional and personal relationships with a wide range of HIV/AIDS service providers and points of entry into care. Ideally, the provider will have MOUs with key points of entry and referral agreements with other providers,

and the peer's job will be to develop relationships with appropriate staff at these facilities.

12. **Resources Required:** This strategy generally involves core services provided by both clinical and peer staff. Typically peers are added on to existing programs; the additional expense includes staffing costs for several full-time equivalent peers as well as supervisory staff, as well as training and operating costs to support the peers.

As described in Strategy #3, Linking PLWH to Care, salaries for peers vary considerably based on location and peer experience. Some community health workers have associate degrees or higher educational levels, and salaries are higher for those with more formal education. The national study of community health workers published in 2007 found that beginning CHWs typically made more than minimum wage (\$7.25 per hour or \$15,080 if full time) but less than \$15 an hour (the equivalent of \$31,200 per year). Experienced CHWs usually made at least \$13 per hour (\$24,040 per year if full-time), and half earned at least \$15 per hour (\$31,200 a year). Many programs hire peers by the hour and employ them less than full time. Because peers serving as members of clinical teams are required to have a particularly diverse set of skills including clinical skills, their wages once they are fully trained and experienced are likely to be higher than those of CHWs doing only outreach or other jobs requiring less technical knowledge.

The *Workforce Study* found that most employers provide benefits to their community health workers, most often mileage reimbursement (provided by 76% of employers), health insurance (71%), sick leave (71%), vacation (68%), personal leave (56%), and some form of retirement plan (54%). Benefits typically depend on the number of hours worked.

Some programs hire PLWH who receive Social Security Disability Income (SSDI) and therefore can generally work less than half-time if they wish to maintain their benefits. However, programs that fit this strategy tend to hire PLWH full-time or nearly full time, since they play a variety of ongoing roles. The heavy investment in training may lead a provider to prefer a full-time worker.

13. **Service Categories:** Several Ryan White core medical service categories can use peers who function as community health workers, operate as part of an integrated clinical care team, and maintain ongoing relationships with client PLWH. The most likely service categories for such program models are:

- HIV-related outpatient medical care
- Medical case management

Early intervention services might also be a possible service category, but only in jurisdictions where this service category is involved with keeping people in care, not just helping them enter care

14. Attached Materials: Attached are:

- Attachment A: Flow chart of the strategy documented here
- Attachment B: Peer Roles in Diabetes Self Management. Diabetes programs often use peers for roles from outreach and case finding to case management and ongoing follow up and support. The Robert Wood Johnson Foundation’s Diabetes Initiative focuses on self management – “what people do to manage their chronic condition and its effects on their physical health, daily activities, social relationships, and emotions.” The Initiative engages peers in self-management support, defined as “the systematic use of education and supportive strategies to increase people’s skills and confidence to manage their health condition and problems that may arise.” The attachment provides a table showing peer roles used in diabetes self management, prepared by Carol A. Brownson of Washington University in St. Louis.
- Attachment C: Peers in Multidisciplinary Teams, a sample “core competency” module from the PEER Center’s toolkit, *Building Blocks to Peer Success*.
- Attachment D: Report of the HRSA/HAB Consultation Meeting on the Utilization and Role of Peers in HIV Interdisciplinary Team, held February 23 in Bethesda, MD.

15. Benefits: This strategy offers important documented benefits, such as the following:

- Increased capacity to reach hard-to-access PLWH groups, develop mutual trust, and help bring people into care.
- Affordable intensive support for PLWH with co-morbidities or other barriers that are likely to negatively affect adherence and long-term retention in care. Peer community health workers make it possible to provide ongoing support to such clients, reducing non-adherence and missed appointments and increasing retention in care.
- Assistance for clinical staff who are under considerable pressure to see as many clients as possible.
- Increased client disease self management skills, which can help programs move to a chronic disease model of HIV/AIDS care. In such a model, after a year or two in care, many clients require less case management or other support beyond their medical care and medications. This frees funds for intensive services to those new to care and/or facing significant barriers.

16. Challenges:

- Successful integration of peer CHWs into a clinical team requires the support of the clinical team, which can be challenging to attain
- This strategy requires extensive PLWH training, which can be both costly and time-consuming. One successful cancer-focused peer navigation program reported

providing 90 days of pre-service training for peer patient navigators. Developing and implementing appropriate training can be a challenge. Moreover, to gain full benefit from such training, high retention rates are necessary.

- This model often requires significant program design refinement, and some programs may decide that the transition must be made when the service category is going out for bid. This may mean a delay of several years before the model can be implemented.

