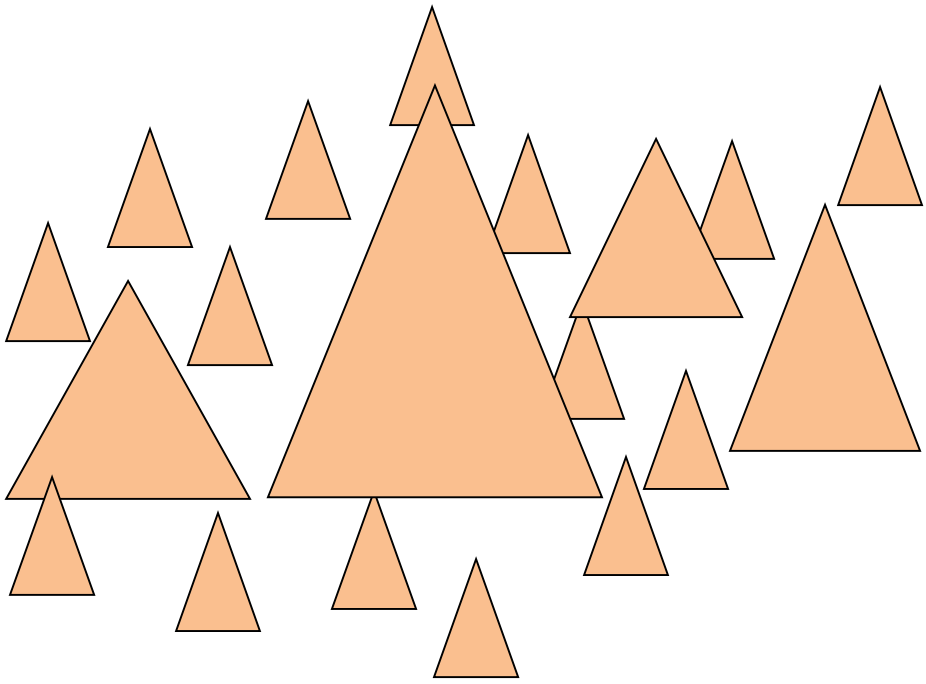
Peer Support

NYLinks Implementation Manual



NYLinks

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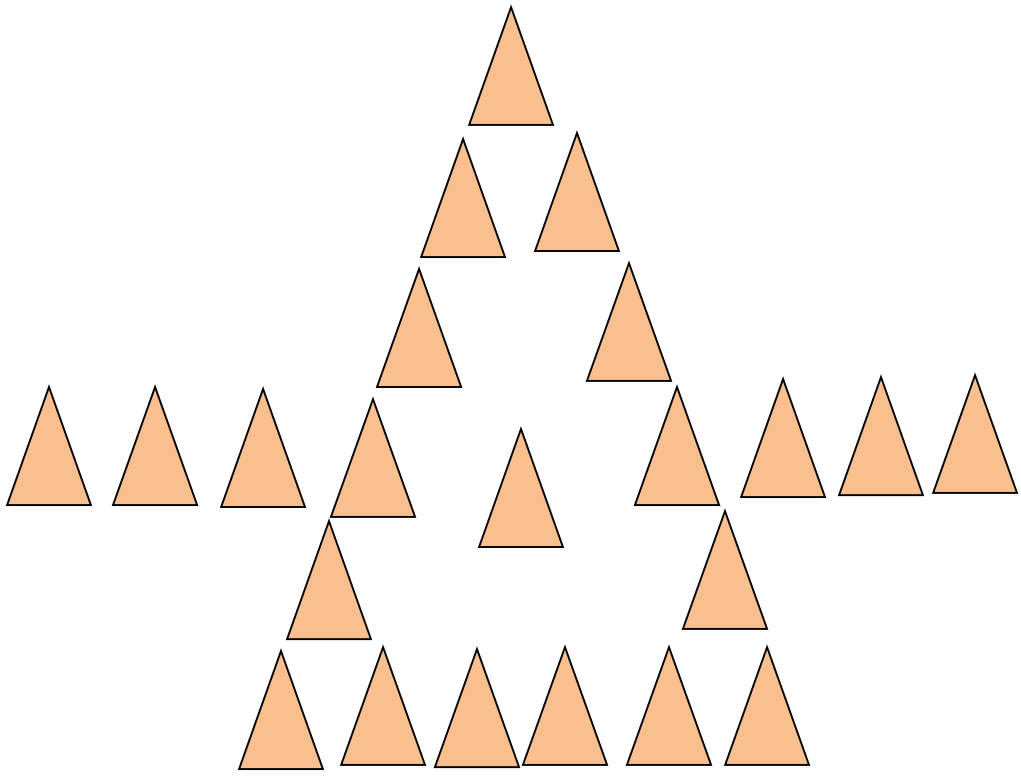

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A. What is the Early Peer Support intervention?

