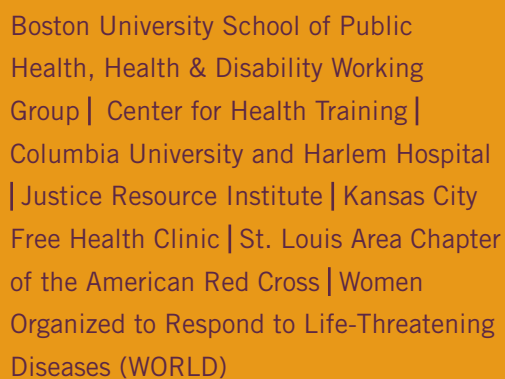


BUILDING BLOCKS TO PEER PROGRAM SUCCESS



A toolkit for developing HIV peer
programs



Boston University School of Public
Health, Health & Disability Working
Group | Center for Health Training |
Columbia University and Harlem Hospital
| Justice Resource Institute | Kansas City
Free Health Clinic | St. Louis Area Chapter
of the American Red Cross | Women
Organized to Respond to Life-Threatening
Diseases (WORLD)

ACKNOWLEDGMENTS

This manual was written, organized, and reviewed by the following individuals:

- **Edi Ablavsky, MA, Health & Disability Working Group, Boston University School of Public Health**
- **Joyce Bathke, St. Louis Area Chapter American Red Cross**
- **Pat Blackburn, MPH, Center for Health Training**
- **Bill Bower, MPH, Peer Advanced Competency Training Project (PACT), Columbia University and Harlem Hospital**
- **Sharon Coleman, MS, MPH, Health & Disability Working Group, Boston University School of Public Health**
- **Paul Colson, PhD, Peer Advanced Competency Training Project (PACT), Columbia University and Harlem Hospital**
- **Marcia Dutcher, MA, Kansas City Free Health Clinic**
- **David Fine, PhD, Center for Health Training**
- **Laura Fizek, LICSW, Justice Resource Institute**
- **Julie Franks, PhD, Peer Advanced Competency Training Project (PACT), Columbia University and Harlem Hospital**
- **Melissa Gambatese, MPH, Health & Disability Working Group, Boston University School of Public Health**
- **Brenda Loscher-Hudson, PhD, Kansas City Free Health Clinic**
- **Shailey Merchant, MPH, Center for Health Training**
- **Shalini Eddens, MPH, Women Organized to Respond to Life-Threatening Diseases (WORLD)**
- **Sally Neville, RN, MSN, Kansas City Free Health Clinic**
- **Denae Phillips, BS, Health & Disability Working Group, Boston University School of Public Health**
- **Simone Phillips, St. Louis Area Chapter American Red Cross**
- **Serena Rajabiun, MA, MPH, Health & Disability Working Group, Boston University School of Public Health**
- **Janie Riley, MFT, Clinical Consultant, Center for Health Training**
- **Marcia Riordan, MSW, Women Organized to Respond to Life-Threatening Diseases (WORLD)**
- **Helen Rovito, MS, Health Resources and Services Administration (HRSA)**

This publication was supported by cooperative agreement #U20HA08557-01-00 from the Health Resources and Services Administration (HRSA). This cooperative agreement is funded through the HIV/AIDS Bureau's Division of Training and Technical Assistance with Minority AIDS Initiative funding. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the views of the funding agencies or the U.S. government

ACKNOWLEDGEMENTS

Review and Contributions by:

- Marilyn Ricker Kases, MPH, St. Louis Area Chapter American Red Cross
- Kate Johnston, St Louis Area Chapter American Red Cross
- Elizabeth Brosnan, Christie's Place
- Bruce Campbell, Community Programs Specialist, Florida Department of Health, Bureau of HIV/AIDS
- Rose Farnan, BSN, ACRN/Truman Medical Center-Hospital Hill
- Elena Felder, MFT
- Joann M. Ferrer, MFT, Christie's Place
- Susan S. Fish, PharmD, MPH, Boston University School of Public Health
- Jonathan Howland, PhD, MPH, MPA, Boston University School of Public Health
- Margaret Perkins, PhD, MPH Consultant, New York
- Jane M. Simoni, PhD, University of Washington
- Jan Anderson Talley, MSW, MA, Swope Health Services, Kansas City, Mo.
- Elizabeth Zobel, LICSW, JRI Health

ACKNOWLEDGEMENTS

About the Peer Education and Training Sites/Resource and Evaluation Center Initiative

This toolkit was produced as part of the Peer Education and Training Sites/Resource and Evaluation Center (PETS/REC) Initiative, which helps organizations plan and implement successful, sustainable peer programs. Funded through the Health Resources & Services Administration (HRSA) HIV/AIDS Bureau's Division of Training and Technical Assistance with Minority AIDS Initiative (MAI) funding, this initiative offers resources, support and experience to help launch a peer program or strengthen one that's already in place. The PEER Center, the initiative's resource and evaluation center, is a collaboration between the Boston University School of Public Health's Health & Disability Working Group and the Justice Resource Institute (JRI). The PEER Center offers resources based on the experience of three national peer education and capacity-building centers, who have extensive hands-on experience with ongoing, successful peer programs:

- Lotus Project in Oakland, CA—a collaboration between the Center for Health Training (CHT) and Women Organized to Respond to Life-Threatening Diseases (WORLD)
- Peer Advanced Competency Training program (PACT) at Columbia University and Harlem Hospital in New York, NY
- People to People in St. Louis and Kansas City, MO—a collaboration between the American Red Cross St. Louis Area Chapter and Kansas City Free Health Clinic

TABLE OF CONTENTS

INTRODUCTION	2-9
2. ORGANIZATIONAL READINESS FOR PEER PROGRAMS	10-14
3. DESIGNING A PEER PROGRAM	15-30
Designing a peer program	15-18
Read more A: Example of peer program plan	19-21
Read more B: Program scenario 1	22-25
Read more C: Program scenario 2	26-28
Read more D: Program scenario 3	29-30
4. PEER ROLES AND RESPONSIBILITIES	31-35
Read more: peers and support groups	36-37
5. RECRUITING, HIRING, AND ORIENTING PEERS.....	38-55
Recruiting, hiring, and orienting peers — Introduction	38-45
Read more A: Cultural sensitivity and peer orientation.....	46-47
Read more B: Confidentiality and peers	48-49
Read more C: Orienting non-peer employees on peer support	50
Read more D: Benefits questions to discuss with peers.....	51-55
6. SUPERVISING PEERS.....	56-110
Supervising peers — Introduction.....	56-60
6.1. Administrative supervision.....	61-67
Read more A: The coaching model for administrative supervision.....	68-70
Read more B: Example 1	71-73
Read more C: Example 2	74
Read more D: Understanding boundaries in peer-client relationships	75-76

TABLE OF CONTENTS

6.2. Supportive supervision	77-81
Read more A: The coaching model for supportive supervision.....	82-84
Read more B: Troubleshooting difficult cases and supporting peer efforts	85
Read more C: Recognizing and addressing countertransference	86-87
Read more D: Tasks and tools for developing a supportive approach	88-101
Read more E: Peer support groups and structured group supervision.....	102-104
6.3. Clinical supervision.....	105-107
Read more: The coaching model for clinical supervision	108-110
7. EVALUATING PEER PROGRAMS	111-151
Evaluating peer programs — Introduction.....	111-113
Read more: Differences between program evaluation and quality assurance	114
7.1. Choosing the outcomes to measure	115-120
Read more A: HRSA indicators	121
Read more B: Sample evaluation plan: A peer program in clinic	122-124
Read more C: Sample evaluation plan: A peer program in a CBO	125-127
7.2. Logic models for peer programs.....	128-131
7.3. Data collection methods	132-139
7.4. Analyzing and disseminating evaluation results	140-143
7.5. Evaluation and resource planning	144-146
7.6. Protection of human subjects and evaluation	147-151
8. FUNDING SOURCES	152-156

1. INTRODUCTION

► WHO ARE PEERS?

The range of terms used to describe community-based, non-licensed health service providers reflects the wide variety of functions that they perform: peer educator, counselor, or advisor; community health worker; lay health worker; buddy; promotores de salud, or patient navigators. Peers may also be defined as individuals who are from infected or affected communities that share similar characteristics with the clients being served. For the sake of simplicity, this guide uses the term “peer” to refer to all non-licensed professionals in health and social service programs whose qualifications and roles rest on their connection with the community they serve.

This manual focuses primarily on peers who use their own personal experience with HIV in the service of improving the HIV care and treatment of people living with HIV/AIDS (PLWHA).

Introduction

Eliminating health disparities in the United States is a primary goal of the Centers for Disease Control and Prevention’s (CDC) ‘Healthy People 2010’ agenda for national health promotion and disease prevention. However, there is growing awareness that traditional structures of health care delivery have not effectively addressed persistent disparities in health outcomes by race and socio-economic status in the US. In response, policy makers, educators, and practitioners have stressed the importance of cultural competence in the delivery of health care services. Incorporating peers into health care teams is an important step towards culturally competent care. Peer collaboration is part of a long tradition of non-professional, community-based health care ranging from midwifery to naturopathy to palliative care. A 1994 CDC report highlighted the effectiveness of using peers in promoting positive health outcomes in impoverished and poorly served communities, particularly African-American communities¹.

In health care, peers may act as a liaison between providers and clients, translate medical information for their clients, provide education and informal counseling, serve as a “navigator” to help clients locate needed services, and provide linkages to other community services. Peers can also relay information from clients to providers so that services are more accessible and culturally relevant. Studies of peer support for various disease treatments have demonstrated their effectiveness in improving medication adherence and appointment keeping among clients².

How can peers contribute to HIV care?

People living with HIV/AIDS (PLWHA) play an instrumental role in advancing access to and increasing the quality of their health care services. Since the beginning of the epidemic, PLWHA have advocated for resources that prevent new HIV infections, expand availability and accessibility of care and services, and promote improved HIV treatments.

¹U.S. Department of Health and Human Services (USDHHS), Community Health Advisors: Models, Research, and Practice, USDHHS, Public Health Services, Centers for Disease Control and Prevention, Atlanta, GA, September 1994

²World Health Organization, Adherence to Long-term Therapy: Evidence for Action ,Geneva, Switzerland, 2003.

INTRODUCTION

No one understands the reality of HIV better than a person living with HIV. Peers, defined as trained consumers living with HIV who work with clients, bring a unique perspective of the reality of HIV that trained health care professionals, social workers or other staff members not living with HIV are unable to offer a PLWHA.

There is ample literature about the benefits of using peers as a part of the health care team for PLWHA and other chronic illnesses. Peer support programs play four important roles:

1. Provide information and support through shared experiences.
2. Model skills.
3. Offer emotional support, including encouragement, reinforcement and decreased isolation.
4. Bring mutual reciprocity through shared problem solving and by giving and receiving help on a shared medical issue.

In the chronic disease literature, these types of peer programs have been shown to effectively improve self-efficacy for managing illness, maintaining health-related quality of life and healthy behaviors, and decreasing hospitalization³.

A study of peer outreach workers trained as patient advocates found that HIV-positive clients who worked with a peer improved their adherence to medical care by keeping appointments, responding to physician referrals, and picking up HIV medications⁴. Peer outreach workers, both HIV-positive and from the same community, were also more likely to find and link other HIV-positive individuals to medical care and support services⁵.

What is the purpose of this guide?

The purpose of this guide is to effectively integrate peers as part of the multidisciplinary care team. Depending on the needs of an organization, peers can work in the following ways: participating as part of an advisory board; working in teams with case managers and other staff to find people who are out of care or at risk of dropping out of services; providing support and education individually or in groups; engaging clients in HIV care; helping clients navigate the service system; and supporting adherence to treatment.

This guide provides information, tools and resources to help organizations and communities work with peers to effectively engage and retain PLWHA in care and treatment.

This guide will help address the following questions:

- What are the goals of peer programs?
- What roles do peers play in improving HIV services for clients?
- What methods can be used to determine community and internal resources available to develop a program or enhance an existing program?
- Who is responsible for the design and implementation of the peer program?
- Who should be involved in generating commitment (from within both the organization and community)?
- What systems, specifically training and supervision, need to be in place to effectively use peers?
- What tools are available for peers and other staff to keep clients engaged in care and treatment?
- What approaches and methods can be used to monitor and evaluate the effect of peer programs on clients' access to and utilization of HIV services?

³California Health Care Foundation. Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success. December 2006.

⁴Broadhead, R. S., Heckathorn, D. D., Altice, F. L., van Hulst, Y., Carbone, M., Friedland, G. H., et al. (2002). Increasing drug users' adherence to HIV treatment: results of a peer-driven intervention feasibility study. *Soc Sci Med*, 55(2), 235-246.

⁵Molitor, F., Kuenneth, C., Waltermeyer, J., Mendoza, M., Aguirre, A., Brockmann, K., et al. (2005). Linking HIV-infected persons of color and injection drug users to HIV medical and other services: the California Bridge Project. *AIDS Patient Care STDS*, 19(6), 406-412.

INTRODUCTION



Paul Colson (right) with a peer trainer and participant at a PACT graduation.

This is not a typical professional relationship. We're asking people to reach out in a personal way to help somebody. We give guidance around health-promoting behaviors we want peers to help clients develop: things like building a good relationship with providers, creating a social support network, identifying personal barriers to keeping appointments or adhering to medication, and focusing on self-care.

Paul Colson
PACT Project Program Director
Harlem Hospital
New York, NY

This guide is divided into sections that follow the general sequence of peer program development. Different parts of this guide may be applicable to a particular peer program, depending on that program's developmental stage.

Who should use this guide?

Successful peer programs are implemented across various organizational settings from small, community-based organizations in rural areas to large, urban hospital based programs⁶. Specifically, this guide is for:

- Program directors/managers
- Supervisors of social services
- Clinic managers and medical directors
- Nurses and case managers
- State and county health officials in charge of HIV program dollars
- Planning councils
- Consumer advisory committees
- Anyone interested in building, enhancing or incorporating peers into a program

How can this guide be used?

This guide serves as a resource outlining a step-by-step process to develop a new peer program or enhance an existing one. This guide begins with conceptualizing a peer program, and each section addresses key activities that foster a sustainable peer program that meets program goals. Suggestions for using this guide include:

- If starting a new program, review all sections in the guide and use the tools and resources available.
- If enhancing an existing peer program, select and review relevant sections based on the program's needs and use the tools and resources available.
- Photocopy/download any sections that may be helpful.

This section is part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, please visit:

http://peer.hdwg.org/program_dev

⁶ Circle Solutions Inc. Organizations that CARE: A Toolkit for Employing Consumers in Ryan White CARE Act Programs. 2006

2. ORGANIZATIONAL READINESS

► STATE OR LOCAL HEALTH DEPT

The tools in this section can be used by health departments (state or local) and private donors to identify local resources and stakeholders available for peer program development and implementation. As a first step, it is important to consider working with state and local consumer advisory groups/boards.

Are you ready for a peer program?

Organizational readiness is an important first step in program development or enhancement. If an organization is not prepared to support a peer program, the likelihood of success is minimal. Therefore, organizations should conduct an assessment of both their capacity to build a peer program and their ability to sustain the program beyond development. This means that the organization needs to value the concept of **peer support** in order to provide the necessary resources for that program. Resources might include: the accessibility and support of key organization decision-makers; the use of available dollars; management structure; peer support; and focused efforts on creating a multidisciplinary care team.

The assessment of peer program capacity consists of three phases:

- **Phase 1: Program Conceptualization**, an initial understanding of the rationale or need for the development or enhancement of a peer program and determining what needs to be accomplished with a peer program.
- **Phase 2: Gathering Information** that can help determine the readiness of the organization to develop and implement a peer program, including the organization's current strengths or capacity.
- **Phase 3: Program Development Process**, creating a program development road map (program planning worksheet) that serves as a guide during the start-up or enhancement.

Each phase of the process needs to include those decision makers and stakeholders who have a vested interest in the program. It is ideal for one or two point people to emerge as the champions or leaders of the process of assessment to determine the information to be gathered, analyze results, and share and act upon the results.

ORGANIZATIONAL READINESS

Phase 1: Program Conceptualization

The first step is to identify why the peer program is crucial and what it ideally should look like when operating at its best. In this way, there is a common goal/vision that directs how the program gets developed or enhanced. In order to create a program goal/vision, the following questions should be answered:

- Why is having or enhancing a peer program important?
- What are the goals or expected outcomes of a peer program?
- How does this peer program fit the organization's mission and existing services?
- What will the program look like when these goals are being met?
- Who needs to be involved in the peer program and at what phases in the process?
- What are the funding options for a peer program?

WHO SHOULD BE INVOLVED IN DESIGNING OR ENHANCING A PEER PROGRAM?

To ensure program success, it is critical to identify key stakeholders in the organization or area with whom to collaborate on establishing goals, objectives and vision for a peer program. Here a few suggested individuals or groups to involve as stakeholders:

- Statewide or organizational Consumer Advisory Boards
- Medical and social service providers working with PLWHA
- Planning Councils
- Community partners
- Board of directors, executive director or other key decision makers, human resources
- Supervisors/department heads where potential peers will be assigned
- Funders and other donors

ORGANIZATIONAL READINESS



A peer (second from right) attends a staff meeting at Kansas City Free Health Clinic.

GETTING COMMITMENT FROM PARTNERS: THE PROCESS TO CREATE A PROGRAM CONCEPT

A program concept is a clear understanding of what a program will look like when it is operational. There are many ways to create a concept for a peer program. It may be necessary to conduct several meetings with different sets of stakeholders to develop a program concept. Program managers may respond differently from agency directors, just as physicians might respond differently from nurses, social workers, case managers, clients or consumers. It is important to develop a plan with many of the individuals or groups who will be involved with peers so that the peer program can be successful and sustainable.

Below are questions to discuss with partners in order to build a collective vision and agreement on a peer program. The questions can be asked either in individual or group meetings with stakeholders.

- Ask participants about their concerns about meeting program goals and/or their concerns about keeping clients engaged in the health care system. (In general,

many organizations cite that keeping clients engaged can be challenging.)

- Ask participants to speculate why it is difficult to meet program goals or to retain clients in care.
- Do stakeholders believe peers could help the program meet its goals or retain more clients?
- Ask each participant to identify three or four ideas of what peers can do to address these gaps, needs, or challenges.
- Identify the key staff and community members that should be involved with a peer program.
- Outline and establish a process with the key stakeholders and staff to implement this vision and begin working on a program design.
- Select a champion/coordinator who will direct and keep stakeholders informed and maintain momentum.

Depending on the number of stakeholder meetings and other assessment activities, collaborative program conceptualization can be a time-intensive process that may require several months.

ORGANIZATIONAL READINESS

Phase 2: Gathering Information

Using formal assessment tools may help an organization think through its program readiness. It is important to think about who should be part of the assessment process.

- Who are the decision makers at the organization?
- Who understands peer programs from a range of perspectives (consumers, clients, patients, program staff etc.)?
- Who from the community could serve as a support or referral mechanism?
- Who is invested in the success of the peer program?

[The Organizational Capacity Building Baseline Assessment Tool](#) in section 2 of the [Program Resources](#) accompanying this toolkit evaluates the strengths and challenges the organization currently has. This will help leaders identify further strengths or challenges that may need to be addressed before a peer program can operate at its best. This tool helps collect basic demographic information as well as program and organizational information. It is recommended that all those involved in the peer program be surveyed in order to get the best possible baseline picture of these programmatic and organizational areas.