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

- Number of PLWH who were out of care and, through assistance by peer clinical team members: (a) are identified, (b) enter care, (c) fully connect to care (as determined by such measures as kept appointments), (d) adhere to treatments, and (e) remain in care after a specified period (e.g., 6, 12, or 24 months)
- Differences in connection, treatment adherence, and retention between clients assisted by peers and clients not assisted by peers
- Reported self efficacy by clients assisted by peers, including skills in navigating the system, adherence, self management of the disease, etc.
- Improved health status
- Cost savings or return on investment, usually in terms of reduced health care costs

There have been more evaluations of this strategy than of most other peer strategies, partly because of the wide use of peer community health workers in a variety of health care settings. The SPNS initiatives include evaluation, and the literature includes numerous evaluations of the success of community health worker programs focusing on diseases such as diabetes, and on the benefits of *promotores* programs. Among the evidence:

- The Community Health Worker report noted that in a “Medicaid population with diabetes and hypertension, CHW care management produced significant reductions in ER visits, hospital admissions, and total patient costs to the Medicaid program.” [See Chapter 6 of the study.]
- Dr. Judith Bradford of Virginia Commonwealth University reported at the HRSA/HAB peer consultation on a SPNS project, 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 evaluation found that “peer navigation programs help clients overcome barriers to HIV care, and build skills, knowledge, and self-confidence that help facilitate their retention in care.” The study found reductions in “structural, financial, and personal barriers,” and “improvements in provider engagement, which resulted in better health outcomes as measured by a 50% increase in the number of clients with undetectable viral loads.” In addition, intense engagement early on led to “greater client independence” later on. (See Section #20 reference to the Report on the HRSA/HAB peer consultation and related PowerPoint presentation.)

- A five-year study of peer navigation for people with cancer, implemented in 2005 by Kevin Fiscella of the University of Rochester Medical Center with funding from the National Cancer Institute (NCI), found that when peer “navigators do their jobs well, medical staff begin to rely on them,” and that “navigators can influence healthy client choices around care and wellness” where there is a strong and trusting relationship. (See the Section #20 report on the HRSA/HAB peer consultation.)
- An evaluation of a *promotores* demonstration peer navigation project examining self-management of diabetes, funded by the Robert Wood Johnson Foundation from 2003-2006, was described by Carol Brownson at the HRSA/HAB peer consultation. At the Gateway Community Health Center in Laredo, Texas, the study found that prior to the demonstration, *promotores* were used, but “were not integrated into the health care team and tended to work alongside, but not necessarily with, health center clinicians.” The demonstration gave them active clinical roles, such as screening clients for depression, participating in client case conferences, and “tracking key diabetes indicators used to assess client progress in self-management.” Demonstration project results included: “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.” In addition to improved health outcomes, clients “received more individualized care and exhibited greater adherence to treatment.” As a result, the health center developed the structures and procedures “necessary to support the ongoing integration of *promotores* into its diabetes program.” (See the Section #20 report on the HRSA/HAB peer consultation and the Brownson PowerPoint.)
- A nurse-led diabetes peer program in San Diego, Project Dulce, which engages peer educators to provide culturally appropriate patient self-management classes. The project serves primarily Latinos but also African American, Filipinos, and Vietnamese communities. In addition to the peer classes, the program engages diabetes-trained nurses and dieticians who work with both patients and their primary care providers, uses standards of care and methods from the American Diabetes Association, and tracks patient outcomes. A study by a health care economist at the University of California, San Diego found that over the past ten years, health care costs for Project Dulce patients have been reduced by 60%. (See reference in Section #20, below).
- A number of other evaluations of *promotoras* programs have reported positive results for patients, such as more health education, improved health outcomes, individualized care, greater adherences, and referrals that meet their specific needs. Providers report benefits such as improved use of their time and improved diabetes control among their patients. Factors that contribute to the success of such programs include peer access to the target population, personal commitment, a unique and trusting relationship with clients that includes providing “critical social supports” and contributes to good self management, peer flexibility to meet client needs where and when they are needed.

18. **Helpful Hints and Lessons:** Experience indicates that this strategy requires careful planning, sound peer training and supervision, and both PLWH and provider commitment. Among the most important lessons and hints:

- The success of this strategy requires support from providers, especially their clinical staff. In planning for this strategy, it is very important to actively engage key provider personnel to inform them about the benefits of the strategy and gain their support. For communities where use of peers as part of an integrated, multidisciplinary clinical team has not previously been attempted, a pilot effort may be useful. Planning bodies interested in this model could use directives to call for pilot testing of this model in several different provider environments, such as both a small and a large clinic, or as part of several different core medical service categories. Testing – and careful evaluation of results – in more than one clinical environment, but with similar peer roles, can provide useful information for decision making about broader use of such a model.
- Generally, peers hired for this strategy need to “look like” the PLWH they serve, and to bring similar life experiences. Shared backgrounds and experiences help in building trust with PLWH clients and modeling health care seeking behaviors. However, factors like gender do not always need to be matched. For example, at Altamed Clinic in Los Angeles County, in a peer-case management model, the target group was young Latino men, but the successful peer was a bilingual Latina. Her skills and character enabled her to successfully build trust and confidence with the target population, who viewed her as a maternal/girl friend figure.
- Peers need to know the local community – in terms of both geography and population – and be effective at both field outreach and at work within a health care setting.
- It is often hard for a provider to ensure ongoing, structured training if the program employs a very small number of peer community health workers. The group is too small for typical training sessions. This problem can be overcome by arranging for joint training for peer CHWs from multiple providers – or having the program contract with a single entity to coordinate training for all peer CHWs.
- Providers need to appropriately categorize and bill peer CHW costs. If the program planning to add peer community health workers budgets and bills based on full-time equivalent salaries, then the process is easy. If the program bills service units, then the peer salary and costs must either be spread across all clinical visits or be charged through a separate, accepted service unit.
- This model should be institutionalized partly through changes or additions to the Standards of Care for the service category involved. Standards should clearly specify peer community health worker roles and expectations, including the importance of marking them a part of the clinical team, with appropriate training, access to records, and participation in clinical team meetings.