Patients who are new to receiving HIV care are particularly vulnerable to falling out of care. This includes patients who are newly diagnosed, those who transfer their HIV care to a new clinic, and those who are returning to the clinic after a lapse in care. A peer, can make a difference in the ability of this newly enrolled patient to routinely attend his/her medical appointments. The peer should be someone who is HIV-infected, receives care at the clinic, adheres to their medication regime and is virally suppressed. The aim of this intervention is for trained peers to engage patients who are new or returning to HIV care at the organization in order to establish a foundation and relationship that enables regular HIV medical care. Services are delivered for up to 6 months.

B. Target population

The intervention is aimed at improving outcomes for newly HIV diagnosed adult consumers (diagnosed within the last 6 months), those transferring their HIV ambulatory care to the clinic, or those returning to HIV care (after going at least 6 months without receiving HIV medical care). This is a voluntary program and patients must agree to receive peer support program services prior to the start of the intervention. The intervention can be targeted to one of the above populations, all of them, or any combination of them.

C. Core elements of the intervention

This section describes the essential components of the intervention. The core elements are critical to the success of the intervention and must be implemented exactly as designed. If one or more of the core elements is altered or dropped, the intervention will be compromised resulting in reduced effectiveness of the intervention.

The core elements of the NYLinks Peer intervention are:

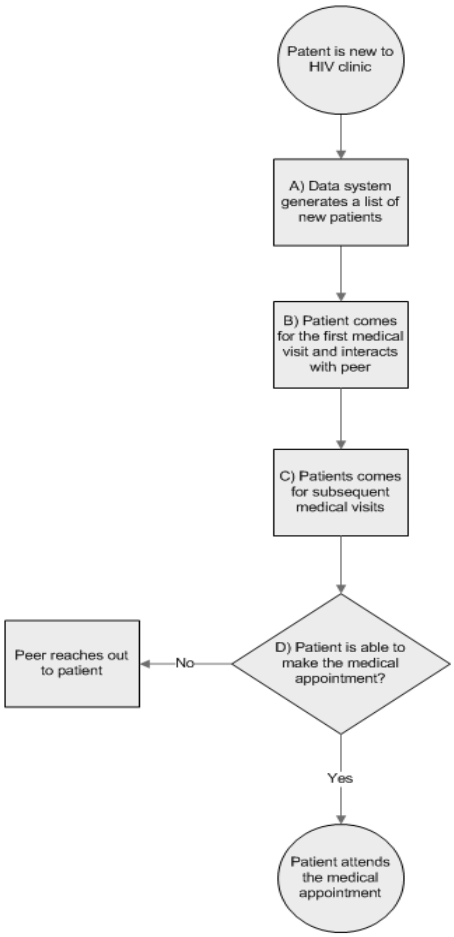
A) Clinic enters a Patient ID into a data collection tool (see Process Measure Log as an example) for every patient eligible for the intervention. This includes every newly diagnosed patient, patients who are transferring their care to the clinic, and patients who are returning to the clinic after being out of care for at least 6 months.
B) Every eligible patient is offered enrollment into the Peer intervention.

C) Peer provides the following services to those patients who accept enrollment into the Peer intervention on their initial medical appointment:

i. Meet and greet patients who are new to the organization
ii. Provide a tour of the facility
iii. Inform the new patients about available services and processes
iv. Introduce patients to appropriate staff
v. Provide educational and organizational materials

D) Peer documents the interaction with patient on the data collection tool (see Process Measure Log as example)

The following flowchart illustrates the necessary steps to engage newly enrolled HIV-infected patients in their HIV care through trained peers: (Full flowchart is on page 17)



D. Adaptable elements of the intervention

Unlike the core elements of an intervention which must be implemented exactly as designed, adaptable elements are activities and delivery methods that can be tailored to meet the specific needs of an organization without compromising the integrity of the intervention.