Ideally, conducting in-person interviews provides the opportunity to build relationships with key people who could then become champions of the peer program. Focus groups or group meetings are another in-person method to gather information. However, if this is not a feasible option, phone interviews or even written surveys can still yield valuable information. With any method, sending the baseline assessment to the respondents in advance saves time, generates interest, and provides

a good place to begin a conversation about the program. This gives the respondents the opportunity to think more succinctly and thoughtfully about the information requested; therefore, more accurate, high quality information will be collected.

[The Organizational Capacity Building In-Depth Assessment Tool](#) in section 2 of the [Program Resources](#) is a set of primarily open-ended questions that help to further identify organization strengths and define challenge areas for peer programs. The coordinator/champion and the stakeholders who are involved in developing or enhancing the program should use the information from this assessment to inform the program design and identify possible gaps and strengths that should be considered prior to program start.

Phase 3: Program Development Process

The third phase addresses all of the programmatic and organizational issues that were identified by assessment tools by using both a work plan and a program planning tool to direct activities toward the goal of program development or enhancement.

Developing a work plan is an ideal way to put the program vision down on paper. To develop the goal of the program, it is important to outline and include objectives, activities, and evaluation methods in your work plan. Objectives are concrete descriptions of the changes to services as a result of the peer program. Activities describe exactly what peers and other key staff or community members will do and the resources that may be needed to achieve objectives and goals. Finally, evaluation measures and methods are proposed mechanisms for determining if the goals and objectives of the program were met.

ORGANIZATIONAL READINESS

The following work plan framework can be used to articulate the peer program vision as well as the information from the assessment tools in a more concrete way.

EXAMPLE OF WORK PLAN FOR A PEER PROGRAM

Program Concept: Peers will work as part of a multidisciplinary care team to help clients manage living with HIV and improve their health care. Peers will have two distinct roles: co-facilitating peer education/support groups each week and accompanying clients to their health care visits.

Goals: Peers will help improve clients' ability to manage living with HIV and use of HIV health care system by ensuring two medical visits per 12 months, ensuring client membership in support groups, and by reaching out to clients who have fallen out of the health care system.

Objectives	Activities	Evaluation Measures
X% of clients will have 2 medical visits in a measurement year	<ul style="list-style-type: none"> • Peers assist case managers in scheduling follow-up appts. for referrals and missed appts. • Peers will accompany HIV clients to appts. as needed 	<ul style="list-style-type: none"> • Number of clients who make at least 2 medical visits within 12 months • Number/demographics of HIV clients who receive peer services
X# of clients will participate in support groups at least twice per month	<ul style="list-style-type: none"> • Peers will co-facilitate support and education groups • Peers will engage clients in membership by contacting clients and surveying clients on areas of interest for group topics • Peers will outreach to clients who are not attending support group 	<ul style="list-style-type: none"> • Number/demographics of HIV clients who attend support groups at least twice/month

Resources for Section 2 (available at http://peer.hdwg.org/program_dev/resources)

- Lotus organizational readiness assessment tool
- Organizational capacity-building baseline assessment tool
- Organizational capacity-building in-depth assessment tool

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

3. DESIGNING A PEER PROGRAM



LaTrischa Miles (right) with a peer and client.

One of the major challenges for any organization wanting to start a peer program is integrating the peers into the organization, making sure you have the buy-in of not just the organization, but of the staff. Because as a supervisor, you want to give the peers the support that they need, and you get the greatest support from supervision if you've got the support of the staff as well. Peers need to know that they're valued in the organization and that they're a part of it.

LaTrischa Miles
Peer Supervisor
Kansas City Free Health Clinic
Kansas City, MO

Once it has been determined that: (1) the organization is ready, (2) the concept for the peer program is clear to everyone involved, and (3) there are leaders who are interested in operationalizing this peer program, then the plan of action needs to be outlined and agreed upon. The following information outlines the steps to executing program design:

The [Peer Program Planning Tool](#) in section 2 of the [Program Resources](#) accompanying this toolkit is a guided program map that helps an organization consider all aspects of program development in greater detail in order to setup a new peer program function or to enhance an existing program. Alternatively, a work plan more broadly outlines the goals and general activities of the program (refer to [Section 2, Organizational Readiness for Peer Programs](#), including several examples for different kinds of programs). The Program Planning Tool addresses all the areas that operationalize a peer program. This is a flexible document, and an organization should edit the program sections to reflect the organization's needs.

The Program Planning Tool can be used for continual program quality management, by acting as a check-in for possible program changes, problems, and strengths. It is recommended that the supervisor or manager review the areas of the program plan that affect the operation of the program on a regular basis, either during weekly or bi-monthly staff meetings or as part of regular supervision of peer staff. There needs to be consistent support of the peer program in order to ensure successful sustainability.

Below are the steps to take and questions to answer before enlisting peers to work or volunteer in the organization:

Step 1: Designing the structure of the program: volunteer vs. paid

Once you have determined the goals and objectives of your peer program, the first step is deciding the structure of the program. If funding is available, employing a peer on a full- or part-time basis is ideal and supports the goal of incorporating the peer into the organization's structure as a full-fledged member of the HIV care team.

In cases where resources are limited and organizations do not have

DESIGNING A PEER PROGRAM

funds available to support a paid position, peers may be incorporated into the organization through a volunteer program working with specific staff members. If peers are volunteers, it is recommended that the organization find opportunities to recognize and honor the volunteers' work on a regular basis through awards or certificates of appreciation, as well as provide professional development opportunities through training and education.

Step 2: Identifying the roles and responsibilities of the peers

Defining the roles and responsibilities of the peer is critical to program success. [Section 4, Peer Roles and Responsibilities](#) provides a description of the various roles peers can play and provides sample job descriptions that can be adapted. Whether peers play a role in providing support, improving adherence or counseling and testing, it is critical to examine their role vis-à-vis other staff members and clearly state who, and in what way, each individual staff member (physician, nurse, case manager, other peers) will work with the peer. It is also important to determine who will be supervising the peer.

If peers will be working individually with clients, such as with adherence counseling or supporting case managers, it is important to consider the size of the client caseload that will be assigned to each peer. It may be best to start small, giving peers no more than 3-5 clients, and gradually increase the caseload if feasible.

Step 3: Establishing supervision and training

systems for peers

Before recruiting peers, an organization should identify who will supervise and train the peers, the type of supervision needed (both administrative and either supportive or clinical), the methods (individual vs. group), and how often supervision will occur. [Section 6, Supervising Peers](#) of this guide provides details about supervision systems for peer programs. This information should be part of the job description or orientation materials for peers, whether they are paid or volunteers.

[Building Blocks to Peer Success](http://peer.hdwg.org/training_toolkit) (available at http://peer.hdwg.org/training_toolkit), the toolkit for training HIV positive peers to engage people living with HIV/AIDS in care, provides best practices, sample lesson plans and curricula for training peers.

Step 4: Recruiting, hiring, and orienting PLWHA to become peers

Once commitment from staff is obtained, clear job descriptions have been developed, and an outline of the supervisory structure has been achieved, active recruitment and hiring of peers can begin. For some organizations, this may require working closely with the human resources department to ensure that all policies are followed appropriately.

Depending upon the community, recruiting peers may be easy or difficult. In areas where HIV stigma remains a barrier, PLWHA may not feel comfortable disclosing their status to other patients even though they may be seeing their doctor regularly and adhering to treatment regimens. Engaging the support of medical providers, case managers, and other service providers to refer willing PLWHA to work as peers is a good strategy, as trust has already been established with that provider.

DESIGNING A PEER PROGRAM



There was a lot of learning on both sides when we started the program. While we told the physicians what was going on, they really weren't involved in the process, so they hesitated in getting too attached to it. There was a lot of reservation on their side in actually using the peer educators. Now they're demanding that I staff [peers] on all their shifts. When you've got providers who say 'I need a peer educator on my afternoon schedule,' you know how successful it has been.

Rose Farnan
Infectious Disease Nurse Clinician
Truman Medical Center
Kansas City, MO

Part of the hiring and orientation process involves interviewing peers who are comfortable disclosing their HIV status with other persons and who understand the importance of confidentiality. For orientation, it is important to provide some basic information about the organization, its services, a staff list, job descriptions, program tools for his/her job and other resources that may be useful to the peer's work. It is also important to think about who could serve as a mentor or would be willing to have the new peer shadow their work to learn about the organization and the environment in which he or she will be working. [Section 5, Recruiting, Hiring, and Orienting Peers](#) and its Read More Sections on [Cultural Sensitivity](#), [Confidentiality](#) and [Orienting Non-Peer Employees on Peer Support, Philosophy and Program Models](#) provide details on these areas.

Step 5: Providing opportunities for professional development to retain peers

Regardless of whether peers are volunteers or paid staff, creating an organizational environment that encourages opportunities for peers to develop their professional interests is recommended. These opportunities can include activities such as:

- Having peers attend in-service trainings related to HIV or client care
- Supporting requests to attend external trainings or conferences related to their roles and responsibilities
- Inviting peers to attend community events with other HIV service or medical providers
- Participating and attending seminars (virtual or in-person)

Step 6: Documenting and measuring the success of the peer program

A successful peer program has specific measures for documenting the activities of peers and how they contribute to overall services. In some organizations, peers are required to document their work in logs or on forms that become part of the client's medical record.

[Section 7, Evaluating Peer Programs](#) provides suggestions for monitoring and evaluating peer programs.

DESIGNING A PEER PROGRAM

► FOR MORE INFORMATION

Read More for Section 3

- [Example of peer program plan](#)
- [Program Scenario 1](#): Peers working to improve access to care and treatment in a clinic
- [Program Scenario 2](#): Peers working to engage HIV-positive individuals in support services in a community-based organization
- [Program Scenario 3](#): AIDS Service Organization to support and link HIV-positive patients in care and treatment

Resources for Section 3

(available at http://peer.hdwg.org/program_dev/resources)

- [Peer program planning tool](#)
- [Peer program planning: questions to consider](#)

The above Read More sections provide concrete examples and case scenarios to help an organization use the tools presented in this guide to design a peer program.

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

3. DESIGNING A PEER PROGRAM

Peer-led support program plan

The following is an example of how the Program Planning Tool details the steps of program development or enhancement in an operational format. This example illustrates what should be in place in order to create peer-led support groups.

Program Area	Activity Description	Who	Timeframe	Desired Outcome
Organizational commitment prior to peer hire	<ul style="list-style-type: none"> Gain agreement of how peers will be part of multidisciplinary team through discussion of how peer worker will collaborate with team on support group curriculum, recruitment of client members Outline need for peer-led support groups by reviewing narrative and other evaluative material that supports the needs of peers co-leading groups 	Current team (case manager, clinic supervisor, social worker, nurse etc.)	1 month	<ul style="list-style-type: none"> Make case for having peer co-lead groups Gain commitment from staff due to expressed need and documentation to support need Clear agreement of goals, operation of support group as well as referral system from providers and other client recruitment
Peer job description	<ul style="list-style-type: none"> Outline peer job description including expectations and goals Outline process for peer selection that includes staff input 	Current Team	2 weeks	Peer job description outlining skills and competencies needed to run support group and methods of contribution to team

READ MORE: PEER PROGRAM PLAN

DESIGNING A PEER PROGRAM

READ MORE: PEER PROGRAM PLAN

Program Area	Activity Description	Who	Timeframe	Desired Outcome
Supervision	<ul style="list-style-type: none"> • Determine who within team is best fit for providing administrative supervision and supportive or clinical supervision • Determine how peer will be integrated into multidisciplinary team • Understand clearly defined job expectations and supports that need to be in place 	Current Team	2 weeks	<ul style="list-style-type: none"> • Present to team • Well defined supervision plan
Recruitment, hiring and compensation	<ul style="list-style-type: none"> • Determine through established process of recruitment any existing clients who might be able to serve as peers • Outline hiring process with team (interviews, references, observation) • Determine method of compensation influenced by funding, disability issues etc. 	Administrative supervisor, supportive or clinical supervisor and team	2 months	<ul style="list-style-type: none"> • Hiring process that is equitable and meets organization needs • Compensation outlined • Peers are hired

DESIGNING A PEER PROGRAM

READ MORE: PEER PROGRAM PLAN

Program Area	Activity Description	Who	Timeframe	Desired Outcome
Orientation	<ul style="list-style-type: none"> Determine and outline orientation plan for peer including introductions to all areas of organization, time period and learning expectations Provide samples of organization policies, procedures and confidentiality agreements Provide ongoing support/ mentoring 	Supervisors and team		<ul style="list-style-type: none"> Well integrated peer that is able to access supports for learning Peer who is acquainted with organizational system and knows who to go to for what
Training	Provide training for peers on how to facilitate a support group, communication styles, content	Supervisors and peers	2 months	Peers trained and ready to co-facilitate support groups
Ongoing peer development	Determine ongoing supervision system that follows the coaching model and addresses areas of development including skill training and job satisfaction	Supervisors		Creation of year-long staff development plan
Performance management/ program goal management	<ul style="list-style-type: none"> Based on goals of program and job description Determine ways to measure effectiveness of peer-led support groups (i.e., client satisfaction survey, attendance sheets, knowledge and practices survey) 	Supervisors and peers		<ul style="list-style-type: none"> Goals for program being achieved through peer-led support groups Clients of peer support groups are retained in medical care i.e., 2 medical visits in the past 6 months

This “Read More” section accompanies [Section 3, Designing a Peer Program](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

3. DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 1

The ABC Clinic wants to improve access to care and treatment

About This Scenario

Below is a program scenario and sample work plan that describes how a peer program may fit into an organizational setting that provides HIV services. This scenario describes a clinic wanting to start a peer program to improve client adherence to treatment.

The ABC Clinic is located in an inner-city community and provides primary HIV care to several hundred adult clients. The program has consistently found it difficult to retain clients in care and to locate clients who have fallen out of care. Its board of directors recommended that the clinic initiate a program to improve retention in care and receipt of needed services in the coming 4-year funding cycle.

At a monthly community-wide HIV service providers meeting, the clinic presented its decision to design a program to improve retention in care and access to services and asked for feedback from other providers. The clinic staff learned that their clients who had fallen out of care often appeared for services at several community sites, including a food pantry, the neighborhood municipal city housing services office, a women's center, and a small community health center that provided family medicine but no HIV care. In addition, a municipal mobile Rapid HIV

Testing (RHT) unit reported that they referred many newly diagnosed HIV cases to the ABC Clinic to initiate HIV primary care, but that the unit did not track how many of its referrals were completed. At the meeting, HIV-positive clients from community organizations described several reasons why people may fall out of care at the clinic, including costs and forgetting appointments, especially appointments scheduled several months apart. They also commented that HIV-positive people may need more education about the importance of regular care, especially lab CD4 and viral load tests every 3 months, even when they do not feel ill, and the importance of long-term adherence to antiretroviral treatment (ART). Based on this feedback, the clinic designed a program that includes both outreach to newly diagnosed people, re-engagement of out-of-care clients and intensive support for adherence to appointments and ART.

The community service sites agree to collaborate with the ABC Clinic to identify out-of-care HIV-positive clients and to return them to clinic services. They will do this by including a few questions on their intake forms about where and when HIV-positive clients had received services, and offering to contact the ABC Clinic for clients who have previously received medical care at the clinic. The RHT unit agrees to allow a clinic employee to travel with the unit and offer clinic services to newly diagnosed individuals.

The clinic will hire three HIV-positive peers to be outreach workers and work part time with the community partner sites (outreach peers). The peers will be located at the clinic but available to respond immediately when the

DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 1

sites identify an out-of-care clinic patient. They will also travel with the RHT mobile unit on designated shifts. Outreach peer responsibilities are to:

- Greet clients and identify themselves as employees of ABC Clinic
- Establish rapport and offer access services, including; scheduling HIV primary care appointments at ABC Clinic; making reminder calls before HIV care appointment; escorting clients to their appointments; and introducing clients to the program case manager, who will facilitate access to other needed services.

Outreach peers will be available to facilitate additional referrals and to provide access services for a period of 12 months as needed and provide emotional support to those newly diagnosed from the RHT unit.

The clinic will also dedicate 3 peers to retention and adherence efforts (adherence peers). They

will collaborate with a program case manager at the clinic or at a community-based site. All clients who are engaged or re-engaged through outreach efforts will be encouraged to enroll in the adherence support program. Adherence peers will be assigned to work one-on-one with clients to identify clients' unmet medical and social services needs and other potential barriers to adherence to medical care and ART. They will complete an intake interview and devise an individualized care and treatment plan with each client. The peer will work closely with an assigned program case manager to review and agree to each client's care and treatment plan and make appropriate referrals for each client. Peers will follow up to ensure that referrals are completed, and encourage clients to keep medical appointments. Clients prescribed ART will receive counseling and coaching on ART adherence, while clients who are not prescribed ART will be assessed for their readiness to begin ART. Peers will also track clients' adherence to medical appointments and ask their clients to self-report ART adherence.

DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 1

PROGRAM PLAN

Goal: Design and implement a peer program to improve retention in HIV medical care and receipt of support services			
Objectives	Activities/Action Steps	Person(s) Responsible	Evaluation Measures
1.1 Link at least 60% of those newly diagnosed with HIV by the RHT unit to HIV primary care at the clinic within 90 days of receiving test results	<ul style="list-style-type: none"> • Outreach peers attend weekly counseling and testing sessions with RHT staff • Outreach peers make initial introduction and appointment for case management services • Outreach peers inform RHT unit that referrals are completed 	<ul style="list-style-type: none"> • Outreach peers • RHT counseling and testing staff 	<ol style="list-style-type: none"> 1. Number/demographics and time to entry to care at the clinic of newly diagnosed individuals 2. Number of HIV-positive referrals to outreach peers from RHT 3. Number of HIV newly diagnosed with at least 2 case management appointments in 6 months' time
1.2 Link at least 60% of out-of-care clients from community partner sites to clinic services	<ul style="list-style-type: none"> • Outreach peers respond to referrals from other partner sites • Outreach peers link out-of-care clients to case managers at clinic and CBO partners 	<ul style="list-style-type: none"> • Outreach peers • Community partner staff 	<ol style="list-style-type: none"> 1. Number/demographics and time to entry to care at the clinic of out-of-care clients 2. Number of HIV-positive referrals to outreach peers from community partner sites 3. Number of HIV-positive clients with 2 case management appointments in 6 months' time

DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 1

Goal: Design and implement a peer program to improve retention in HIV medical care and receipt of support services			
Objectives	Activites/Action Steps	Person(s) Responsible	Evaluation Measures
1.3. Provide HIV primary care and social support services to 30 newly diagnosed persons living with HIV, 100 out-of-care clients and 1000 currently enrolled HIV-positive patients	<ul style="list-style-type: none"> • Adherence peers w/ case managers develop care & treatment plan for HIV-positive clients • Adherence peers make follow-up phone calls for HIV medical visits, lab tests and case management appts • Adherence peers accompany HIV-positive clients to HIV social services appts and medical visits as requested 	<ul style="list-style-type: none"> • Adherence peers • Case managers at clinic and CBO partners • Clinic staff 	<ol style="list-style-type: none"> 1. Number/demographics of HIV-positive clients with care and treatment plan 2. Number/demographics of HIV-positive clients who achieve care and treatment plan goals 3. Number/type of services referred and used by HIV-positive clients 4. Number/demographics of HIV-positive clients with at least 2 medical visits in measurement year (both on ART and those not on ART) 5. Number/demographics of HIV-positive clients (both on ART and those not on ART) with at least 2 CD4 and viral load lab tests in measurement year
1.4 Provide adherence education to at least 600 HIV-positive clients in the clinic	<ul style="list-style-type: none"> • Adherence peers provide support to HIV-positive patients currently on ART • Adherence peers assess HIV-positive patients' readiness for ART 	<ul style="list-style-type: none"> • Adherence peers • Medical staff at clinic • Case managers 	<ol style="list-style-type: none"> 1. Number of HIV-positive clients receiving ART education adherence sessions 2. Number of HIV-positive clients with ART assessments completed 3. Knowledge, practice, and attitude regarding ART for HIV-positive clients who receive adherence education sessions

This “Read More” section accompanies [Section 3, Designing a Peer Program](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

3. DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 2

Community-based organization wants to engage HIV-positive individuals in care

About this scenario

Below is a program scenario and sample work plan that describes how a peer program may fit into an organizational setting that provides HIV services. This scenario comes from a community-based organization wanting to support clients' engagement in services.