19. **Source(s) of Information:** Many sources of information contributed to the preparation of this document. The most important included the following:

- The University of Tennessee Medical Group Part D Program, including interviews with staff and review of the program's three in-depth implementation manuals.
- *Community Health Worker National Workforce Study*, conducted with support from HRSA's Bureau of Health Professions by the Regional Center for Health Workforce Studies of The University of Texas Health Science Center at San Antonio, and published in March 2007.
- A journal article by Judy Bradford et al. on "HIV Navigation: An Emerging Model to Improve HIV Care Access," which appeared in *AIDS Patient Care and STDs*, Volume 21, Supplement 1, 2007.
- Various PowerPoint presentations and discussion at the HRSA/HAB consultation on the Utilization and Role of Peers in HIV Interdisciplinary Teams, held February 23, 2009 in Bethesda. Of particular relevance to this strategy were presentations from the PEER Center of Boston University, Cicatelli Associates' work on "integrating peer advocates as essential members of multidisciplinary clinical teams," and the Los Angeles Department of Health SPNS project on young African American and Latino MSM, describing OASIS and Altamed clinic programs that use a peer-delivered case management model.
- The PEER Center four-day regional training in Memphis in May 2009, and the manual that was the focus of the training: *Building Blocks to Peer Success*.
- Professional experiences of the Mosaica Consumer LINC project team.

20. **References and Resources:**

- Report on and PowerPoints from "The Utilization and Role of Peers in HIV Interdisciplinary Teams," a HRSA/HAB consultation held February 23, 2009 in Bethesda, MD.
- *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 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. Funded through a cooperative agreement with HAB's Division of Training and Technical Assistance (DTTA). A second toolkit for providers employing peers is in development. Current toolkit available online at http://www.hdwg.org/peer_center/training_toolkit.
- *Peer Support for HIV Treatment Adherence: A Manual for Program Managers and Supervisors of Peer Workers*. Prepared by the Harlem Adherence to Treatment Study (HATS), Harlem Hospital, New York, in 2003. The guide provides training modules and evaluation tools designed to help managers add a

- peer adherence component to an existing program. Available online at [http://www.peernyc.org/Assets/web_docs/Peer%20Adherence%20Support%20Manual%20\(HIV\).pdf](http://www.peernyc.org/Assets/web_docs/Peer%20Adherence%20Support%20Manual%20(HIV).pdf).
- Harold P. Freeman Patient Navigation Institute, which provides training and certification in patient navigation, with a focus on cancer care. At least one of the SPNS projects based its client navigation approach on the Freeman model. See the Institute website, www.hpfreemanpni.org.
 - Fenway Institute’s plain-language training module on “The Role of the Health Systems Navigator,” one product of the SPNS grant, available online at http://www.fenwayhealth.org/site/DocServer/What_is_HSN_abbreviated.pdf?docID=365.
 - Sample procedures to guide *promotoras*, available from the Migrant Clinician Network in English and Spanish, at <http://www.migrantclinician.org/mcn/health-center-policies-and-procedures/promotora-community-health-worker-policies/index.html>,
 - A description of the Project Dulce services and outcomes. A San Diego collaboration between Scripps Health’s Whittier Diabetes Institute and other clinics and community-based organizations, this diabetes program has successfully used peer health educators for over ten years, successfully reducing the costs of their health care by focusing on education and prevention. See an article in the *North Country Times* on July 8, 2009, at <http://www.nctimes.com/articles/2009/07/08/health/za7ee91b71a3f9be6882575d800094e1e.txt>. For additional information about the program, see the Scripps Health website, at <http://www.scripps.org/services/diabetes/project-dulce>.
 - *Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success*. Prepared for the California Healthcare Foundation, December 2006. Provides detailed models of seven programs, using such diverse approaches as reciprocal peer partnerships, support groups, self-management training, coaching, and telephone- and internet-based peer support. Report describes models, provides cost information, and presents at least one case study showing how an organization is using the model. Report available online at http://www.fachc.org/pdf/mig_building%20peer%20support%20programs-seven%20models.pdf.