The adaptable elements of the NYLinks Peer intervention are as follows:

- Peers can be either volunteers or paid staff
- Peers can work with patients in more integrated ways, working as part of the medical services team e.g.,
    - Answer questions as appropriate
    - Provide reminder and follow-up calls to patients and check in with patients to reduce the formation of barriers
- A peer that is a current employee could be used as a peer navigator
- Additional elements may be added to the work of the peer. These elements can be related to patient education, advocacy, emotional support, system navigation outside of the HIV system, etc. Only elements for which the peer is knowledgeable or has been trained should be added

E. Length of time the intervention is delivered to each patient

This intervention begins when a consumer is linked to HIV care at the organization. Interactions with peers occur as needed by the patient but happen at least during each scheduled medical visit while the patient is receiving the intervention. The intervention is delivered to each patient for a minimum of six months or until the patient decides s/he no longer wants or needs a peer. Each patient should be regularly assessed to determine continued need.

F. Staffing requirements/roles and responsibilities

Peers: Peers must demonstrate good self-management skills, consistent adherence to prescribed ARVs, and adherence to treatment for at least one year. Peers should be a model for patients. Peers should abide by all agency policies and procedures including confidentiality and disclosure, have an empathetic attitude and show commitment to helping other people living with HIV. Peers need to be able to handle a variety of tasks including provision of one-on-

one support, communicating with providers, referrals, the provision of education, and the documentation of services provided.

The peer should be able to speak openly about his/her experiences with HIV and the HIV service system with empathy, cultural and linguistic competence. The peer needs excellent interpersonal relations skills and should be organized and have the ability to multi-task and be non-judgmental.

Finally the peer needs to have a solid understanding of the boundaries that exist in their roles as peer and client, and where to seek clarifications if questions arise.

Care coordinator: Oversee all peer activities. This supervisor role will possess the skills and have the time to provide training on agency policy and procedures, provide the peer with psycho-social and emotional support, communicate peer expectations as a member of the multi-disciplinary clinic team, and have the authority to enforce agency policy and procedures.

G. Staff training

Care coordinators and other staff overseeing the peer support program will be responsible for training peers on agency policy and procedures for peer support services. This includes the use of confidentiality agreements, boundaries, agency rules and regulations, and safety protocols. Peers or support staff will also need to be trained on how to consistently collect and maintain process measure data.

Training in confidentiality/disclosure, active listening and communication skills, ARV adherence, medication side effects, co-morbidities (e.g., mental health, substance use, and Hepatitis C), coaching/mentoring skills, teach back and basic motivational interviewing skills would be beneficial for peers to have. At a minimum, peers will need a general knowledge of HIV terminology, clinic infrastructure, and health system resources.

H. Resources suggested for implementing the intervention

A peer recruitment and selection process should be standardized (as a sample process see http://peer.hdwg.org/sites/default/files/RecruitingHiringAndOrientingPeers.pdf) to develop, disseminate, collect, review, interview, and select peers to provide this service. Peers will need to follow organizational confidentiality agreements. It will take time for care coordinators to supervise

peers, oversee intervention activities and to organize and/or deliver initial and ongoing training sessions.
It is important to have patient input on the goals and progress of the peer support program prior to and during the implementation.

- A process map detailing the flow of patients in care should be developed
    - Review the process flow map to understand where the peer support program fits in with the current flow of service provision.
    - Redraft the process flow map including all steps in the peer support process, showing how these interact with the existing process flow.
    - The process flow map should be used in drafting an action plan detailing the peer program.
- All stakeholders including patients, medical providers (for clinical programs) and program leadership should come to consensus and agree upon the plan.

As the peer program is implemented, supervisory staff and peers should review all aspects of the process, and revise the action plan as needed. Supervisor facilitated review of the plan and revision of the plan as needed should occur frequently--weekly at minimum-- upon first implementing the program, then at least on a quarterly basis going forward. The facility should consider variations among patients and patient needs when reviewing and revising the plan.