The Smith County Service Program (SCSP) is a community-based organization (CBO) whose mission is to provide outreach and support services for people at risk or living with HIV/AIDS. The staff members provide outreach and prevention education to people at risk for HIV and refer them to counseling and testing services at a nearby clinic. If these adults test positive, the clinic refers them back to SCSP for case management services and education/support groups. At their recent consumer advisory board meeting, the group identified two areas for improving their services.

1. SCSP has been concerned with both the lack of referrals to the education/support groups as well as the inconsistent attendance at these groups. The support groups have been historically facilitated by a staff person who may or may not be living with HIV.

2. The case management program has seen an increase in their caseload, and has been struggling with meeting all the needs of their clients, specifically accompanying them to medical/health care visits. Case managers have HIV-positive clients who are in need of housing assistance, food vouchers, childcare assistance, and other support services. Case managers often are unable to follow up with their clients on clients' HIV medical visits.

The education/support group facilitators and the case managers have joint meetings at the agency. At a recent meeting, these areas for improvement were raised. The program manager asked the team to brainstorm some possible ways to address these areas. One idea was proposed: peers would join this team regularly to address any program challenges.

Support group facilitators, together with peers, felt that if peers were integrated into a co-facilitator role, there might be a greater likelihood for clients to stay engaged. The group also thought that if peers could take on the role of supporting clients in terms of accompanying them to their medical/health care visits, this would reduce the work burden of the support group facilitators.

DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 2

PEER PROGRAM PLAN

Goal: Increase HIV-positive clients' access to and engagement in support and medical services			
Objectives	Activities/Action Steps	Person(s) Needed	Evaluation Measures
1.1 Provide at least 2000 outreach encounters to at-risk HIV individuals, targeting substance users, homeless persons, MSM, women, and communities of color	<ul style="list-style-type: none"> • Conduct at least 8 education and outreach activities at the agency and in the community per week. • Identify and build relationships with at least 8 other social service agencies (food agencies, housing organizations, substance treatment providers, etc) to outreach to at-risk populations • Refer at-risk individuals to HIV counseling and testing at the clinic 	Prevention education coordinator and peer outreach workers	<ol style="list-style-type: none"> 1. Number of prevention education activities 2. Number and demographics of outreach encounters 3. Number of partner agencies conducting monthly prevention/education sessions 4. Number of referrals to counseling and testing at the clinic
1.2 Provide at least monthly case management services to 100% of HIV-positive newly diagnosed or lost-to-follow-up individuals referred from the clinic	Hold monthly meetings with clinic staff to identify newly diagnosed or lost-to-follow-up HIV-positive clients.	<ul style="list-style-type: none"> • HIV case management supervisor • Peer • Case manager • Clinic staff 	<ol style="list-style-type: none"> 1. Number/demographics of HIV-positive clients referred to HIV case management services 2. Number/demographics of HIV-positive clients enrolled in HIV case management services 3. Number of HIV-positive clients with case management plans and service goals 4. Number/types of services provided

DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 2

Goal: Increase HIV-positive clients' access to and engagement in support and medical services			
Objectives	Activites/Action Steps	Person(s) Needed	Evaluation Measures
1.3 Get 80% of HIV-positive clients to attend weekly support groups	<ul style="list-style-type: none"> • Conduct at least 2 groups/week around HIV care and treatment adherence, positive living, resources, and other consumer-identified topics • Recruit HIV-positive clients into support groups 	<ul style="list-style-type: none"> • Peer leader • Staff support group leader • Program manager 	<ol style="list-style-type: none"> 1. Number and topics of support groups 2. Number of HIV-positive clients who attend support groups
1.4 Link 80% of HIV-positive clients into medical and social support services	<ul style="list-style-type: none"> • Conduct reminder and follow-up phone calls regarding medical and social service appointments • Accompany HIV-positive clients to medical and social service appointments 	<ul style="list-style-type: none"> • Peers • Case managers • Clinic staff 	<ol style="list-style-type: none"> 1. Number of HIV-positive case-managed clients with at least 2 medical visits in measurement year

This “Read More” section accompanies [Section 3, Designing a Peer Program](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

3. DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 3

AIDS service organization to support and link HIV-positive patients in care and treatment

About this scenario

XYZ center is an AIDS Service Organization whose mission is to provide outreach, prevention and support services for people at risk and living with HIV/AIDS. The staff members include both peer and non-peer staff and volunteers who provide HIV prevention education and counseling and testing. The agency also has a social worker on staff to run support groups for HIV-infected clients and affected family members. The agency provides HIV counseling and testing for at-risk individuals, and those who are diagnosed with HIV are referred to a local clinic for case management and medical services.

At a recent partner, staff and consumer advisory board meeting, the clinic presented results from recent evaluation of its services which indicated that their case managers are facing challenges with managing large client caseloads. The case managers have a significant proportion of patients who are missing medical appointments. The clinic would like assistance with supporting patients to ensure they are keeping up to date with their medical appointments and treatment. They have offered to provide funding for two part-time, HIV-positive peers to work with clients, case managers, and medical providers. Below is a potential program plan to integrate the two peers into the agency's services.

PEER PROGRAM PLAN

Goal: Increase HIV-positive clients' retention with HIV support and medical services			
Objectives	Activities/Action Steps	Person(s) Responsible	Evaluation Measures
Link 80% of newly diagnosed HIV-positive clients into medical and social support services	<ul style="list-style-type: none"> Prevention staff and peer leader provide support, education, and referrals for case management and medical services to newly diagnosed HIV-positive patients 	<ul style="list-style-type: none"> Prevention education staff Peer leader Case manager from partner agency 	1. Number of newly diagnosed HIV-positive clients that have a case management and medical appointment within 6 months of diagnosis

DESIGNING A PEER PROGRAM

READ MORE: PROGRAM SCENARIO 3

Goal: Increase HIV-positive clients' retention with HIV support and medical services			
Objectives	Activities/Action Steps	Person(s) Responsible	Evaluation Measures
Link 80% of HIV-positive clients into medical and social support services	<ul style="list-style-type: none"> • Conduct reminder and follow-up phone calls regarding medical and social service appointments • Accompany HIV-positive clients to medical and social service appointments 	<ul style="list-style-type: none"> • Peer leader • Case managers • Clinic staff 	1. Number of HIV-positive case-managed clients with at least 2 medical visits in measurement year
Get 80% of HIV-positive clients to attend weekly support groups	<ul style="list-style-type: none"> • Conduct at least 2 groups/week around HIV care and treatment adherence, positive living, resources, and other consumer-identified topics • Recruit HIV-positive clients into support groups 	<ul style="list-style-type: none"> • Peer leader • Staff support group leader • Program manager 	<ol style="list-style-type: none"> 1. Number and topics of support groups 2. Number of HIV-positive clients who attend support groups

This “Read More” section accompanies [Section 3, Designing a Peer Program](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

4. PEER ROLES & RESPONSIBILITIES



Dr. Clanon (right) with peer Aries Brown

“I think the most important thing my patients get from working with peer advocates is hope for the future. No matter how much I talk to them about the potential for them to live long and healthy lives, seeing someone living that promise is more powerful.”

Dr. Kathleen Clanon
Alameda County Medical Center
Oakland, CA

Peers serve in various roles as part of care teams in medical and social service settings, working to improve and enhance the lives of those living with HIV. Peer education can take place in small groups or through individual contact in a variety of settings such as churches, community-based organizations, clinics, hospitals, on the street, in a shelter, or wherever people gather. Peers may also be involved in community work such as outreach and education, participation on HIV advisory and planning council committees, and speakers' bureaus.

Regardless of the peers' specific tasks and objectives, they are uniquely positioned to provide insight and support to HIV-positive individuals. As a part of a multidisciplinary team, peers can facilitate client-provider communication and provide a sense of how other individuals experience HIV diagnosis and treatment. Peers may be better able than professionals to perceive misunderstandings and barriers to client-provider communication. Because their interactions with clients are based on empathy and shared experience, and because they frequently have more open access to clients, peers may glean more information about actual and potential challenges for clients and may also communicate the health care team's messages to clients most effectively.

Regardless of how peers are used, it is essential to define their roles, responsibilities, and interaction with clients. Because the job skills and activities entailed in peer work are different in nature from more traditional professional positions, it is necessary to be more explicit in defining peer roles, responsibilities, and activities. Defining a clear role for peers in the agency can also help to avoid overlapping or duplication of responsibilities with other members of the health care team such as case managers.

The roles and responsibilities of peers can vary widely depending on the focus of the organization or program. Peer roles can include:

- Engaging and supporting HIV-positive persons in the management of the disease, including being adherent to medications.
- Providing emotional and practical support to clients
- Supporting clients to practice healthy behaviors

PEER ROLES & RESPONSIBILITIES

- Identifying HIV-positive persons in the community and linking them to care
- Helping people living with HIV/AIDS (PLWHA) navigate the service system and assisting them to access and participate in care and treatment services
- Providing community work such as awareness, advocacy and prevention education
- Advising programs on all aspects of service delivery

The specific responsibilities or activities of peers in these roles vary, and the qualifications and skills of peers are different depending on their roles.

Engaging and supporting HIV-positive persons in the management of the disease

Peers in these roles often deliver services through a combination of one-on-one support and/or peer-led support groups. For one-on-one conversations, the peer needs to be comfortable disclosing his or her HIV status, be able to ask open-ended questions, and provide accurate information that is relevant to the client's needs. Support group facilitation requires the peer to disclose his or her HIV status and have the knowledge and skills to manage the group dynamics so that participants feel comfortable and safe in sharing very personal and emotional issues. (Support group facilitation is a specialized skill which is addressed in detail in the [Read More: Peers and Support Groups](#).) The specific peer roles related to engaging and supporting HIV-positive persons to manage the disease and adhere to medications can be as limited or as broad as the organization desires and include:

- Explaining the HIV life cycle and how medications work, providing treatment adherence information and strategies for complex HIV/AIDS treatment regimens

- Engaging in problem solving with clients to address adherence problems
- Engaging “harder-to-reach” clients who have fallen out of care or have not entered care (this is similar to outreach roles described above)
- Becoming familiar with the context of the clients' lives
- Facilitating client communication with health professionals
- Gathering information for medical providers
- Following up with clients who miss appointments
- Answering clients' basic questions

Providing emotional and practical support to clients

This is a key role for peers and, regardless of their other interaction with clients, the peer will serve as a role model for living and thriving with HIV. Peers can provide hope to HIV-positive clients and share strategies with them to overcome difficulties of living with HIV. Client interactions can occur one-to-one or in groups and can include:

- Sharing personal knowledge and experiences when appropriate
- Providing encouragement and psychosocial support to address ongoing challenges of HIV-infected individuals, their partners, families and caregivers, including disclosure to partners and others in their life
- Demonstrating self-care strategies to clients
- Assisting clients to understand and move through various stages of commitment to their care (i.e., moving from pre-contemplation of using HAART medications to taking action to begin to use HAART medications and then sustaining their use of HAART) and strategies for living with the lifelong reality of adhering to medications

PEER ROLES & RESPONSIBILITIES



The people that we reach out to are people who really need help. I know; I've been there and I wish that 20 years ago there had been peer educators... I'm hoping that I can help people to have an easier time adjusting to living with HIV and living good lives.

Lionel Biggins
Peer Educator
Truman Medical Center
Kansas City, MO

Supporting clients to practice healthy behaviors

Healthy behaviors for HIV-positive clients are critical for continued health and well-being. Peers can help to educate clients about HIV and dispel myths that prevent a client from managing HIV in a healthy manner. Peers can provide information and support to clients to practice health promotion behaviors (such as making and keeping doctor's appointments) avoid risks (such as utilizing safer sex supplies distributed by peers) improve health routines (such as taking medications accurately and regularly), and reduce harmful situations (such as violent relationships).

Identifying HIV-positive persons in the community and linking them to care

A peer with this focus may work in the community or at a clinical facility. They may be involved in supporting HIV testing by conducting the test and/or providing one-on-one counseling to clients about test results. For HIV-positive individuals, these peers provide resources and support to link them to care services.

Helping PLWHA navigate the service system and access care and treatment services

Again, peers in these roles often deliver services through a combination of one-on-one support and/or peer-led support groups. The areas that a peer covers with clients can be as limited or as broad as the organization desires, including:

- Helping clients find and become familiar with HIV health and social service systems
- Providing referrals for in-house services and community resources
- Helping clients obtain services by assisting them to make appointments, reminding them of appointments and/or providing transportation to and from appointments
- Participating in case conferences with the multidisciplinary team to represent the client's concerns

PEER ROLES & RESPONSIBILITIES

- Helping clients prepare for health care providers' visits by modeling how to ask questions about their health status or medications and processing the information received during a medical visit
- Providing translations services for non- or limited English speakers
- Providing insight into the most effective way to engage and educate a client
- Assisting in coordination of day-to-day care activities to ensure continuity of care

Providing community awareness, advocacy and prevention education

For work in the community, peers must be comfortable with disclosing their HIV status and have the ability to speak in front of groups. Peers may provide activities related to prevention education including: conducting presentations or one-on-one conversations with HIV-positive or at-risk individuals; encouraging individuals or groups to get an HIV test; linking positive clients to care and educating individuals about HIV transmission, including harm reduction and safer sex approaches. Usually, community awareness activities include sharing of personal stories and experiences by the peer in an effort to encourage others to know their HIV status and seek treatment if they are positive. Advocacy usually involves providing personal and factual information about services and support for HIV-positive individuals in an effort to improve current systems or attitudes. Peers provide a strong voice in advocacy, since many policy makers want to hear directly from people who are living with HIV/AIDS. Another important component of community awareness that peers help support is a message of anti-stigma. HIV/AIDS stigma continues to impede prevention and care efforts globally. People living with HIV have a unique and powerful opportunity to tell their story and put a human face on the epidemic.

Advising programs on all aspects of service delivery

Peers in these roles must have the confidence to express their thoughts in meetings and gatherings in such settings as local or state planning councils, consumer advisory committees, AIDS service organizations, boards or focus groups. Their roles involve providing input on policies, procedures, program design and implementation, and evaluation activities that impact the lives of HIV-positive individuals. Many planning and advisory groups have a requirement to include HIV-positive members. It is critical that peers receive adequate training and preparation to participate in meaningful ways in these important groups. These peers may also provide advice on grant proposals by articulating the needs and ideal approaches for addressing non-medical services for HIV-positive clients.

Following are three case examples that describe how HIV-positive peers have been utilized:

Peers as support group facilitators/coordinators for newly diagnosed individuals

Peers participate and assist with a weekly, drop-in support group, with one peer taking the lead in facilitation and coordination. The two-and-a-half hour session includes 30 minutes to eat and catch up socially as a group and then approximately 45 minutes for an educational presentation on topics selected by the group, such as HIV disclosure, substance abuse and addiction issues, working successfully with your doctor, how to read your labs, etc. The last segment of the session focuses on support for participants. All attendees have the opportunity to share difficulties and successes in their lives. Members offer support and encouragement to one another and are an ongoing social network for each other. Newly diagnosed individuals are especially welcomed by participants who

PEER ROLES & RESPONSIBILITIES

have lived with HIV/AIDS for many years, with the message, “You are not alone.” The peers facilitate the discussion, making sure that ground rules are followed, that all participants have opportunities to share, and that individuals who are in crisis and require additional support can meet with a peer following the meeting. By using peers to do group coordination and facilitation, the organization is able to provide an “HIV-positive individuals only space,” something that is difficult to find when traditional professionals are in the leadership roles. The peer team is able to bring up difficult or challenging group issues with a peer supervisor and/or a clinical supervisor.

Peers working one-on-one with HIV-positive women

In one community-based organization, a peer worked as part of a care team to assist a woman in crisis. She was living with a physically and emotionally abusive boyfriend who was restricting her movement and contacts outside of the home. On a parallel track, the woman’s health had deteriorated significantly over the prior year and she had not been receiving regular medical care. In consultation with supervisors and the HIV clinic case manager, the peer began talking with the client about what it would take to leave the boyfriend and what types of services were available to her in order to make this transition. The peer took the client to visit a women’s shelter and also made an appointment to see a pro bono attorney so that the client was clear about her legal rights and options. The woman was fearful and overwhelmed, but wanted to get out of the situation. She was fairly mistrustful of service providers but was able to establish good rapport with the peer because she said, “You’ve been through it all, too.” The peer was able to give her the support she needed to get out of the dangerous relationship, get into transitional and eventually permanent housing, re-establish medical care and participate in a weekly support group.

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

Peers in a clinic-based ART adherence support program

Three peers collaborate with a case manager and health educator to help clients adhere to their medications. Peers are trained in listening and communication skills, providing support, establishing boundaries, and making effective referrals. They use these skills to help their clients identify and address a wide range of barriers to adherence, including substance use, mistrust of, or poor communication with, medical providers, fears about taking medications in front of others, and remembering to take medications on time. Peers are also mentored by program staff to use the experiences and characteristics that they share with clients effectively in their work. They talk to their clients weekly by phone or in person, and over time develop good rapport and trusting relationships that support their clients through the ups and downs of long-term adherence management for a chronic disease. The peers meet biweekly with the program case manager and health educator in case management meetings in order to share information, coordinate client services, and brainstorm about approaches to best meet their clients’ needs.

Read More for Section 4

- [Peers and Support Groups](#)

Resources for Section 4

(available at http://peer.hdwg.org/program_dev/resources)

Support group information:

- [15 steps to starting an HIV support group \(The Lotus Project\)](#)
- [Peer guide to starting an HIV support group \(Kansas City Free Health Clinic\)](#)
- [HCSP support group manual](#)

Sample job descriptions

- [Peer job descriptions \(Kansas City Free Health Clinic\)](#)
- [Peer advocate job description \(The Lotus Project\)](#)
- [Sample peer advocate and manager job descriptions \(The Lotus Project\)](#)
- [Peer adherence counselor/family advisor job descriptions \(Project ARK\)](#)

4. PEER ROLES AND RESPONSIBILITIES

READ MORE: SUPPORT GROUPS

PEERS AND SUPPORT GROUPS

Some peer programs utilize peers as facilitators or co-facilitators of support groups. Having a peer in a leadership role in a support group sends a powerful message to both the peer and the group participants regarding the value of peers to the organization, to the peer program and to the program participants. It also demonstrates a clear understanding that the life experience of peers and their deep understanding of group member struggles, will have a positive impact on the overall outcomes of the group.

Group facilitation requires skills that not all peers may have. Just like any staff member under consideration for a new role, it is important to assess the inherent skills and abilities of the peer. A peer who by nature is shy may not be comfortable speaking in a group or attempting to re-direct the focus of the group. At the opposite end of the spectrum, a peer who is gregarious and out-going may not be able to engage quieter members of the group in the process. Some peers are more open to new experiences and learning new skills than others. There is no hard and fast rule regarding whether peers can or should facilitate or co-facilitate a group. There are, however, some suggested factors to consider when planning to use peers as group facilitators or co-facilitators.

Group purpose

Groups can provide a range of services from social support or education to therapy groups, with a myriad of options within this continuum. It is important that the purpose of the group be consistent with the knowledge, skills and training of the peer. Without training and licensure, a peer would not be able to facilitate a therapy group,

but could, in appropriate circumstances, assist a trained therapist with facilitation. At times, this model can be the best of both worlds: a trained clinician and a peer with kindred life experience working together to provide leadership. A peer with training in group facilitation skills and knowledge of HIV disease and treatment could facilitate or co-facilitate an educational group focusing on an aspect of self management. Similarly, a peer with a demeanor that is well suited to facilitation, given appropriate clinical support from management and training in facilitation skills, could facilitate a support group where women or men living with HIV come together socially and discuss life challenges and triumphs.

Peer Training

Assessing the peer's strengths and skills is the first step in determining additional training needs of the peer. There are many options to providing the needed training. (The Building Blocks to Peer Success toolkit guide for people who conduct peer training includes a facilitation section which may be useful to peers learning to facilitate support groups.) Assessing your organization's ability to provide that training, either on site through existing staff resources, or off site through educational programs is the next step. An important aspect of developing the peer's group facilitation skills is providing on going feedback, support and guidance. It is often most helpful to have the peer function in the beginning as a "group helper" (logistics, set up, note taking) to observe the group process with a trained facilitator. Feedback and discussion with that facilitator immediately after the group

PEER ROLES AND RESPONSIBILITIES

READ MORE: SUPPORT GROUPS

provides some of the best “real-world” training for the peer. As the peer observes and learns the trained facilitator can increase the peer’s role in the group to include actual facilitation responsibilities. Again, immediate feedback and discussion regarding the successes and challenges experienced during the group is most helpful.

Facilitator or Co-Facilitator?

The decision about whether a peer should facilitate a group alone or be a co-facilitator depends on several factors. The first and foremost is the peer’s group facilitation skills and abilities. The peer’s interest in either role must be taken into account as well. Finally, the organization’s ability to supervise the peer and provide ongoing support and guidance must be considered. If the organization has a clinical manager or consultant available, this is an important area in which they can assist peers. Providing regular check-ins with the peer facilitator will be important in helping them understand group dynamics, individual issues and facilitation strategies.



Peers facilitating a support group.

The [Program Resources](http://peer.hdwg.org/program_dev/resources) (available at http://peer.hdwg.org/program_dev/resources) contains three helpful tools for peers who facilitate support groups:

- [15 steps to starting an HIV support group \(The Lotus Project\)](#)
- [Peer guide to HIV education and support groups \(Kansas City Free Health Clinic\)](#)
- [HCSP support group manual](#)

This “Read More” section accompanies [Section 4, Peer Roles and Responsibilities](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

5. RECRUITING, HIRING, AND ORIENTING PEERS



LaTrischa Miles (left) with Peer Educator Training Site Manager Alicia Downes.

Some of the skills that I look for in hiring a peer are good listening skills and being resourceful. Some knowledge can be taught, but some of those innate qualities that you have to have cannot be taught: compassion, being non-judgmental, being able to connect with others, and being positive and respectful of others as far as cultural diversity.

LaTrischa Miles
Peer Supervisor
Kansas City Free Health Clinic
Kansas City, MO

A. Recruitment

Qualifications

Unlike positions with strict educational requirements, peer roles usually draw on unconventional assets. These include experience living in the client population, experience dealing with one or more difficulties faced by the client population (such as unstable housing, substance abuse, domestic violence), fluency in a specified language, ability to relate easily to clients and program staff alike, non-judgmental acceptance of alternative perspectives and lifestyles, good communication skills, willingness to voice opinions and share information with others, and the ability to work independently.

However, these “unconventional assets” are unlikely to be documented with diplomas, degrees, or certificates. In fact, many excellent peers cannot present a resume or application which meets minimal requirements at many Human Resources (HR) departments. In such cases, the directors or managers of the peer programs may have to explain to HR staff why peer positions require a different skill set. It also suggests that the recruitment process may involve different approaches from those traditionally used for program staff, as discussed below.

HIV care teams that include peers should define peer job skills explicitly and operationalize them so that peers and supervisors have objective criteria for assessing peers’ initial qualifications and their on-the-job development.

Below are some recommendations for qualifications for peers engaged in HIV services. These qualifications can be adapted to program- and agency-specific needs:

- Direct experience with HIV treatment (either as a patient or a care giver)
- Local resident or familiarity with the community
- Ability to work with professionals as part of an HIV care team
- Ability to reflect on and apply life experience
- Good communication skills
- Open-minded (non-judgmental)
- Committed to working with others to improve HIV care
- Not currently using street drugs or abusing alcohol

RECRUITING, HIRING, AND ORIENTING PEERS

Programs will find it helpful to define objectives for peers in advance of constructing a program-specific peer job description. Taken together, these objectives comprise a peer role that both furthers program goals and maximizes the unique contribution of peers to the program. The [Program Resources](#) for [Section 4, Peer Roles and Responsibilities](#), include sample job descriptions for peers that can be adapted to meet program-specific needs.

The Recruitment Process

Because peers often don't have conventional resumes (as discussed above), the traditional HR hiring practices may need to be amended slightly. One useful step is for peer program managers or supervisors to take a proactive stance in encouraging applications among appropriate candidates. This may be done through several means:

- Soliciting names of possible candidates from clinic providers, peers, and other staff
- Emails, postings on websites, e-blasts on listservs
- Sending flyers or other materials to clinics, community-based organizations, AIDS service organizations, planning councils, etc.

After gathering these nominations, one may want to conduct brief interviews in person or over the telephone with interested candidates. It is preferable that these interviews involve both the peer program supervisor and a current peer. A program may also want to involve other non-peer staff such as case managers in interviews if the peer candidate will be working with other staff. This may happen before, after, or simultaneously with traditional HR practices such as posting positions.

Sample questions for this interview include:

- How did you hear about the peer program?
- Why are you interested in being a peer?
- What do you expect to get out of working for this program, personally?
- Tell us about any HIV/AIDS training programs that you've been involved in.
- Tell us about your work or volunteer experience in the field of HIV/AIDS.
- Are you aware that we will not tolerate the use of street drugs during your employment with the peer program? Do you have any concerns about this issue?
- Are you comfortable sharing your HIV status with co-workers, supervisors, and clients while working for this program? If you were asked, "Are you HIV positive?" what would your response be?
- How would you go about telling someone close to you that you have HIV/AIDS?
- How would you go about telling a client that you too have HIV/AIDS?
- What would you tell a client about your sexual or drug-using history?
- How comfortable are you when discussing issues around sex and drug use? How would you rate yourself on a scale of 1 to 10, with 1 being very uncomfortable and 10 being very comfortable?

The [Program Resources](#) for [Section 5, Recruiting, Hiring and Orienting Peers](#), provide more sample interview scenarios and screening questions.

Some agencies may have a standard protocol through their Human Resources department for recruiting and interviewing candidates. It is important to gather that information for the interview process and be aware of some of the challenges the process may cause for peer candidates. For example, the standard HR hiring process may itself pose a number of challenges for peer applicants:

RECRUITING, HIRING, AND ORIENTING PEERS

- If online applications are required, peers may be unfamiliar with such programs or may not have access to computers.
- Some applicants may have criminal histories or may not be able to pass drug screening.
- Due to limited work histories, some applicants may not be able to provide two professional references.
- Some applicants may not be accustomed to a formal interview process.

Keeping these points in mind and being prepared to communicate the process and policy clearly to the candidate can help reduce challenges to getting a peer hired.

Disclosing HIV Status

One characteristic that distinguishes the hiring of peers from that of other employees is the issue of disclosing one's HIV status. Many peers come from situations, such as Alcoholics Anonymous, where anonymity is valued. Additionally, the stigma attached to HIV/AIDS makes most people cautious about revealing that information indiscriminately.

The tradition of peer work in HIV/AIDS, however, is built upon the concept that those who are “infected or affected” will use their personal experience to assist clients. This goes beyond the normal expectation of empathy in the helping professions; HIV/AIDS peers can draw upon their own experiences in being diagnosed, having to deal with disclosure to family and friends, taking medication, experiencing side effects, etc. to aid clients. Many peer program supervisors believe that a peer who insists on anonymity is not fulfilling the peer role.

While an HIV-positive peer may not be allowed to keep his or her status secret, special steps should be taken regarding disclosure. By publicly defining

peers as someone with HIV, some early programs may have unwittingly revealed their peers' status, leading to stigmatization. Job announcements which set HIV status as a job requirement may discourage many potential candidates.

A better approach to the issue of requiring candidates to be infected or affected, while not unduly compromising their health information, may include some or all of the following suggestions:

- Job announcements could require “firsthand knowledge in HIV/AIDS issues.”
- Announcements could be distributed to groups or places where many individuals who see it are likely to be HIV-positive.
- In interviews, candidates could be asked how they envision using their “firsthand knowledge” instead of having to explicitly confirm their status.
- In interviews and other communications, peer programs could stress the importance of peers having shared characteristics with the target population.

B. Hiring

Special Considerations

Salaries, stipends, or other monetary compensation paid to HIV-positive peers might, in some cases, affect or risk their benefits/entitlements. Any decrease or loss of benefits can present a substantial disincentive to doing peer work. During the hiring process, supervisors or program directors have a responsibility to raise peers' awareness of this risk, and provide information and referrals to legal or other services where they can receive training or individualized guidance regarding their benefits. In most cases, supervisors do not have the background or resources available to analyze the case of

RECRUITING, HIRING, AND ORIENTING PEERS

It's important to make sure the peers are adequately trained, feel comfortable, know the expected roles and feel adequate. Some of the people that we've trained decided after a couple of trainings that it isn't for them.

Marcie Brainerd
Peer Program Coordinator
Waterbury Hospital
Waterbury, CT

each peer, but they can encourage peers to consult with a lawyer or a benefits specialist concerning the limits of how much they can earn without jeopardizing existing benefits. See [Read More: Benefits Questions to Discuss with Peers](#) for more information.

Another special consideration in hiring peers is the practice of running background checks on applicants, particularly with respect to criminal history. The peer program supervisor should be aware of what is required by the organization and consider asking for a waiver of this requirement if it seems likely to eliminate many otherwise worthy candidates. In such cases, the supervisor may need to present evidence that program activities are geared toward reaching those with drug-using or criminal histories.

C. Orientation and Training

Peers may come to their position with an advanced degree or without a high school diploma. They may have extensive training in health care provision or none at all. In any case, most programs will find it necessary to provide some job-specific training to new peers. An organizational environment that supports learning is the best way to ensure that peers are adequately prepared to do their job. Furthermore, policies that encourage education and training strengthen motivation and expose peers to possibilities that they may not have envisioned before taking on a peer position. Creating a supportive learning environment may take time, especially for supervisors working within institutions that do not promote ongoing development in non-traditional fields.

Orientation and training for peer workers generally entails the following components:

- Standard “new employee” orientation for the organization
- Specific role-based training with peer supervisor or with external training program
- “Shadowing” current peers as they work
- Special attention to issues of confidentiality (See [Read More: Confidentiality and Peers.](#))

RECRUITING, HIRING, AND ORIENTING PEERS

Training of Peers

Depending on the peers' responsibilities, it is recommended that peers complete a comprehensive training course on HIV (knowledge about transmission, the virus life cycle, and treatments), communication skills and their role as a peer. A sample of training sections can be found at [Building Blocks to Peer Success \(http://peer.hdwg.org/training_toolkit\)](http://peer.hdwg.org/training_toolkit), a train-the-trainer toolkit. If the agency staff is not prepared to conduct trainings, there are many agencies that provide peer training. For further opportunities for training that may be suitable for peers and consumers, consult the [Target Center website \(http://www.careacttarget.org/\)](http://www.careacttarget.org/), which provides technical assistance for the Ryan White community.

Training Non-Peer Staff

It is critical to the success and sustainability of peer programs that all employees within organizations understand the unique roles, philosophy and goals of peer programs. This understanding will also provide a workplace culture that is more likely to value peer work and leadership within the organization. Inclusion of peer work, whether it is paid or volunteer, in new employee orientation demonstrates that the organization values peer work. It also helps to set the stage for new employees to view peers as their colleagues and co-workers. (See [Read More: Orienting Non-Peer Employees on Peer Support.](#))

Continuing Training

As peers become a more central component of health and social service interventions, programs can expect to see increased regulation of their role,

particularly with respect to training requirements and certification. In such cases, emergent concerns with quality assurance may change the way organizations perceive peers, paving the way for program managers to develop more progressive continuing education policies.

An open-door policy for specific training requests will encourage peers to inform their supervisors of perceived gaps in their knowledge and skills. If program managers communicate with peers regularly about job requirements, they will have a concrete understanding of peers' capacities and training gaps and therefore can prioritize individual peer and collective training needs.

On-the-job follow up to training can reinforce training sessions and help tailor new skills and knowledge to the workplace. Peers can bring new information back to their colleagues in brief presentations to stimulate discussion, and supervisors can reinforce new information with handouts or references to sources of further information. Some programs encourage training "graduates" to train other peers and/or program staff when they return to work.

The [Program Resources](#) for Section 5 (Recruiting, Hiring, and Orienting Peers) contain sample orientation packets for peers.

D. Retention of Peers

One way to justify investments in recruiting and training peers is to make sure they remain productive team members. Attending to peer needs by providing an appropriate work context, training, and skills development, in addition to opportunities to give feedback, recognition and appreciation, and tangible benefits is important to keep peers motivated and able to perform their job. The following elements have been shown to contribute to optimal peer performance as well as high retention rates.

RECRUITING, HIRING, AND ORIENTING PEERS



Staff from Christie's Place participate in the San Diego HIV Health Services Planning Council.

If peers are given the opportunity to share their work with external networks, they receive acknowledgment for their contribution.

Monetary Compensation

Many programs have funding to employ peers in full- or part-time positions. Others may provide stipends for peers or offer other benefits. While stipends are not salaries, they are an excellent way to reward and compensate peers for their time and hard work.

Transportation reimbursement is also a good way to help peers fulfill their role. In addition to work transportation, an effort should be made to provide transportation to any work-related events such as training, meetings, client appointments, or outreach activities. As mentioned above in Hiring, there may be some dangers inherent in providing different forms of monetary compensation to peers, as receipt of such compensation may affect benefits they receive.

Non-Monetary Benefits

Programs that actively seek meetings and conferences of interest to peers enable peers to expand their

horizons by interacting with and learning from a community of professional and lay service providers. Program-sponsored training courses designed to upgrade peer knowledge about HIV and adherence and to improve social support skills demonstrate a program's commitment to the peer and will engender peer motivation and program loyalty. For example, workshops might be organized to address peer wellness issues, including stress management, dramatic expression and valuing diversity. Supervisors need to recognize that taking the time to consider peer preferences will improve their job performance and satisfaction.

Supervision

Supervision is covered in detail in [Section 6: Supervising Peers](#) of this toolkit. However, it is important to note that good supervision is a key component in retaining peer workers. The role of the peer worker has many challenges, with peer workers living on the "front lines" of the difficulties associated with HIV/AIDS. To the extent that these challenges are addressed through clear job descriptions, acknowledgment and acceptance among other workers in the organization, and supportive and sympathetic supervision, peers will be more likely to contribute fully and feel good about their work.

Advocacy, Activist, and Service Provider Networks

Peers assist and encourage each other in much the same way they assist clients. Peers tend to see themselves as members of a small team within the overall program. Having trained together, discussed difficult clients, and shared personal issues affecting their job, peers build bonds that surpass those normally formed in the workplace. Programs can enhance this natural source of support by setting aside time and space for peers

RECRUITING, HIRING AND ORIENTING PEERS

MAKING THE MOST OF EXTERNAL TRAINING OPPORTUNITIES

- Acquire information on content, location and space availability
- Submit peer registration form, await confirmation, keep peers updated on registration process
- Keep registration records for follow-up purposes
- Provide peers with training details as they become available
- Adapt program operations to accommodate peer absence
- Establish training expectations with peer: attendance, how the peer is expected to use information and skills acquired, responsibility for training others, reporting, if applicable
- Create a feedback loop for follow up and future reference with training facilitator
- Make appropriate logistical arrangements: provide peer with transportation and food
- Maintain contact with peer during the training
- Review and adjust peer activities based on information and skills acquired during training

to conduct their own support groups. An open, friendly work environment with designated space for peers encourages discussion and collaboration. By aiming to build internal peer support, a program ensures greater personal resources for peers to face work and personal challenges. Further, if peers are given the opportunity to share their work with external networks (at conferences, meetings, and other public forums), they receive acknowledgment for their contribution.

Effective Feedback Loops

One of the most important reasons to engage peers is to better serve a hard-to-reach population. Peers are uniquely placed to provide direct services to clients and carry back information about the client population to the program. Program evaluation must always include a plan to elicit peer feedback, whether it be through focus groups, individual interviews, or systematic discussion in individual

supervision. In this way, a program can devise more effective strategies to meet client needs, based on peers' first-hand experiences and insights. Peer feedback should inform all aspects of a program and may serve as the basis for fundamental changes in operations. Peers make valuable contributions to research meetings, social service coordination meetings, interdepartmental meetings, and strategic planning sessions. Peers can also play an important program development role in selecting new peers, facilitating workshops, and presenting the program at conferences and special events.

External Training Opportunities and Professional Development

External training resources can provide peers with valuable opportunities to develop skills and extend their service-related networks. However supervisors or program managers should select and monitor these resources carefully to ensure a beneficial experience for the peer.

RECRUITING, HIRING, AND ORIENTING PEERS

► FOR MORE INFORMATION

Read More for Section 5

- Cultural sensitivity and peer orientation
- Confidentiality and peers
- Orienting non-peer employees on peer support, philosophy and program models
- Benefits questions to discuss with peers

Resources for Section 5

(available at <http://peer.hdwg.org/program-dev/resources>)

• Recruitment and Hiring

- o Hiring checklist (JRI)
- o Sample interview questions (JRI)
- o Interviewing peers: sample questions and possible responses (The Lotus Project)
- o “Do and don’t” interview questions (JRI)
- o Peer selection process: what staff and potential peers should consider (Project ARK)
- o Guide to writing job descriptions (JRI)
- o Creating a recruitment plan (JRI)
- o Applicant assessment template (JRI)
- o Avoid common interview mistakes (JRI)
- o Peer interview scenarios (Kansas City Free Health Clinic)
- o Sample peer screening questions (The Lotus Project)

• Orientation

- o Orientation checklist (JRI)
- o Sample orientation training plan (JRI)
- o Sample peer orientation agenda and resource packet (Kansas City Free Health Clinic)
- o Sample peer-client confidentiality agreement (The Lotus Project)

• Cultural Competency

- o Awareness spectrum (JRI)
- o Cultural competence model (JRI)
- o Cross model of cultural competency - information
- o Cross model of cultural competency - handout (JRI)

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

5. RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: CULTURAL SENSITIVITY

Cultural Sensitivity and Peer Orientation

Recent immigrants account for an increasingly large proportion of persons with HIV in the United States. Degrees of acculturation, culturally specific beliefs related to health and illness, and perceptions of the U.S. medical and public health care systems all impact the success of health promotion and prevention interventions. Therefore, health care providers should interact with patients in culturally appropriate ways that maximize the effectiveness of the adherence support they offer. (Note: Profound cultural differences may also exist among persons born in the United States, not just among those coming from other countries.)