A process should be developed to introduce the peer to the new, transferring or returning to care patient. The name of the peer who will be available to provide a warm welcome during the patient's first clinic visit should be provided if known.

I. Implementation

The following organizational elements are required for this intervention:

A) Peers (who are HIV-infected and who receive HIV care at this clinic), and who are interested in working with new or returning patients. Staff resources need to be available to recruit and support these peers.

B) A data system that can generate a list of patients, on a regular basis, that meets at least one of the following criteria:

    i. Newly HIV diagnosed
    ii. Newly transferred their HIV ambulatory care
    iii. Returning to HIV care after at least a 6 month absence from HIV care

C) The ability to share the generated list with the peer(s) implementing this intervention. At a minimum this list should contain:

i. Patient name and contact information
ii. Dates of last and upcoming HIV medical appointments
iii. Date of last and upcoming non-HIV medical appointments

D) Staff resources available to supervise Peers in the data documentation and submission process. This includes regular monitoring that the process measure tracking tool (Appendix A) is being properly and routinely filled out by Peers, and that once a month the patient-level data is aggregated and submitted to the NYLinks team.

Once a list of patients who are eligible for the Peer intervention has been generated and shared with the Peers:

- Patients are introduced to peer program and accept or refuse involvement
- Peer connects with patient.
- The peer introduces the patient to clinic staff and to available educational materials/resources, letting the patient know of available services on and off site and how to access them, and providing liaison services as needed between clinic staff and the patient.
- All contact is recorded (see Process Measure Log for example) and communicated to care team.
- Peers are supervised.
- Intervention process is reviewed and adapted as needed.
- Patients receive peer services for limited period of time (up to 6 months) based on need.
- Data is collected and used to inform decision making.

J. Data to be routinely collected and reported

The importance of data

Date is critical in analyzing patient care and progress. The more detailed your data the easier it is to understand where performance improvement can take place. There are two types of data measures: Process and Outcome. While it is not critical to collect and analyze data for this intervention to be effective since it is evidence informed, collecting and analyzing data will enable you to better identify areas where patient or population level improvement might take place. We offer below, some suggested ways you can utilize data.

Process measures

Process measurements are an assessment of intervention related activity connected to a desired outcome. This type of measure involves basic counts of intervention related procedures. For example, the number of patients who were referred to a program, the number of staff trained etc. Process measures are used to identify areas where improvements can be made during implementation of an intervention or as a tool in on-going monitoring of an intervention.

The NYLinks staff has developed process measures that were used in the statewide evaluation of this intervention. A data collection tool has been developed to aid providers to systematically track process measure information (Appendix A- Process Measure Log). These tracking tools should serve as a guide and are not required to be used as long as the provider has an alternative tracking method in place. The tracking tool is designed to be used electronically but may be printed for manual record keeping. Providers should develop a schedule to perform routine quality assurance on the data to ensure that information is being collected and recorded accurately and frequently.

The following naming convention may be used for the log in Appendix A to track process measures monthly:

Filename: Peertrackingtool_MMYYYY.xls where MMYYYY represents the 2-digit month and 4-digit year of the data contained in the file.

Aggregate process measure data will primarily be used in the statewide and multi-state evaluation. In order for providers to report aggregate data to the NYLinks team, process measure data should be collected and recorded for each patient affected by the intervention and then aggregated as a total for all patients every month. For example, whether or not a client accepted enrollment into the peer support intervention would be aggregated into total number of clients offered the peer intervention and the total number of clients who accepted enrollment into the intervention during that month.

Many of the patient-level data elements for the process measures described below may already be routinely collected by providers. These include patient name, unique patient identifier and the date the patient came in for a service. Although patient-level data will not be reported to the NYLinks team, all of the data elements that would need to be tracked to accurately report aggregate process measure data is provided below. Optional data elements are also suggested for providers who are interested in gathering additional information for their intervention. **No**

patient identifiers should be included in any aggregate data process measure report that is sent electronically to the NYLinks team.