Cultural awareness or inclusiveness refers to the body of knowledge and interpersonal skills that allow providers to understand and collaborate with staff and patients from diverse cultures. Beyond self-awareness, cultural sensitivity requires awareness and acceptance of cultural differences, familiarity with the relevant patient cultures, and adaptation of appropriate skills.

The first step towards cultural sensitivity is for supervisors and others involved in peer programs to increase their awareness of how their own cultural backgrounds influence their approach to others, whether they are peers or patients. The Cultural Competency resource under Section 5 in the [Program Resources](#) can help organizations and individuals assess their cultural sensitivity.

The second step towards cultural sensitivity is increasing one's familiarity with the populations being served. At a basic level, this includes determining the primary languages spoken and which cultural groups predominate in the community. If resources for interpreters or translators fluent in relevant languages are insufficient, HIV programs may reach out to community-based organizations serving immigrant populations, which may be a source of qualified interpreters/translators at low or no cost.

Next, one should become familiar with the values and beliefs that prevail in the populations being served. Peer supervisors and others should not assume that a given peer or patient will exhibit all characteristics of his/her culture of origin, but should use their familiarity with the culture of origin to facilitate and deepen communication with the peer. This will create a foundation from which patient perceptions about health, illness, and health care systems, especially in relationship to HIV, can be explored.

A culturally sensitive approach to care can help build trust and credibility. This is especially important among populations in which HIV is stigmatized and who are unfamiliar with the U.S. medical and public health systems. Focus group discussions with community members and leaders, international medical graduates (IMGs), and former and current patients can provide insight into the beliefs and practices of a particular population, as can online resources. Collaborations with community-based organizations (CBOs) can also yield information and insight, and bring HIV treatment programs into community networks.

RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: CULTURAL SENSITIVITY

► CULTURAL SENSITIVITY RESOURCES

Resources on cultural sensitivity are widely available, including manuals, training materials, and courses. Local health departments and medical associations may also offer workshops for health care providers, some of which are free of charge and/or offer continuing education units. Some resources for developing cultural sensitivity are listed on HRSA's website:

<http://www.hrsa.gov/culturalcompetence/>

Staff members should be educated about relevant cultural beliefs and practices of the communities they serve and should practice techniques for good communication with patients. This knowledge is crucial, as misinterpretation of certain behaviors or intentions can adversely affect the peer-supervisor or patient-provider relationships.

Employing individuals from the community with a diversity of backgrounds also helps to create a culturally sensitive environment. However, incorporating small changes, such as ensuring that patient forms and educational materials are available in multiple languages, can have a big impact on the comfort level of foreign-born patients.

In Summary: Basic Steps Toward Cultural Sensitivity

- Use translators, preferably the same gender as the patient or parent/caregiver.
- Ensure that educational materials are available in multiple languages.
- Provide medical history and consent forms in multiple languages.
- Work with CBOs and community leaders to build partnerships to establish trust and credibility with community members.
- Involve community members as volunteers and/or employees for the program.
- Collaborate with volunteers and patients to identify common misconceptions about HIV and address these issues with patients and parents/caregivers.

This “Read More” section accompanies [Section 5: Recruiting, Hiring and Orienting Peers](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

5. RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: CONFIDENTIALITY

Confidentiality and Peers

Protection of private health information is a legal concept that is incorporated into agency culture, policies and procedures and that agencies have a duty to insure that all employees and volunteers practice. It is a concept that all professionals working in health care learn early in their training and integrate into all aspects of their practice. The history of stigma and discrimination in the HIV/AIDS epidemic make maintaining strict confidentiality on behalf of clients a critical issue. Maintaining confidentiality and protecting the privacy of health information is a responsibility of peers just as it is a responsibility of all health care workers. Peers, especially those with no experience working in a health care setting, may not be as familiar with these concepts, and the practices needed to implement these concepts, as their co-workers and colleagues. In addition, the unique nature of peer work, that is, that the

peer is from the community he or she serves, may place the peer in difficult and confusing situations related to confidentiality.

Health care professionals have education, training and experience to deal with these situations. Peers usually have not. It is beneficial that all employees receive ongoing training on confidentiality; it is a complex issue that can challenge the most seasoned professional. Without orientation, training and ongoing supervision, peers may react to these situations from their personal point of view rather than from their role as a peer worker. It is imperative that peer programs recognize this and develop activities to provide peers with the tools they need to protect privacy and confidentiality.

A thorough review of the agency's policies and procedures regarding confidentiality and privacy is usually included in any employee orientation. Following this agency review, a review by the peer supervisor with the peer may be helpful. The focus of this review should include application of the agency's policies and procedures to the peer role. Most importantly, this review should include the unique aspects of the peer role and special circumstances, like the examples in the box to the left, which the peer may encounter. Role playing these situations may be most helpful for the peer. Encouraging peers to discuss confidentiality and actions peers will take to protect their clients' confidentiality may alleviate some awkwardness if situations like the examples occur. It is helpful for the new peer to hear from experienced peers about strategies and situations that they have needed to navigate regarding confidentiality.

▶ **EXAMPLES OF DIFFICULT SITUATIONS** related to confidentiality which peers might encounter:

- The peer is at a social gathering and overhears someone say, "I hear John (client of the peer) has AIDS"
- The peer is making appointment reminder phone calls for his clinic and recognizes a name on the patient list as a member of his church.
- A peer is meeting a friend for dinner and sitting at the table next to him is patient at the HIV clinic where the peer works.

RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: CONFIDENTIALITY

Additional training regarding the Health Insurance Portability and Accountability Act (HIPAA), health information privacy and confidentiality may be helpful. (For more about HIPAA, see [Section 7.6: Evaluating Peer Programs: Protection of Human Subjects and Evaluation](#)). It is important for all of us, not just peers, not to get bogged down in legal terms, but an understanding of the legal foundation of confidentiality and privacy may be beneficial. Giving peers a brief historical context around confidentiality and HIV/AIDS will help them understand why there is a significant emphasis on this issue.

Training regarding the agency's policies, procedures and forms that protect health information is necessary. Assisting peers

in understanding these documents and discussion regarding implementing them can empower peers to better protect their clients' confidentiality. Confidentiality and protection of privacy must be a part of peer orientation, training and ongoing supervision.

Finally, supervision, whether administrative, supportive or clinical, is an excellent opportunity to discuss situations, role play responses, review policies and procedures, complete forms and otherwise work with peers to assure their protection of private health information.

The [Peer Role section](#) (Workplace Issues) of [Building Blocks to Peer Success](#), a toolkit for training HIV-positive peers, provides several training modules which address issues of confidentiality. The [Program Resources](#) section for Chapter 5 (Recruiting, Hiring, and Orienting Peers) contains a [sample confidentiality agreement](#) created by the Lotus Project.

This "Read More" section accompanies [Section 5 Recruiting, Hiring, and Orienting Peers](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

5. RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: ORIENTING NON-PEER STAFF

Orienting Non-Peer Employees on Peer Support, Philosophy and Program Models

It is critical to the success and sustainability of peer programs that all employees within organizations understand the unique roles, philosophy and goals of peer programs. This understanding will also provide a workplace culture that is more likely to value peer work and leadership within the organization. Inclusion of peer work, whether it is paid or volunteer, in new employee orientation demonstrates that the organization values peer work. It also helps to set the stage for new employees to view peers as their colleagues and co-workers.

The actual orientation may include the following topic areas:

1. The philosophy of peer support and services: what peers bring to the service system that is unique and how it can impact program outcomes
2. Having a peer speak to new employees as part of orientation is a key component. Discussing their role as a peer, the impact that they see with clients and how they came into the work
3. A training component on cultural competency considerations in working alongside employees who are HIV-positive and may bring very different life experiences to the work
4. Some brief reading on peer models of service delivery, challenges and successes

Providing non-peer staff orientation can result in the following outcomes:

1. Peer employees, who may not have the depth of professional experience that other employees bring, will enter into a work culture that is welcoming and values their skills.
2. Non-peer employees will be in a better position to know when to access peer support and services. They will be able to maximize overall support for clients they may be working with.
3. Non-peer employees will know how to discuss peer service with the broader community of service providers and clinicians.
4. Diversity within the organization will be enhanced. More often than not, the inclusion of peers within the employee pool enhances diversity in terms of life experience, HIV status, race and class. This creates a stronger team in supporting people living with HIV.

Because formalized peer models of support are still fairly new to most clinics and organizations serving people with HIV, it is important that a focused orientation for non-peer employees is in place. This will help avoid a situation where the peers are isolated and underutilized within organizations.

This “Read More” section accompanies [Section 5: Recruiting, Hiring, and Orienting Peers](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

5. RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: BENEFITS QUESTIONS

Benefits questions to discuss with peers

Salaries, stipends, or other monetary compensation paid to HIV-positive peers might, in some cases, affect or risk their benefits/entitlements. During the hiring process, supervisors or program directors have a responsibility to raise peers' awareness of this risk and provide information and referrals to legal and other services where they can receive training or individualized guidance regarding their benefits. Below are some of the questions potential peers may ask about how working as a peer might impact their benefits, with information about things to consider. This information is of a general nature—you may wish to consult with state agencies, local case managers or employment benefits counselors for more specific information.

Will receiving a stipend affect my Medicare part D, Medicaid, SSI, Food Stamp Program (SNAP), or Housing Program (HUD)?

This information is of a general nature. We provide some guidelines; however, you are strongly advised to contact your state agency regarding your benefits.

Receiving a stipend may affect your other benefits. This is not an easy question to answer because it depends on your specific situation. Some programs vary depending on the state you live in. The best we can do is give you some idea of where to look for more information about each program. Read more below for information. A local case manager or employment benefits counselor may be able to provide you with more information.

Medicare, Part D: If you receive Medicare Part D prescription drug coverage, which is a Social Security disability benefit, any additional income should be reported to the Social Security Administration (SSA). In general, if your disability still meets regulations, you can keep your Medicare coverage for at least 8½ years after you go back to work (including the nine-month trial work period, during which a beneficiary receiving Social Security disability benefits may test his or her ability to work and still be considered disabled).

Please refer to this link about specific questions related to working and keeping your Medicare benefits:

<http://www.socialsecurity.gov/disabilityresearch/wi/extended.htm>

For more information about the Medicare part D program, please refer this link:

<https://www.medicare.gov/part-d/>

Medicaid: Medicaid provides medical coverage to income-eligible individuals and families. The state and federal government share the costs of the Medicaid program. Medicaid plans and services vary by state. Some people who are blind or disabled (16-65) and who have Medicaid prior to going back to work can continue to have Medicaid while working if their disabling condition is still present.

To learn more about working and still receiving Medicaid benefits, please refer to this link:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html>

RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: BENEFITS QUESTIONS

Social Security: Social Security Income (SSI) gives assistance to aged, blind and disabled individuals (minors <19) who have limited income and do not qualify for SSDI (Social Security Disability Insurance) or whose SSDI is less than the SSI standard benefit amount (\$637 in 2008).

When income goes up, SSI goes down. SSI will discontinue if your income is more than the limit, which in 2008 was \$637. However, SSA disregards the first \$85 of earned income, and also disregards Impaired Related Work Expenses (transportation, job coach, etc) and half of your earned income. Below is an example:

If you lose SSI because of earned income and then lose your job, you can request to have your SSI benefits begin again. No new disability application needs to be completed if it's within 5 years of benefits stopping. For more information on SSI, please refer to this link: http://www.ssa.gov/pgm/links_ssi.htm

To talk to a SSI representative: 1-800-772-1213
You can go to this link to find a Social Security office near you: <http://secure.ssa.gov/apps6z/FOLO/fo001.jsp>

▶ AN EXAMPLE OF HOW WORKING MAY AFFECT YOUR SSI BENEFITS

Before you started to work, you received the standard SSI benefit amount of \$637 per month.

In December 2008, you started working and earned: \$1,000

SSA disregards the first \$85: \$1000-\$85=\$915

SSA then disregards ½ of your remaining earned income: \$915 divided by 2=\$457.50

The remaining amount will be deducted from your previous SSI payment. Your SSI payment will be: \$637-\$457.50=\$179.50

Your December income: \$1,000 (Earned Income) +\$179.50 SSI
=\$1179.50

RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: BENEFITS QUESTIONS

The Ticket to Work Program: SSA's Ticket to Work Program is an employment program that is available to most Social Security beneficiaries with disabilities who meet certain criteria. The Ticket to Work special rules are called "work incentives" which allow you to keep your cash benefits and Medicare or Medicaid while you test your ability to work. The Social Security Administration notifies those beneficiaries who are eligible to participate in the Ticket Program by issuing them a Ticket. The medical conditions of all beneficiaries of Social Security are given the designation of "medical improvement expected", "medical improvement possible", or "medical improvement not expected". Most, if not all, individuals receiving Social Security due to HIV-related illness have had their conditions designated as "medical improvement not expected" and will receive tickets.

You can find out more about the Ticket to Work program from these links:
<http://www.socialsecurity.gov/work/>
<http://www.yourtickettowork.com/>

Food Stamps: The food stamp program (Supplemental Nutrition Assistance Program or SNAP) is a nutrition assistance program for families and individuals who meet income eligibility criteria. Because eligibility is based on income, a change in income may affect your eligibility.

Please refer to this link for more information and examples about income and the Supplemental Nutrition Assistance

Program (SNAP):

<http://www.fns.usda.gov/snap/eligibility>

To email a SNAP representative for more specific information, please refer to this link:

<http://www.fns.usda.gov/snap/state-informationhotline-numbers>

Housing and Urban Development (HUD) Housing:

Eligibility for this program, which offers housing to income-eligible families, the elderly, and persons with disabilities, is income-based, so a change in income may affect your eligibility. Each year, there is a set program income limit for each state. To find out your state income limit, please refer this link:

<http://www.huduser.org/datasets/il.html>

For HUD housing counseling agencies by state:

<http://www.hud.gov/offices/hsg/sfh/hcc/hcs.cfm>

To find your Local Public Housing Agency (PHA):

<http://www.hud.gov/offices/pih/pha/contacts/index.cfm>

How much can I work before my SSI benefits are affected?

This information is of a general nature. We provide some guidelines; however, you are strongly advised to contact your state agency regarding your benefits.

The SSA offers a Ticket to Work Program, which is an employment program that is available to most Social Security beneficiaries with disabilities who meet certain criteria. The Ticket to Work special rules are called "work incentives" which allow you to keep your cash benefits and Medicare or Medicaid while you test your ability to work. By using the Ticket to Work Program, you can have a Trial Work Period. The government does not consider services performed during the trial work period as showing that the disability has ended until services have been performed in at least 9 months (not necessarily consecutive) in a rolling 60-month period. In 2008, any month in which earnings exceed \$670 was

RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: BENEFITS QUESTIONS

► QUESTIONS TO CONSIDER

An organization can help a peer to ensure that working or receiving a stipend will not impact benefits by becoming informed about state benefit requirements and possibly referring a peer to a benefits counselor to discuss the peer's specific situation. The organization should take benefits into account when discussing with the peer how many hours the peer will work (part-time/full-time) and negotiating a pay rate.

Questions to consider include:

- How many hours can the peer work?
- What is an appropriate pay rate?
- What are the peer's career goals?
- How will the position accommodate the peer's medical needs?

Organization staff and the peer candidate should discuss these questions during the employment process and revisit them on a periodic basis to ensure both the peer and organization are benefitting positively from the work.

considered a month of services for an individual's trial work period. In 2009, this monthly amount increased to \$700.

If you lose SSI because of earned income and then lose your job, you can request to have your SSI benefits begin again. No new disability application needs to be completed if it's within 5 years of benefits stopping. You can still qualify for other work incentives, like the Ticket to Work Program which can help you get back to work without affecting your benefits for a period of time.

You can find out more about the Ticket to Work program from these links:

<http://www.socialsecurity.gov/work/>
<http://www.yourtickettowork.com/>

For more about the trial work period, visit this link:
<http://www.ssa.gov/OACT/COLA/twp.html>

For more about how working may affect your benefits, please see the answer to the question [Will receiving a stipend affect my Medicare part D, Medicaid, SSI, Food Stamp Program \(SNAP\), or Housing Program \(HUD\)?](#)

What other questions should I consider as an HIV-positive peer?

This information is of a general nature. We provide some guidelines; however, you are strongly advised to contact your state agency regarding your benefits.

Beyond considering how working might impact your benefits, (see the above questions Will receiving a stipend affect my... benefits? and How much can I work before my SSI benefits are affected? for more information), you may want to think about your peer work in the context of your personal and career goals. You may consider setting life and career goals

RECRUITING, HIRING, AND ORIENTING PEERS

READ MORE: BENEFITS QUESTIONS

for yourself and creating a plan of action. Examples of goals might include:

- Supplementing your income
- Testing your ability to work
- Improving your benefits portfolio

Working as a peer can be very empowering, but only you as a peer can determine what is most important to manage your condition and live the life you want.

Don't sell yourself short, be realistic and set your goals incrementally. And most importantly, have fun in the process!

This “Read More” section accompanies [Section 5, Recruiting, Hiring and Orienting Peers](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6. SUPERVISING PEERS



Sally Neville (left) with Peer Supervisor
LaTrischa Miles

From a policy and procedure viewpoint, our peers have developed into equal members of the interdisciplinary team.

Sally Neville, RN, MSN
Director, HIV Primary Care
Kansas City Free Health Clinic
Kansas City, MO

Introduction

As in most helping professions, peers set out to work with a population of people who are facing major life stressors. In the fields of psychology and social work, it is well understood that practitioners in helping roles periodically experience elevated levels of emotional stress as a result of working with distressed clients. Particularly, helpers who have experienced challenges similar to those of their clients may be more susceptible to varying levels of emotional and/or psychological strain.

Effective peer supervision calls for supervisors to develop a highly supportive supervisory style that borrows from mental health counseling, social work and supervision. Pioneer peer programs across the nation have witnessed the high, early drop out rate of peers; and programs, such as Women Organized to Respond to Life Threatening Disease (WORLD), have found that the implementation of clinical or supportive supervision positively affects retention rates.

Peers thrive under supportive work conditions that provide structure, flexibility, and supervision that responds to the unique challenges of their jobs and their particular life circumstances as peers. Regardless of who supervises peers, a problem-solving approach and supportive style of supervision will develop peer-specific capacities while strengthening the team approach to client service. Peers who are supported and supervised will feel like valued team members. Just as it is essential to prepare the peer for his or her role as a peer, it is equally important to establish the nature and expectations of the peer-supervisor role.

One of the biggest challenges in supervising peers is that peers are operating in a non-licensed capacity, and yet, they are playing a helping role. Though supervisors should provide needed training and other supports for peers to improve performance, it is important not to impose license-level standards on peers who complement professional social services. Peers do not usually have the education or licensing needed to offer clinical and certain professional services. The value of peers derives from the empathic support and personal connection they offer their clients, and the

SUPERVISING PEERS

extent to which peers can effectively draw on their own life experiences and common background to assist clients.

This section discusses the rationale, framework and sample models of administrative, supportive, and clinical supervision for peer programs.

Types and Frequency of Supervision for Peers

Successful peer programs provide **both** administrative **and** supportive *or* clinical supervision for peers. In any model of supervision, there should be a relationship built between the supervisor and the peer of open communication, support and continuous feedback. In this way, peers are able to grow in an environment that honors their contribution as peers and allows for both positive and constructive feedback.

Although it is recommended that a peer receive both administrative and either supportive or clinical supervision, the level and frequency of supportive or clinical supervision depends on the peer's job responsibilities and level of engagement with clients. When peers serve in intensive one-on-one roles with clients, the benefit of regular supervisory support is more evident, while some other peer roles may require less supervisory involvement. In other words, a peer who is providing emotional and practical support to many individual clients at once will certainly benefit from regular supportive supervision, while a peer who is less personally engaged with individual clients may not need as much frequency. Some examples of less personally engaged roles may include prevention educator, serving as an advisor to clinics or programs, and providing short-term follow-up services to newly diagnosed clients or clients who are hard to reach. However, while some roles don't initially seem as intensive, supervisors may find that peers still

benefit from some level of individualized support. While some roles may not include as much one-on-one interaction, they may still challenge peers' current level of skills in communicating with colleagues, the community, and people like themselves who are living with chronic and/or life threatening illness. In short, it is important that the supervisor and the peer understand the nature of the peer's work in order to determine the level of supervision necessary. Often, the level and frequency of supervision can be adjusted with time, as the supervisor and peer worker(s) become more aware of the optimal level of supervisory support.

Most importantly, supervisors should set up regularly scheduled meetings with peers to meet the goals described below for each level of supervision.

Administrative Supervision

Administrative supervision functions as the operational method by which supervisors work with peers to accomplish the goals of the organization. This includes managing peer hours, caseloads, benefits, interactions with colleagues, quality of work, attainment of program goals, peer job satisfaction, resources, and development for peers—including additional training and/or mentoring, etc. Administrative supervision is often the most common type of supervision within agencies for staff and should be offered on a regular basis to peers, whether they are paid staff or volunteers, as part of the benefit of working in a system. [Subsection 6.1, Administrative Supervision](#) provides an in-depth discussion and examples of administrative supervision.

Supportive Supervision

Supportive supervision is an approach that offers a unique form of supervision to peers. Supportive supervision takes into account the varied experiences of many peers who arrive on the job with little or no professional background—albeit with a wealth of personal wisdom and knowledge about the lives

SUPERVISING PEERS



Supervising peer educators is an ongoing, evolving learning experience for myself because I can't predict what's going to happen. I always think I have a good plan in place, and then something happens before I have truly readied the peer educator for that position. But I'm always surprised with how resourceful and how incredibly giving the peer educators can be.

Rose Farnan
Infectious Disease Nurse Clinician
Truman Medical Center
Kansas City, MO

of their clients. Supportive supervisors aim to support peers in bringing their authentic selves and experiences into their peer work, as well as supporting the peers' acclimation and integration into the work culture. In order to support peers to be successful, supportive supervisors offer a supervisory structure designed to provide peers with frequent and consistent opportunities to receive encouragement, individualized support, coaching on how to perform a helping role, and guidance on how to address personal challenges that arise. Methods to provide supportive supervision vary, but generally include components designed to build on the strengths of peers and support resilience. [Subsection 6.2, Supportive Supervision](#) illustrates some of these key components.

Unlike clinical supervision, supportive supervision can be provided by non-clinically trained supervisory staff. While the methods of supportive supervision borrow from a clinical approach, they merely require additional supervisory skills that can be obtained with some extra support and training for the supervisor. Supervisors do not need to obtain an additional degree, and many seasoned supervisors will already have a formal or intuitive grasp of the concepts. [Subsection 6.2, Supportive Supervision](#) is an ideal starting place for administrative supervisors to begin incorporating a supportive approach.

Clinical Supervision

Clinical supervision functions as a psychological support mechanism for peers to have the opportunity to share/talk about how their work with clients affects them. Issues of transference (client's unconscious feelings towards peer) and counter-transference (peer's unconscious feelings towards client) are discussed and managed in order to equip peers with a way in which to process their reactions and responses to working with others living with HIV. Clinical supervision may or may not be offered depending upon the peer's role and the resources available at the organization. Clinical supervisors may want to refer to [Subsection 6.2, Supportive Supervision](#) to include peer-specific components into a clinical approach originally designed for psychology interns.

SUPERVISING PEERS

As stated previously, because of their unique role, peers will benefit most from receiving **both** administrative **and** supportive or clinical supervision. It is recommended that a minimum of one hour of administrative supervision **and** one hour of supportive or clinical supervision be scheduled every two weeks. Some peers may need weekly supervision or daily check-in, as determined by the needs of the peer and the supervisor. For new peers, it may be necessary to meet more often based on the competency and comfort of the peer.

It is important for supervisors to clearly delineate meetings with peers as administrative, supportive or clinical in order to preserve the integrity of each method. Administrative supervision is used to measure a peer's performance, which can impact their growth and promotion in an organization. Supportive and clinical supervision is in large part designed to help peers manage how their work affects them personally and should not be used as a way to measure the peer's performance.

See [Subsection 6.3, Clinical Supervision](#) for a more in-depth discussion of clinical supervision.

Who can provide supervision to peers?

Peers are generally administratively supervised by the director (coordinator or manager) of the department or program in which they work. For example, in a clinic setting, a peer may be supervised by a nurse manager or social worker. In a community setting, peers may be supervised by a program director, coordinator, health educator, or case manager. In other cases, a volunteer coordinator may be the appropriate supervisor.

Administrative supervisors, licensed or non-licensed, may opt to provide supportive supervision to peers. The key to a successful supervision system

is identifying who is best suited and able to provide administrative **and** supportive supervision to a peer. This decision may be determined by financial and human resources. For some organizations, one staff member may have administrative responsibilities and another staff member may provide supportive supervision. This is an ideal system to ensure that a person does not use confidential information shared during supportive supervision to assess the peer's work performance. Yet for many agencies, resources are more limited, and the same person may need to provide both administrative and supportive supervision. In these agencies, a supervisor must be clear with the peer when a session is considered administrative versus supportive.

Clinical supervision is always offered by a licensed professional since this modality requires specialized training in psychological theory. Some organizations are unable to fiscally support having a clinical supervisor on staff. A program with limited resources may want to consider contracting with a consultant for clinical supervision on a per diem or monthly basis. Although clinical supervision may be ideal, supportive supervision is a very good alternative and is often fiscally more viable for many organizations.

Integration into Inter/Multidisciplinary Teams

Supervisors can play a key role in assisting peers with integration into HIV care teams. Programs intending to add a peer component to their existing services must first recognize the need to review standing operations and identify specific areas to which peers can contribute and specific mechanisms through which peers will be integrated into client services. It will be important for supervisors to play a mentoring role with peers as they become accustomed to working within a care team. Supervisors further assist peers in practicing how to present themselves and explain their function to other professionals.

SUPERVISING PEERS

To the extent that the job skills and activities entailed in peer work are innovative additions to health care teams, peer roles, responsibilities, and activities need to be explicitly defined. An effective supervisor will provide peers with a clear job description (See [Section 4, Peer Roles and Responsibilities](#) for more about job descriptions) based on established peer objectives and expectations. Other members of the support team may also want to give input on mechanisms in which peers can join in the team effort. Peers themselves might be asked to help shape the role that they are intended to fulfill, bringing attention to issues faced in the field and suggesting creative ways to address them.

In a similar fashion, programs should ensure that mechanisms for regular dialogue among peers and other team members are established and maintained. One such mechanism would be inter/multidisciplinary case meetings in which the physician, nurse, peer, health educator, case manager, social worker, and others discuss individual clients. In this way, peers gain the benefit of hearing from service providers to gain insight into client issues. In turn, other team members gain the benefit of hearing the peer perspective.

► FOR MORE INFORMATION

Additional Supervision Subsections

- Supervising Peers: Introduction
- [6.1 Administrative Supervision](#)
- [6.2 Supportive Supervision](#)
- [6.3 Clinical Supervision](#)

Resources for Section 6

(available at http://peer.hdwg.org/program_dev/resources)

- Framework for supportive supervision case discussion (JRI)
- Framework for clinical case consultation tool (JRI)
- Administrative supervision tools (The Lotus Project)
- Supportive supervision tools (The Lotus Project)
- Supervision Tools (The PACT Project)
- Peer weekly staffing report (project ARK)

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.1 SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION



“If something comes up that you feel uncomfortable with or you don’t know how to deal with, you can always ask, because that’s how you learn.”

Carol Garcia
Peer at Christie’s Place
San Diego, CA

Introduction

Peers, like most employees, benefit from having an administrative supervisor. While many general approaches to administrative supervision are appropriate for peers, there are some specific issues that program managers will want to take into account when setting up and conducting this supervision for peer staff. Below are descriptions of some key issues. Addressing these issues in an ongoing manner will support program success and peer retention rates.

Conducting Individual Status Review Meetings

Depending on the size of the program, individual weekly or bi-weekly meetings between the administrative supervisor and peer should be established. It is critical that these meetings happen on a regular basis to ensure positive client outcomes. The most important function of administrative supervision is to support the peer in following the program’s protocol for receiving referrals, following up with clients, and working collaboratively with clients and the multi-disciplinary team. Many peers are hesitant to take a pro-active stance with new clients. The most prevalent reason that peers hesitate to successfully launch new cases is that they are afraid of being intrusive. There are a host of reasons why clients may not show enthusiasm for receiving supportive services, and most of these reasons do not indicate clients’ lack of need or desire for services. It is important for peers to have an administrative supervisor who will encourage them to take a pro-active stance while also respecting client boundaries.

The [Read More: The Coaching Model for Administrative Supervision](#) in subsection 6.1 illustrates some key approaches to conducting individual status review meetings with peers.

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

Areas of Administrative Supervision

Administrative supervisors can check on the following:

- Peer caseload levels
- Status of new referrals
- Type of contact for each client (i.e. phone, clinic, home visit)
- Frequency of contact for each client (i.e. weekly, bi-weekly, monthly)
- External or internal barriers prohibiting optimal client contact
- Appropriate level of collaboration with multidisciplinary team
- Clients' appropriateness for peer advocacy
- Clients' need for referrals or higher levels of care
- Initial troubleshooting in reaching client goals
- Peers' level of job satisfaction and need for additional support or time off
- Peers' need for additional training or mentoring

During status review meetings, the administrative supervisor can review the peer's activities since the last meeting and discuss specific peer-client one-to-one interactions, exploring ways to maximize peer support for the client, and helping to meet the client goals. The administrative supervisor must carefully monitor client progress and respond to evolving needs for more intense case management or support. As a team, the administrative supervisor and peer can determine which next steps might best meet client needs. The choice of peer support strategies should always be based on the most recent client assessment and adherence plan.

As will be discussed in the next [Subsection 6.2, Supportive Supervision](#), peer-client relationships thrive when peers receive support around issues related to identifying with their clients. Peers might react to certain situations or issues brought up by the client without knowing that

their own personal issues and problems influence their reaction. (This phenomenon is known to therapists as *countertransference*.) As stated previously, administrative supervisors have a variety of options available for administering this next level of supervision. Administrative supervisors who want to oversee this next level are encouraged to read the next subsection on supportive supervision and utilize some of the tools provided. Administrative supervisors who would like to recruit the help of another team member or a mental health professional may want to review the supportive supervision subsection as well as [Subsection 6.3, Clinical Supervision](#) for ideas about incorporating this additional level of supervisory staffing.

Responding to Health Issues

Peers encounter some of the same health challenges as their clients, many of which can affect their ability to perform job duties. Administrative supervisors should attend to any negative changes in work quality or lapses in peers' responsiveness to job duties. Sudden changes can indicate that a peer is experiencing exhaustion, depression, anxiety or lack of energy associated with serious emotional or medical problems. An administrative supervisor may become aware of these signs even before the peer acknowledges any health difficulties. If the administrative supervisor chooses to intervene, he or she must be prepared to propose supportive options to help the peer appropriately deal with the health issue. Temporarily decreasing a peer's caseload could be one solution, but other options should be openly explored with the peer.

Establishing and Maintaining Peer-Client Boundaries

Clear guidelines help to create a setting in which both peers and clients feel safe in disclosing personal histories, thoughts, and feelings. Peers usually do

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION



I had to learn to put up boundaries, because at first I was bringing things home, and it was affecting my health.

Fred Glick
Peer Educator
Truman Medical Center
Kansas City, MO

not rely on the recognized indicators of professional health care providers, such as a white coat, degrees hanging on the wall, or initials after their last name. Such formal signs can create a hierarchical separation between peer and client. Without the familiar indicators of a health care provider, it may be more difficult for clients to understand the parameters of the relationship, and peers must be explicit about what types of interactions fall outside those boundaries. Furthermore, clients may be unfamiliar with the notion of peer support itself, so they will need to be reminded of what to expect from this type of relationship.

Peers develop strategies to define and safeguard interpersonal boundaries in the context of building a mutually respectful relationship with their clients. While these strategies vary from peer to peer and are tailored for individual clients, they should indicate the boundaries of peer support in three crucial domains:

- Peers must define the limits of their expertise, so that clients do not confuse education about a prescribed HIV regimen with medical advice, or a sympathetic ear with psychotherapy.
- Peers must be clear about the amount of time and energy they can give, especially if they are available to clients outside of normal working hours.
- Peers should advise and periodically remind clients of any program requirements that limit the duration of support.

Attention given to establishing boundaries is especially important in peer work because the peer is building a relationship with the client expressly to achieve desired health outcomes, such as medication adherence. For some clients, the presence of a person who listens, cares, and is willing to go an extra mile to help may be unfamiliar and confusing. These actions may be interpreted as an effort to establish an intimate, even sexual, relationship and that may be either welcomed or rebuffed. Clients who respond to a perceived mutual interest may then feel betrayed or misled when the peer suggests that such behaviors are inappropriate. Therefore, discussing the nature of expectations and limitations of the peer-client relationship is essential as part of the initial meeting between the peer and the client.

Similarly, it is possible that peers may feel an attraction toward certain clients or may find themselves responding to overtures

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

▶ SAMPLE QUESTIONNAIRE

	Yes	No	N/A
Did I establish rapport in my greeting and opening conversation?			
Did I ask open-ended questions?			
Did the client speak as much or more than I did?			
Did I get information about the client's perspective on his or her illness and treatment?			
Did I give information in response to goals, concerns, and problems that the client expressed?			
Did the client show that he or she understood the meaning of information provided?			
Did I provide too much information?			
Did I assess whether the client has adequate social support?			
Did I discuss referral needs and options with the client?			
Did we agree upon a plan of action for the immediate future?			
Did I deal with the client's and my own emotional reactions?			
Modified from: Quality Assurance Measures for Voluntary Counseling and Testing Services IMPACT/ AIDSMARK June 2001			

initiated by their clients. It is extremely important that the administrative supervisor carefully monitor peers for any indication of *countertransference*, a phenomenon that occurs when a peer forms an attachment with a client that goes beyond the professional relationship. In initial and ongoing training efforts, the message must be conveyed that intimate relationships between peers and clients cannot be allowed because they hold the same potential for abuse that other helper-client relationships have.

Because the peer is in this specialized role of support, understanding the nature of the peer-client relationship is just as important for the peer as it is for the client. Having access to supportive or clinical supervision gives the peer an opportunity to express any concerns he or she may have regarding feelings toward the client (countertransference) or perceived feelings from the client (transference). These feelings may be positive or negative and may trigger an unexpected reaction. Talking about this phenomenon both normalizes it and increases the likelihood that the unexpected reaction will be well-managed, ultimately leading to a productive, appropriately bounded relationship between peer and client. The checklist in Subsection 6.1 [Read More: Understanding Boundaries in Peer-Client relationships](#) can provide a supervisor with a framework to discuss potential boundary issues between a peer and a client.

Using Checklists for New Clients

Administrative as well as supportive supervisors may find it useful to use the Sample Questionnaire (see left sidebar) to help peers assess the effectiveness of their approach when establishing a new client relationship. The checklist may be completed by the peer in advance of meeting with the supervisor, or it can be completed while reviewing cases together within the supervisory session.

Although the sample questionnaire is an effective, interactive way for the administrative supervisor and the peer to discuss each client, it is important for the supervisor to follow up with more open-ended questions in order to better understand how the peer is engaging with clients. Some examples of follow-up, open-ended questions are:

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

- In what way did you establish rapport with the client?
- What information did you share with the client?
- In what ways did you assess the social support of the client/what social supports did you ask about?
- In what way did you manage the client's emotional reactions?
- In what way did you manage your own emotional reactions?

Monitoring Peers' Stress Levels and Needs for Additional Support

Scheduled supervision allows the administrative supervisor to help the peer identify personal needs such as additional training, support, or other services. The supervisor is responsible for making sure that peers do not become overwhelmed, and for providing all necessary resources and support to help peers perform their role. Monitoring client demands on individual peers will help administrative supervisors evenly distribute the workload. If a peer experiences a personal crisis or suffers from poor health, the supervisor might decrease that peer's workload by temporarily reassigning clients to other peers. Administrative supervisors should not function, however, as the peers' therapist. In some cases, the appropriate supervisor response to peers' personal issues might be to refer peers to an employee assistance program, clinical supervision, or outside services.

Providing a Clear and Consistent Structure

Notwithstanding the crucial role that individual peer supervision can play in client outcomes, program effectiveness, and the individual peer's skill building, supervision cannot take the place of good program structure. Providing peers with structure is as important as building in program flexibility.

Clear expectations, regular supervision, and open lines of communication will minimize misunderstandings and encourage peers' sense of personal responsibility. A well-structured environment actually decreases the need for micro-management by laying out ground rules, program goals and expectations as well as consequences for poor performance. Inadequate structure disguised as program flexibility too easily results in poor accountability and unreliable client services, weaknesses that cannot be corrected in individual supervision.

Administrative Documentation

Methods for documenting peer contributions will reflect the specific needs, strengths, and limitations of individual programs, as well as the roles peers play. It may not be feasible for all programs to ask peers themselves to document their activities, but programs should consider the valuable contribution that peers can make to program evaluation when they keep a detailed record of their interactions with clients. Peers' experience adds a unique, vivid dimension to an assessment of overall program effects, and a comprehensive evaluation gives voice to that experience.

Recording Format

When choosing or developing a format for documenting peer work, programs should balance their need for information with the burden of collecting and recording information. A checkbox format allows peers to quickly log standard items and an open space encourages peers to share any other information about the interaction at their discretion. Peers use the form to document the support they provide to clients in terms of basic "reporter's details": who, what, where, when and how. For examples of formats for documenting

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

► TOPICS FOR REVIEW IN CASE MANAGEMENT MEETINGS

- Clients initiating treatment
- Changes in treatment regimen
- Significant medical and/or social situations confronting individual clients
- Resolution of barriers and necessary referrals for individual clients
- Specific adherence problems
- Strategies for reaching out to clients who have not returned to clinic
- Issues pertaining to cultural competency
- Other needed client supports

peer-client contact and other peer work, see the [Sample Forms for Documenting Peer Work](#) in the [Program Resources](#) for Section 7 (Evaluation).