The following data elements will need to be collected *each month* to create process measures for the Peer intervention:

Patient-level data elements:

1) Patient Name/Unique Identifier
2) Was patient offered the Peer intervention (yes/no)
3) Did patient accept a peer (yes/no)
4) Type of patient (Newly diagnosed, transferring care, or returning to care)
5) Date patient enrolled in or declined participation in the Intervention
6) Reason for Peer Encounter #1 (Initial visit, appointment reminder, rescheduling missed appointment, navigational services, or liaison services)
7) Date of Encounter #1
8) (Repeat Reason and Date for as many encounters a Peer has with patient)
9) Number of peer encounters each patient had in the reporting period month
10) Date of final encounter with Peer

Aggregate data elements:

1) Total number of patients who were eligible for care during the reporting period month (all newly diagnosed patients, all transfer patients, and all patients returning to care)
2) Total number of patients who were offered a peer during the reporting period month
3) Total number of patients who were enrolled in the Peer intervention during the reporting period month
4) Percentage of patients who were offered a Peer who enrolled in the intervention during the measurement month
5) Total number of patients new to the log this month with *at least one* peer encounter during the reporting period month
6) Total number of patients from previous month(s) log with *at least one* peer encounter during the reporting period month
7) Total number of patients who had more than one encounter during the reporting period month
8) Total enrolled patients who ended their intervention during the reporting period month

Calculations possible from the aggregate data elements:

Percent of eligible patients who were offered a peer = 100* (aggregate data element #2 / aggregate data element #1)

Percent of eligible patients who accepted a peer= 100* (aggregate data element #3 / aggregate data element #1)

Percent of patients who were offered a peer that accepted a peer = 100*(aggregate data element #3 / aggregate data element #2)

Percent of patients with at least one peer encounter = 100* (aggregate data element #4 / aggregate data element #3)

Using the Process Measure Logging Tool:

The tool found in Appendix A may be used to collect the outlined Process Measure data, or an alternative tool may be created by the agency to fit their needs, provided that all of the data is collected and is able to be aggregated and submitted monthly to NYLinks.

Process measure data needs to be collected for *every* patient who is eligible for the Peer Intervention: every patient who is new to the clinic, who is transferring care to the clinic, or who has been out of care at the clinic for at least 6 months. Each month, all of the patient level data (see the Patient Monthly Log tab in Appendix A) will need to be summarized onto the Aggregate Monthly Log tab.

The Peer Intervention spans more than one monthly reporting period. The tracking tool is intended to be a dynamic roster of patients who are eligible for a peer, who has been offered a peer, and who is enrolled in the intervention. Therefore, patient information for persons who are enrolled and still ongoing in the intervention should be carried from one monthly tracking period to the next until the patient chooses to end their involvement in the intervention.

K. Assessing fidelity to the intervention

In program evaluation, fidelity examines the extent to which an intervention is conducted as it was originally designed. Monitoring fidelity ensures that specific elements of an intervention are implemented according to protocol. This maximizes the effectiveness of the intervention and the likelihood of seeing the desired outcome.

We suggest, that to adequately monitor the fidelity of the Appointment Procedures intervention, 3 reviews take place. The first review should occur shortly after implementation (2 to 4 weeks) of the intervention to help identify if the core components are being implemented or delivered as planned. This will allow for early corrections and improvements to be made if it is found that deviation from the essential elements of the intervention has occurred. Additional reviews should occur at 6 and 12 months to assess if fidelity is maintained over time. It is suggested that the fidelity review be performed by someone who is not involved in implementing the intervention. This removes any potential bias from the review process.

Fidelity should be assessed by confirming that the intervention as it is being implemented meets the requirements in the core elements. A fidelity monitoring tool is part of this implementation package.

L. Acronyms and key definitions

Care Coordinator: A person who enrolls consumers into HIV programs and verifies eligibility. A care coordinator performs a comprehensive assessment of the consumers' needs and develops a comprehensive plan to address (New York City Department of Health and Mental Hygiene http://www.nyc.gov/html/doh/downloads/pdf/ah/ah-care-coordination-fact-sheet.pdf). Care coordinators supervise peers. Case Managers, nurses, care managers, or other staff can be Care coordinators.

Peer: HIV positive individuals who share identifying characteristics with individuals or population groups receiving care or services. Peers share similar experiences and challenges related to class, race, age, gender, language, culture and recovery from substance abuse and/or trauma. These common characteristics often provide peers with deep insight into the feelings and behaviors of clients, and help them forge both personal credibility and trusting relationship with clients. In the field, they are also called coaches mentors, community health workers.http://hab.hrsa.gov/newspublications/peersmeetingsummary.pdf. Peers are supervised by care coordinators.