Peer training should include instruction on the record keeping peers will be expected to perform. Even if peers are not directly responsible for documenting the services they provide, program managers should engage peers in a discussion of the rationale and need for a detailed recording of their activities, including funding and other institutional requirements, program-specific purposes, and peers' contribution to monitoring the effectiveness of the program. Administrative supervisors should emphasize that if peers' work is not documented, their efforts will not be part of the program success story. It is recommended that each interaction between peers and clients is tracked, as well as peers attempts to contact clients.

Multidisciplinary Team Meetings

Inter/multidisciplinary case management meetings provide a forum for the exchange of information and perspectives relevant to individual client cases and promote collaboration among team members. Case management also allows for monitoring of peer activities in a group setting.

Administrative supervisors can play a leading role in ensuring that peers are actively included in multidisciplinary or case management meetings. These meetings will also provide supervisors with additional support in monitoring and evaluating peer efforts.

In case management meetings, support teams review all cases, discuss particularly difficult cases, identify barriers to adherence and other treatment supports, and update patient action plans. While supervisors do not necessarily need to attend meetings, it is important to have a basic understanding of how these meetings are conducted.

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

These group meetings should involve all program staff involved in client services to coordinate activities and update the team strategy. Peers might begin by presenting new developments and summarizing the general situation of their clients, taking the time to highlight particularly challenging cases. While it is probably not feasible to review each and every client in detail, group meetings allow peers to know something about their colleagues'

cases. This insight is especially helpful in the event that a peer's illness or other circumstances require his or her cases be reassigned to another peer. Updated client assessments should be available for review by program social service providers, allowing staff to intervene with additional referrals or interventions to improve client well-being.

► FOR MORE INFORMATION

Read More for Subsection 6.1

- The coaching model for administrative supervision
- Goal-setting framework for peer programs that outreach to clients...
- Goal-setting framework for peer program working with providers...
- Understanding boundaries in peer-client relationships

Additional Supervision Subsections

- Supervising Peers: Introduction
- 6.1 Administrative Supervision
- 6.2 Supportive Supervision
- 6.3 Clinical Supervision

Resources for Section 6

(available at http://peer.hdwg.org/program_dev/resources)

- Framework for supportive supervision case discussion (JRI)
- Framework for clinical case consultation tool (JRI)
- Administrative supervision tools (The Lotus Project)
- Supportive supervision tools (The Lotus Project)
- Supervision tools (The PACT Project)
- Peer weekly staffing report (Project ARK)

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

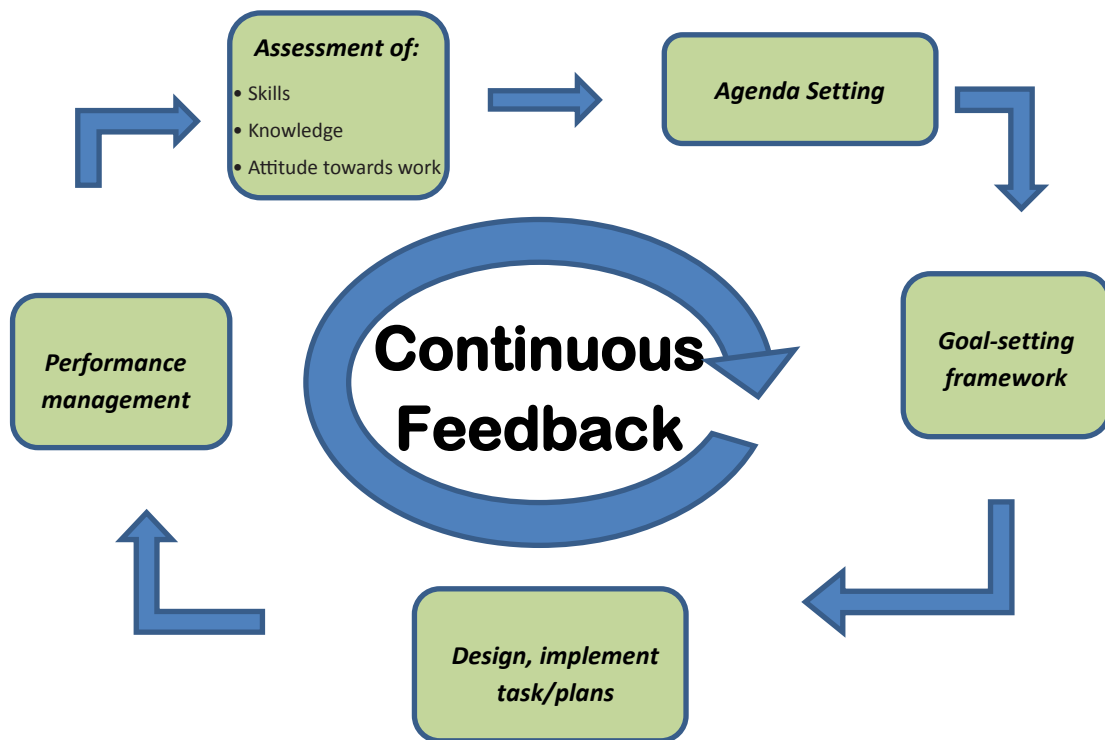
6.1 SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: COACHING MODEL

Coaching Model for Administrative Supervision

The coaching model below illustrates some key approaches to conducting individual status review meetings with peers. Administrative supervisors who are also providing supportive supervision may prefer to utilize the supportive supervision coaching model introduced in the next section.

Administrative Supervision Model



SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: COACHING MODEL

Administrative Peer Assessment

To assess peer skills, knowledge, and job satisfaction, it is recommended that the administrative supervisor have an understanding of whom he or she is supervising in terms of the peer's current skill set, knowledge about the work, and the peer's degree of job satisfaction. In this way, the supervisor can explore ways in which the peer can enhance his or her skills and knowledge in order to meet program goals. In addition, making sure that peers get satisfaction from their work encourages retention and the sustainability of consistent peers in the system.

Agenda Setting

It is important to set an agenda with the peer even if it is loosely articulated so that both the peer and supervisor know what will be discussed. The supervisor can and should raise issues that may be challenging or difficult for the peer with regard to meeting the goals of the program. Some agenda items may be standardized and become part of each supervisory session such as:

- Client successes and challenges
- Client caseload/paperwork/documentation
- Professional development/job satisfaction

Goal-Setting Framework

The role of the administrative supervisor is to work with the peer to set goals for his or her work. These goals are specific and in line with the job expectations set up when hiring the peer. Goals should be S.M.A.R.T.: Specific, Measurable, Agreed upon, Realistic and have

Timelines attached so that the administrative supervisor and peer have an understanding of how to support the general program goals as well as the peer's professional development. Goal setting helps guide the concrete program work, expands the peer's ability to achieve those goals, and supports the overall mission of the organization.

Refer to the [Read More: Goal-Setting Framework for Peer Programs that Reach Out to Clients](#) and [Goal-Setting Framework for Peer Programs Working with Medical Providers](#) for examples of how an administrative supervisor might use goal setting with a peer.

Design and Implement Tasks and Plans

Once goals have been set, it is important for administrative supervisors to work with peers to develop tasks and plans to meet those goals. Designing tasks and implementing the plans for those tasks provides outputs and outcomes to meet the mission of the organization. In this way, peers become integrated into the work environment and become an active member of the multidisciplinary team. This is also an opportunity to evaluate the effectiveness of the peer program. Designing and implementing tasks that are intended to meet goals provides an ideal way for measuring program effectiveness. Utilizing the expertise of peers better ensures the likelihood of a well-thought-out design and implementation plan.

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: COACHING MODEL

Performance Management

Once goals that are in line with the organization's mission have been set and tasks have been designed and implemented, it is important to measure the success of those goals and tasks in part through measuring the peer's performance. All goals and tasks should be S.M.A.R.T. Peers need to be evaluated on a realistic set of job expectations that have been articulated as part of the hiring and orientation process. Performance feedback should never be a surprise to a peer, as continuous feedback should be part of any

administrative supervision. It is important to consider all aspects of having peers as part of the organization.

This includes:

- Limited schedules
- Health issues
- Professional/work experience
- Social supports as they relate to the peer's health

Therefore, some exceptions within reason need to be considered as part of managing peer performance.

This "Read More" section accompanies [Subsection 6.1, Supervising Peers: Administrative Supervision](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.1 SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

Goal-setting framework for peer programs that reach out to and engage clients lost to medical care

READ MORE: GOAL SETTING #1

Goal setting is relevant, but should have a degree of flexibility in the way in which it is achieved. The basic framework of goal setting is outlined in this section to guide the discussion of how to formulate goals with clear expectations. Whether these are formally written or verbalized in a conversation and then written in another format with the needed information should be determined by the learning styles of both the peer worker and the supervisor.

The following example illustrates a dialogue between a peer and his or her supervisor. The peer is struggling with reaching clients who have not shown up for their medical appointments. In a supervisory session, the supervisor works with the peer to develop strategies to find clients.

Supervisor: How are things going with your clients?

Peer: Good. I actually made contact with a new client I am meeting later this week

Supervisor: That's great. What are some of the things you are hoping to work on with this client?

Peer: Well, I think they have had some trouble keeping their medical appointments so I am going to find out what's going on and see if I can help with that.

Supervisor: That sounds like a good plan. I have noticed that there are several clients who have missed appointments over the last 3 months and I would like to work with you to brainstorm some ways we can reach out to them. You have been so successful in working with our clients in helping them to keep their appointments; I thought this might be a good goal to work on over the next month. What do you think?

Peer: Thanks. I think it's important to reach out to the clients, because it took me a long time to accept all the things I have to do to stay healthy.

Supervisor: So, what ways have you tried to keep your clients coming back in for their medical appointments?

Peer: Let's see...I make phone calls; sometimes meet them at their church or I might mention something in the support group that I lead; sometimes, talk to the case manager and see what they've tried or if they have something planned like a social meeting, I might go to that and see if I see them.

Supervisor: All those sound like great strategies. If we look at our agency information on who has missed appointments over the last month, and identify 3 clients, do you think we can come up with a plan for each client depending upon what we know about them?

Peer: Yeah, definitely.

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: GOAL SETTING #1

Supervisor: So, let me get the information and then let's come up with a plan for each client that uses the strategies you have already tried. We might think of additional strategies as we find out some details about the client.

Peer: Sounds good.

Supervisor: So, here is client #1-she is an African American female who was diagnosed only 6 months ago and has been sporadic in her health care visits. She does seem to attend support group regularly and is connected to some community services, according to her case manager. Her case manager hasn't been able to reach her, and it is unclear whether her phone has been disconnected.

Peer: Well, I am wondering if she can't pay the bills. I also think maybe she thinks that the medication will cost her money because she hasn't gone on meds, but that (going on meds) might have been the next step. I am glad she comes to support group. I know who she is and I think I'd like to try to connect with her this week if she comes. If not, I think I will try to go check out some of the community places and see if I can just talk to her.

Supervisor: You are approaching this by thinking about what she might be experiencing and then trying to understand all the possible reasons why it might be hard for her to keep her appointments and then trying to check it out with her. That sounds like a great plan. What are you hoping will happen?

Peer: I would be so happy if she tells me what is up with her and then comes to her next doctor's visit. I would be glad to go with her, and I'll tell her that. But, I also hope that I can reassure her about the medication not costing her and that it might be a good thing to talk with her doctor about trying it.

Supervisor: Great. Let me know how it goes. Should we look at taking this same approach for two other clients who have fallen out of care?

Peer: Yeah. That sounds good.

The dialogue between supervisor and peer worker continues until the goal of connecting with at least three clients who have fallen out of care has been detailed in a way that both supervisor and peer worker have an understanding of the work involved.

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: GOAL SETTING #1

Based on the dialogue between the supervisor and peer, the following goals and framework were developed.

Goal #1: To reach out to and engage three clients who have not shown up to their medical appointments

Activity	Description	Time	Output	Outcome	Impact
<ul style="list-style-type: none"> • Locate client contact information • Review venues where client visits • Support group 	<ul style="list-style-type: none"> • Utilize agency resources to get most updated client contact information on 3 identified out of care clients • Determine through community contacts and any information on client the likelihood of locating client • Determine online connections • Utilize support group as mechanism to enlist engagement by raising medical appointments as an educational topic 	By x date	<ul style="list-style-type: none"> • Updated information for 3 clients • Venues where clients are likely to go • Educate support group clients on importance of medical appointments • Educate clients on navigating medical health care system 	<ul style="list-style-type: none"> • Access to 3 clients • Educating clients on medical health care system • Teaching advocacy 	<ul style="list-style-type: none"> • Engagement with 3 clients • Advocacy for and with clients

This “Read More” Section accompanies [Subsection 6.1, Supervising Peers: Administrative Supervision](#), part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.1 SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: GOAL SETTING #2

Goal-setting framework for peer programs working with medical providers to retain patients in care

Below is an example of a goal-setting framework for supervisors to work with peers who may be facing challenges with keeping patients in care. Based on a dialogue between the supervisor and peer, the following goals and framework were developed to help the peer work with providers in order to retain clients in care.

Program Goal #2: Develop engagement strategies with the medical providers to support clients keeping appointments.

- The supervisor will guide the peer in:
- Brainstorming engagement strategies
 - Connecting with medical providers
 - Understanding how medical providers relay appointment and medical follow up information to clients
 - Creating a process jointly with administrative supervisor to brainstorm with the medical providers to determine joint strategies to work through client barriers to appointment adherence

Goal #2: Develop engagement strategies with the medical providers to support clients keeping appointments.

Activity	Description	Time	Output	Outcome	Impact
<ul style="list-style-type: none"> • Connect with all medical providers working with these 3 clients • Conduct brainstorm session with medical providers • Create plan to address barriers to keeping medical appointments 	<ul style="list-style-type: none"> • Meet or reconnect with all medical providers • Work with administrative supervisor to arrange a meeting with medical providers to: <ol style="list-style-type: none"> 1. Better understand their medical appointment protocol 2. Brainstorm ways to collectively engage client in keeping medical appointments 3. Brainstorm/ create plan to address barriers 	By X date	<ul style="list-style-type: none"> • Engage medical providers in keeping clients in healthcare system • Peer learns how to navigate internal system • Peer learns facilitation skills by mentoring from administrative supervisor 	<ul style="list-style-type: none"> • Strategies that can be replicated are developed • Healthcare system is engaged as a whole 	<ul style="list-style-type: none"> • System is more comprehensive in supporting client retention • Peers develop skills to address client needs

This “Read More” section accompanies [Subsection 6.1, Supervising Peers: Administrative Supervision](#) part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.1 SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: PEER-CLIENT BOUNDARIES

Understanding Boundaries in Peer-Client Relationships

On the next page is a checklist that can be used in preparing the peer to think about possible boundary issues prior to engaging the client. This checklist can be modified in relation to the type of work the peer will be doing as well as to the organization's standard protocol. Once the peer has filled out the checklist, review items with the peer and discuss strategies to address the potential boundary issue with clients. Be clear about what the agency's protocol is in each of these areas.

There may be some areas where the peer and the supervisor may disagree due to the complex nature of the peer-client relationship. In these cases, it is important for the supervisor to clearly outline when exceptions could be made and why or if no exceptions can be made, then provide the peer with ways in which the peer can respond to the client that can continue to honor

the special nature of their relationship without compromising the role of the peer or the agency.

For example: the peer may feel that it is sometimes okay to loan money to a client, but the agency policy prohibits this. The supervisor may need to help the peer prepare a response to the client that is caring, but clear, such as, "I would really like to be able to help you with your money situation, but our agency doesn't allow us to lend money. What other ways can I help you solve this issue?" (There may be other resources available to the client through case management and the peer can refer the client to his or her case manager.) "Maybe your case manager could help you with this. Would you like me to go with you when you meet with your case manager?" In this case, the peer can offer emotional support while referring the client to the appropriate resource.

SUPERVISING PEERS: ADMINISTRATIVE SUPERVISION

READ MORE: PEER-CLIENT BOUNDARIES

Boundaries in Helping Relationships

Decide whether for you each of these situations is clearly: 'Always Okay' or 'Never Okay'. If there are times when it might or might not be okay, depending on the circumstances, check 'Sometimes Okay'. Then make a note as to when or under what circumstances that behavior would be okay.

Behavior	Always Okay	Never Okay	Sometimes Okay / When??
1. Keep your attraction to your client secret from supervisor/team			
2. Keep client's attraction to you secret from supervisor/team			
3. Keep boundary concerns secret from supervisor/team			
4. Bend the rules for an individual client			
5. Share religious/spiritual beliefs with client			
6. Advocate for a client despite your team/agency's opposing view			
7. Share after-hours social time with a client			
8. Bring a client to your home for any reason			
9. Share a meal with a client			
10. Engage in common interest with client			
11. Spend time alone with client in his/her apartment			
12. Loan money to a client			
13. Loan personal items to a client			
14. Accept a loan of money from a client			
15. Accept a loan of personal items from a client			
16. Give a gift to a client			
17. Accept a gift from a client			
18. Call a client after work hours			
19. Accept a call from a client after work hours			
20. Accept a call from a client at your home			
21. Invite client(s) to a party at your home			
22. See a former client as a friend			
23. Date a former client			
24. Accept a hug from a client			
25. Initiate a hug with a client			
26. Accept a massage from a client			
27. Initiate a massage with a client			
28. Take a client to your religious institution (church, mosque, temple)			
29. Take a client to your self-help meeting			
30. Ride in a client's vehicle			

This "Read More" section accompanies [Section 6.1, Supervising Peers: Administrative Supervision](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.2 SUPERVISING PEERS: SUPPORTIVE SUPERVISION



It can become sort of overwhelming at times because I live with HIV myself and then I work with HIV and I go to seminars about HIV. I'm learning ways to balance it by reading and listening to classical music and spending time with people, with my family.

Lionel Biggins
Peer Educator
Truman Medical Center
Kansas City, MO

Introduction

While the supportive supervisory approach borrows from clinical supervision, non-clinical staff can readily utilize the methods and tools described here. Many clinics and organizations choose to identify one person who will provide both administrative and supportive supervision, while other programs may choose to separate the roles and have one person provide administrative supervision while another team member, licensed mental health professional, or intern provides supportive or clinical supervision to peers on an ongoing basis. As stated earlier, it is important to preserve the integrity of the role of supervisor, whether administrative, supportive or clinical, when providing the guidance appropriate to that role. Although it is cost effective to have the same individual provide both administrative and supportive or clinical supervision, it can create some role confusion for the peer as well as the organizational system. It is recommended to have two individuals designated to provide two distinct types of supervision.

What is the rationale for a supportive approach and how do peers benefit? In the fields of psychology and social work, it is well recognized that people serving in a helping capacity require a supportive approach to supervision and training. Formal structures within psychology and social work programs are set up to provide students and interns with weekly clinical supervision, support from colleagues, and even their own short- or long-term psychotherapy treatments. These requirements serve the function of helping students deal with stress and teaching them to navigate a profession in which they are expected to hold and contain clients' stress and problems without absorbing it in a harmful way.

Peers have strikingly similar challenges to those faced by psychology and social work students and interns. While this applies more heavily to peers who specifically provide emotional support, most peers, no matter what their role, face situations that require them to attend to clients who are presenting with acute or chronic stress and other psychosocial challenges. The difference is that peers usually have received little or no formal training in the helping professions, nor have they benefited from the structures in place for social work

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

and psychology students. Supportive supervision for peers is part of the solution for addressing this difference, so that peers may thrive in their roles.