Peer navigator: A person who can achieve rapport with patients, Identify and addressing barriers to care, anticipate and pre-empt potential problems, promote patient self-efficacy through teaching and coaching; and provide emotional support.

http://hab.hrsa.gov/newspublications/peersmeetingsummary.pdf. Like other peers, peer navigators are managed by care coordinators

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N. References

Emily Gantz McKay, Harold Phillips, Hila Berl, Project Consumer LINC webinar, December 5, 2011Developing a Peer-Based Early Intervention Services Program: https://careacttarget.org/library/developing-peer-based-early-intervention-services-program-project-consumer-linc-webinar
The Target Center: https://careacttarget.org/content/organizations-care-toolkit-employing-consumers-ryan-white-care-act-programs
The Peer Education and Evaluation Center: http://peer.hdwg.org
Community Health Workers National Workforce Study: http://bhpr.hrsa.gov/healthworkforce/chw/

Building Blocks to Peer Success - 2 toolkits - PEER Center, Boston University:
http://www.hdwg.org/peer_center/training_toolkit
Integrating Peers into Multidisciplinary Teams: 2 toolkits - Cicatelli Associates -
http://careacttarget.org/ library/peers/ToolkitForPeerAdvocateSupervisors.pdf
"The Utilization and Role of Peers in HIV Interdisciplinary Teams" - HRSA/HAB Consultation -
http://hab.hrsa.gov/newspublications/peersmeeting summary.pdf

O. Appendices

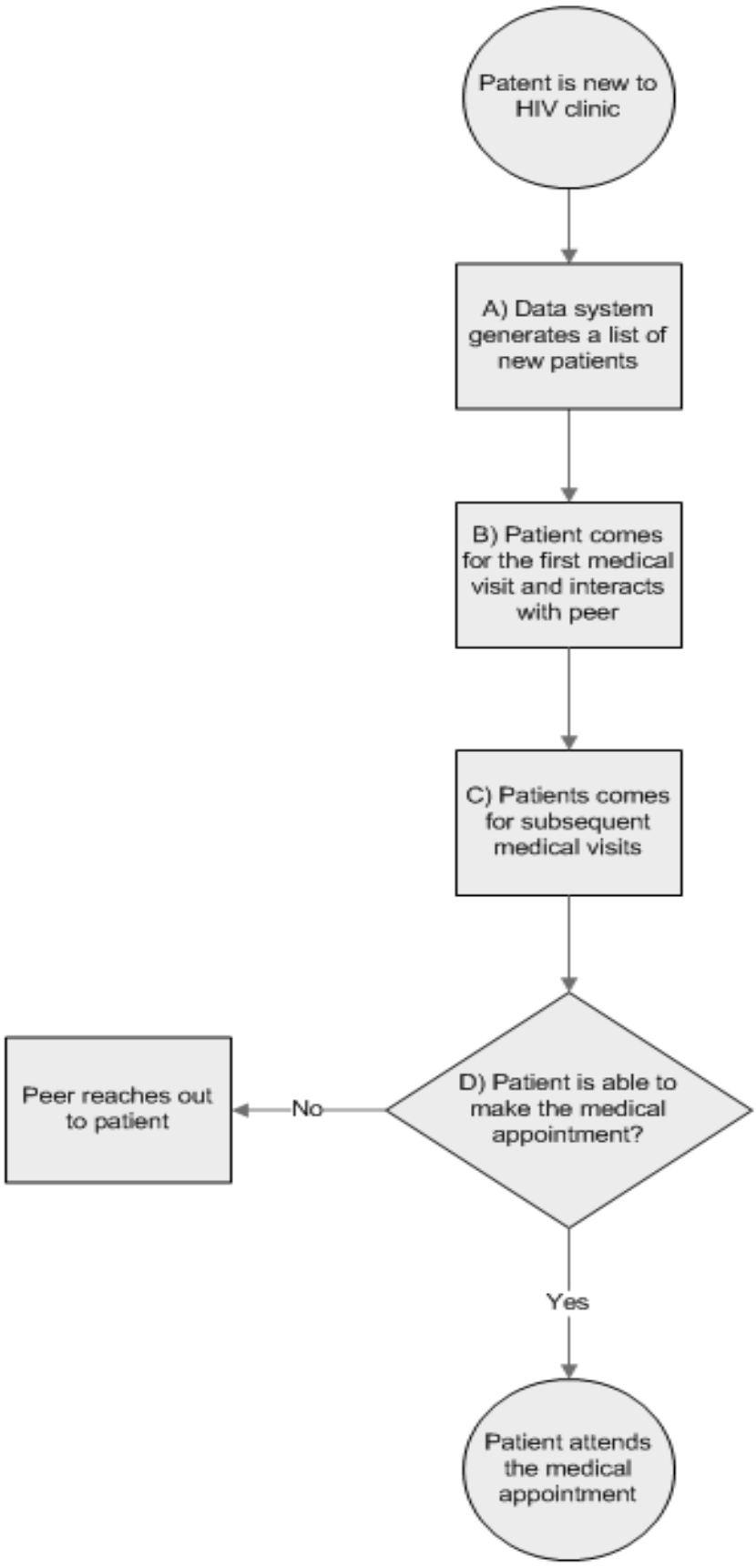
Appendix A . Peer Process Measure Logging Tool
Appendix B. Peer Support Readiness Assessment Tool

P. Resources Available for Implementing the Intervention

1. Peer Program Planning Resources
    - Peer Program Planning Questions to Consider (Building Blocks to Peer Program Success (http://pper.hdwg.org/program_dev)
    - Organizational Readiness Assessment for Integration of Peer Staff (The Lotus Project)
    - Peer Program Organizational Capacity Building In-depth Assessment (Peer Education and Evaluation Resource Center)
    - Appointment check-list
2. Peer Program Policies and Procedures (St. Lukes's Roosevelt Hospital Center for Comprehensive Care)
    - Example of Peer Program
    - Confidential Agreement (University of California San Diego, New York State Department of Health, AIDS Institute)
    - Job Descriptions (St. Luke's Roosevelt Hospital, Hudson River Health Care, UAB Family Clinic, The Lotus Project)
    - Peer Screening Questions (Women Organized to Respond to Life-threatening Diseases)
    - Peer Selection Process (Project ARK/Washington University)
    - Supervisor's Checklist to Review Peers' Approach to Clients (The Lotus Project)
    - Peer Weekly Staffing Report (The Peer Education and Evaluation Resource Center)
    - Peer Educator Self-Assessment (The Peer Education and Evaluation Resource Center)

- Peer Program Evaluation Patient Survey (St. Luke's Roosevelt Hospital)

3. Training Resources
    - Case Conferencing Forms (Cicatelli Global, Inc.)
    - Sample Maintenance in Care and Retention Consistent Messages
    - Making Sure Your HIV Care is the Best It Can Be (The National Quality Center http://nationalqualitycenter.org/index.cfm/6181/13886)
    - Making Sure HIV Self-Management Works (The National Quality Center http://nationalqualitycenter.org/index.cfm/6181/16134)
    - Navigating Clients to Services (Cicatelli Global, Mosaica Project Consumer LINC)
    - New York State People Living with HIV/AIDS Leadership Training Institute (Cicatelli Global, Inc.) http://www.caiglobal.org/caistage/index.php?option=com_content&view=article&id=233&Itemid=498)
    - Peer Encounter Checklist (Peers in action PACT)
    - Positive Life Workshop (New York City Department of Health and Mental Hygiene http://www.healthsolutions.org/hivcare/?event=page.resources)
    - Understanding Patient-Centered Care, Consumer Involvement and Patient Self-Management (New York State Department of Health AIDS Institute http://www.hivguidelines.org)
    - 100 Questions and Answers About HIV/AIDS (New York State Department of Health AIDS Institute http://www.health.ny.gov/diseases/aids/facts/questions)
    - Peer Educator Contact Form (The Peer Education and Evaluation Resource Center, Harlem Hospital Center)


Patent is new to HIV clinic
A) Data system generates a list of new patients
B) Patient comes for the first medical visit and interacts with peer
C) Patients comes for subsequent medical visits
D) Patient is able to make the medical appointment?
No
Peer reaches out to patient
Yes
Patient attends the medical appointment