Supportive supervision draws on the tenets of clinical supervision to offer peers the opportunity for individualized support and training. However, there are some distinct differences between a clinician-client relationship and a peer-client relationship. Peers do not provide a clinical service to clients, and it is not in their scope of work to diagnose and treat any kind of clinical condition. On the contrary, peers present to clients an allied relationship in which the client is free to feel unconcerned about being diagnosed and treated. Ironically, what often occurs between peer and client is inadvertently therapeutic, due to the safe nature of the relationship. This is why a supervision approach that borrows from social work and mental health is so crucial for peers.

A supportive supervisor can help peers appropriately respond to clients who begin to share serious concerns that may ultimately merit attention from the larger clinical team, or from other community agencies. Furthermore, the supportive supervisor can help the peer set appropriate functional and emotional boundaries with clients. In a therapeutic relationship, the goal of the clinician is to intervene in difficult interpersonal dynamics to help clients become aware of dysfunctional patterns. In a peer relationship, the goal is for the peer to sustain the relationship. This type of support may be therapeutic for the client, but it is not the goal. A supportive supervisor will want to help a peer sustain the relationship with the client by helping with boundary setting and staying within the scope of work as a peer.

Most importantly, peers benefit from support in managing the stress involved in serving multiple

clients. Understandably, peers come into the field feeling as if it is their duty to help clients in measurable ways. In fact, their work may actually be measured through organizational quality assurance efforts. For peers, it can feel tremendously disempowering to run up against perceived failures to help clients in an immediate fashion. When these perceived failures happen frequently, and with clients whom they care for, this can feel overwhelming and disillusioning. Peers do begin to care for their clients, and this is in alignment with the work of a peer, as it distinguishes peer work from the more “objective” stances of medical and mental health providers.

In short, supportive supervision provides an opportunity for peers to talk openly and safely about their work with clients. As described above, supportive supervision offers the peer a way in which to work effectively with clients while understanding that the peer’s own personal experiences may impact his or her work.

General Principles for Conducting Supportive Supervision

Supportive supervision lends tremendous assistance to peers in their efforts to manage the multi-layered dimensions of their own lives with HIV while supporting clients in managing theirs. Engaging in a process of supportive supervision for non-clinical staff, specifically for peers, is essential for building staff competency, knowledge, and retention. It is recommended that supportive supervision occur in a consistent way, whether it is weekly, bi-weekly or monthly. In this way, the supervisee can rely on having regular time to discuss work issues including the nature of the work and how it may impact him or her, both personally and professionally.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION



LaTrischa Miles (left) with a peer.

Some of the important skills used in supervision are good listening skills, good communication skills, verbal and non-verbal. Being open-minded in a supervisory role is very important, because as a supervisor, I don't have all the answers. [Peers are] living with a chronic disease, so you need to have some flexibility.

LaTrischa Miles
Peer Supervisor
Kansas City Free Health Clinic
Kansas City, MO

There are several components that make up the foundation of supportive supervision: building a trusting relationship between the supervisor and the peer; allowing the peer to explore feelings and reactions that emerge; and creating a model of the peer-client relationship. The following outlines the general principles of conducting supportive supervision:

- The supervisor recognizes that this supervision time is dedicated to the peer.
- The supervisor creates a safe space. There are no interruptions during supervision, if possible, and the peer is encouraged to share any concerns.
- The supervisor sets a time that is consistent and convenient for the supervisor and peer.
- The focus of the supervision meeting remains on the development needs and concerns of the peer.
- The supervisor and peer set the agenda together.
- The supervisor is open to exploring the feelings and reactions of the peer that can help the peer reflect on working with clients who are part of their community.
- The supervisor uses open-ended questions to help the peer share their work with clients. The supervisor can use a case discussion framework.
- The supervisor is responsive and empathic and encourages the peer to use his or her insight into the community to respond to client issues.
- The supervisor provides guidance and resources.
- The supervisor remains non-judgmental in his or her approach.

Supportive Supervision Objectives and Supervisory Goals

A supportive supervisory approach will allow the supervisor to:

- Build and sustain trusting relationships with peers.
- Support successful client outcomes.
- Promote positive peer retention rates.
- Help peers transfer personal knowledge to peer work.
- Offer personalized support and training to peers.
- Provide a venue for consistently offering supervisory feedback.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

During individual and group supervision meetings, a supportive supervisor will want to:

- Provide individualized support and training for each peer.
- Monitor case loads.
- Assist the peer in forming client care plans.
- Help peers manage feelings that arise about/towards clients.
- Support peers in identifying and addressing work and personal stress related to working with clients.
- Help peers link their personal experience and knowledge to their work with clients.
- Help peers identify and build on what works with clients.
- Help peers maintain appropriate expectations for themselves and their clients
- Ensure that peers stay within their scope of work and make appropriate referrals when necessary.
- Periodically evaluate peers' work performance in collaboration with the administrative supervisor (if these roles are played by separate people).

Development of a Supportive Supervisory Perspective

The supportive supervisor's perspective determines how he or she will approach peer supervision and how peers will respond to the approach. Peers usually have little or no formal professional training, yet they are hired for their expertise with the client population. It is critical that supportive supervisors communicate in verbal and non-verbal ways and show respect for the value that peers bring to the organization.

Supportive supervisors can develop a supportive perspective by:

- Actively listening and learning from the peers they supervise.
- Taking into account cultural differences and HIV-status differences between supervisor and peer.
- Maintaining a stance of active curiosity by asking open-ended questions.
- Asking clarifying questions when confused about how or why a peer is taking a specific approach with a client before inserting a “professional” opinion.
- Periodically ask peers if they are getting their needs met in supervision and group settings.

[Read More: Coaching Model for Supportive Supervision](#) illustrates some key approaches to providing supportive supervision to peers.

Helping Peers Link Personal Experience to Client Work

This is truly the heart of peer work. Peers offer clients a perspective based on personal experience—experience that often mirrors the challenges that clients themselves face. The power of the peer is his or her ability to draw from and share personal experience with clients in order to help clients feel that they are not alone, and that they too can solve challenging problems. A supportive supervisor can coach peers to draw from personal experience to help peers understand how they can be helpful to clients. A supportive supervisor can also help peers offer clients personal examples in a way that respects the differences between the peer and the client.

To read more about supportive supervision, including a breakdown of how these functions can be addressed, along with tools, suggested approaches and approximate time lengths for each component, see the Program Resources and Read More sections listed on the next page.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

► FOR MORE INFORMATION

Read More for Subsection 6.2

- The coaching model for supportive supervision
- Troubleshooting difficult cases and supporting peer efforts
- Recognizing and addressing countertransference
- Tasks and tools for developing a supportive approach
- Peer support groups and structured group supervision
- Understanding boundaries in peer-client relationships

Additional Supervision Subsections

- Supervising Peers: Introduction
- 6.1 Administrative Supervision
- 6.2 Supportive Supervision
- 6.3 Clinical Supervision

Resources for Section 6

(available at http://peer.hdwg.org/program_dev/resources)

- Framework for supportive supervision case discussion (JRI)
- Framework for clinical case consultation tool (JRI)
- Administrative supervision tools (The Lotus Project)
- Supportive supervision tools (The Lotus Project)
- Supervision Tools (The PACT Project)
- Peer weekly staffing report (Project ARK)

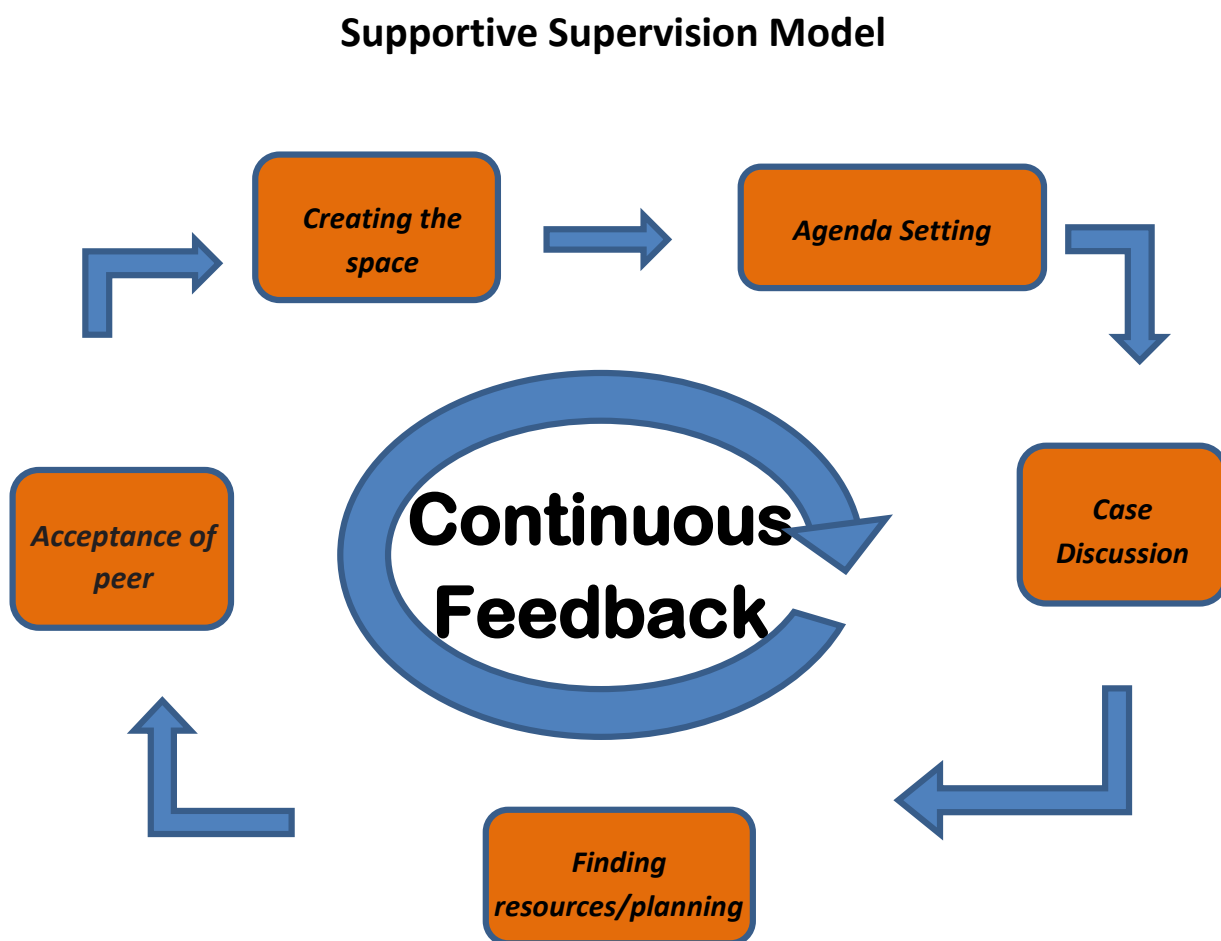
This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev.

6.2 SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: COACHING MODEL

Coaching Model for Supportive Supervision

The coaching model below illustrates some key approaches to individual supportive supervision meetings with peers.



SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: COACHING MODEL

A **supportive supervisor** is defined as someone who supervises peers using a supportive approach that borrows from some of the tenets of clinical supervision. Supportive supervisors are often unlicensed (for example an intern, nurse practitioner, or unlicensed social worker), but have worked in the same field in which they are providing supportive supervision.

Creating the Space

As a supportive supervisor, it is important to invite peers into a space that is designated as “protected,” allowing the peer to be vulnerable and share how work is affecting his or her personal life. In this way, the supervisor can learn what struggles the peer faces and reduce the possibility that the peer will act them out negatively toward the client (countertransference). In this space, the peer is able to talk openly about anxieties and concerns, knowing that the supportive supervisor will be empathic. Creating this space, however, does not rule out the necessity of “breaking” that space, meaning that in the event of a misuse of the peer-provider relationship, the supportive supervisor will need to break confidentiality (e.g., the same situation applies to breaking a boundary with a client - see [Read More: Tasks and Tools for Developing a Supportive Approach](#) for an example dialog which addresses a potential boundary issue.)

Agenda Setting

It is important to set an agenda with the peer even if it is loosely articulated so that both the peer and supervisor know what will be discussed.

The peer should be involved in the agenda setting since the primary role of a supportive supervisor is to give guidance to the peer in areas where the peer feels vulnerable or is requesting support. The supervisor can and should raise issues that may be challenging or difficult for the peer and where the peer may be reticent. However, these issues should be raised in a safe, nonjudgmental way so that the peer is able to explore his or her reactions and responses as they relate to clients and work. Some agenda items may be standardized and become part of each supervisory session such as:

- Client successes
- Client case discussion
- Resources

Case Discussion

The key difference between supportive and clinical supervision is the framework of case discussion. Case discussion in supportive supervision is the section where the peer can talk about the client and create a supportive plan. In clinical supervision, case consultation is the section where the peer and supervisor talk about the client in the context of a therapeutic intervention, and the supervisor and peer delve into deeper issues of transference and countertransference.

In supportive supervision, case discussion is the section dedicated to client work and focuses generally on how a peer is working with a particular client. Peers may want to talk about all their clients if time allows, but in general, peers should be encouraged to discuss their most challenging clients. Case discussion is an opportunity to share the client story with the

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: COACHING MODEL

supervisor in order to gain perspective on the client, the work, and the peer's concerns as they relate to both the client and the scope of work. (see: Supportive Supervision Case Discussion)

Finding Resources and Planning

An important aspect of supportive supervision is to provide an environment beyond the physical environment that helps the peer think about how best to support the client as well as acquire support for him or herself. The supportive supervisor does this through actively listening to the peer and helping to identify what resources and supports the peer can offer the client, as well as what resources might be useful for the peer. It is important to plan ways in which the peer can best communicate this support to the client. If a peer initiates this type of planning, it is a good indicator that the client is willing to consider utilizing the support.

Planning encourages client goal setting and a process by which the peer and client can set goals together. Supportive supervision in the context

of finding resources and planning gives the peer an opportunity to sort these options out in the supportive nature of a supervisory session.

Acceptance of Peer

In this context, the supportive supervisor's role becomes that of accepting the peer in their efforts to support their clients. This requires the supervisor to be an active listener, to remind the peer of the importance of boundaries when working with clients who seem similar to the peer, and to act as a sounding board to explore ways to work with clients and the issues that clients raise. It is also imperative for the supportive supervisor to recognize when the discussions or client issues become overwhelming and to be able to secure clinical supervision for the peer in order to best serve the peer and ultimately the client.

See the [Read More: Recognizing and Addressing Countertransference](#) for more information.

This "Read More" section accompanies [Section 6.2, Supervising Peers: Supportive Supervision](#), part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.2 SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TROUBLESHOOTING

Troubleshooting Difficult Cases and Supporting Peer Efforts

Supportive supervisors will find that peers will bring their most difficult client scenarios to supervision. If a supervisor finds that a peer is not doing so, it may be prudent to check in with the peer about whether or not he/she is getting enough support. This is also an indication that more trust needs to be built between supervisor and peer.

The BALANCE Model is an easy-to-remember checklist that provides supportive supervisors with a plan for helping a peer troubleshoot a difficult client scenario.

BALANCE Model for Supportive Supervisors

B- Be Present	Breathe, focus, relax
A- Ask Open-Ended Questions	What, How, Why
L- Listen	Stay open-minded.
A- Affirm	Make positive statements. Remember body language. This includes being responsive nonverbally.
N- Normalize Feelings	Feelings can't be controlled; actions can. Discussing feelings often leads to more appropriately managing actions.
C- Check Counter-transference - Challenge Assumptions - Consider Alternatives	What does this remind you of? Who does this remind you of? In what way are we sure we're right about this? What are other ways to approach this?
E- Express Appreciation!	"You are doing such good work." Be specific about the good work and say, "Thank you!"

In addition to the BALANCE Model, there are three additional supervisory approaches: Identifying and Building on What Works; Realistic Expectations for Self and Clients; and Helping Peers Balance Flexibility and Boundaries to Peer/Client Distress. These can be found in the [Supportive Supervision Tools](#) in the [Program Resources](#) for [Section 6, Supervising Peers](#). In addition, [Read More: Tasks and Tools for Developing a Supportive Approach](#) contains further information about troubleshooting difficult cases.

This "Read More" section accompanies [Section 6.2, Supervising Peers: Supportive Supervision](#), part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.2 SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: COUNTERTRANSFERENCE

Recognizing and Addressing Countertransference

The supportive supervisor can help peers examine feelings that could affect their reactions or perceptions towards clients. This is one of the key objectives of supportive and clinical supervision alike. **Countertransference**, feelings that a peer has toward the client, regularly occurs, and it is important for the peer to understand that feelings that they have toward the client—positive, negative, and at times both—are normal. These feelings can help a peer recognize and understand his or her own reactions as well as what a client might be experiencing. Peers benefit from being regularly reminded not to become personally frustrated or disappointed about issues or concerns that their clients may have, or not to have unrealistic expectations, but rather to be open to understanding where the client is in his or her life at that moment.

In some cases, peers unconsciously take on the task of trying to “fix” their clients, because they feel they may be at a healthier place in their own lives. As a result, they take on the responsibility of making their clients “better” according to their view of better. This can create a situation where the client no longer takes responsibility for his or her own behavior and in fact, becomes dependent upon the peer in an unhealthy way. Administrative supervisors can use the assistance of clinical or supportive supervisors in helping the peer manage countertransference and foster a productive relationship with the client.

Recognizing and Addressing Countertransference

Countertransference may be occurring if one or more of the following is true:

- Belief of exactly what a client needs to do
- Assumptions about a client without checking them out with her or him
- Going out of the way for a client, over-extending oneself even though client is not working very hard for him- or herself.
- Avoiding a client(s)
- Feeling of being manipulated
- Ignoring or forgetting boundaries or the boundaries that have been set by the organization
- Spending too much time with one client for an extended period of time
- Attraction to a client
- Unrealistic expectations of a client
- Client reminds peer of someone in the peer’s personal life
- Worrying about a client(s) excessively
- Beginning to use client for own stress relief
- Feeling confused about the peer role with a client(s)
- Feeling angry, sad or judgmental about a client(s) much of the time
- Being late consistently with a client
- While meeting with a client, an intense feeling suddenly arises—anger, sadness, or any other feeling, even a “positive” one. The feeling distracts from a normal ability to listen well.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: COUNTERTRANSFERENCE

We just had a countertransference issue recently. One of our peers went out to visit a positive woman who had a stroke and she's homebound, and she's about to get evicted. The peer had been through that same experience, so she came back to the office and was very upset. We had another example where we had to involve the child protective services, and the peer who had to make the call had her children taken away at one point.

Elizabeth Brosnan
Executive Director
Christie's Place
San Diego, CA

How to address countertransference?

Encourage and advise peers to:

- Consider feelings about the client(s) that trigger these feelings or reactions. Use supervision as a place to discuss this.
- Consider the possibility of over-identifying with client (perhaps there are some similarities that trigger feelings). Sometimes these similarities are hard to acknowledge.
- Talk to a trusted colleague, supervisor, counselor, or other supportive person.
- Engage in a stress-reduction technique of any sort.
- Reassess boundaries with a client(s).
- Consider spending more or less energy on this person(s)
- Question assumptions.
- Remember limits.
- Remember that supporting clients does not always have ideal outcomes
- Remember that the peer role is not to fix people—people are ultimately responsible for themselves.
- Get help if needed.
- Get supportive feedback
- Remember that the most important job is to role model self-care

This “Read More” section accompanies [Section 6.2, Supervising Peers: Supportive Supervision](#), part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.2 SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASK AND TOOLS

Tasks and Tools for Developing a Supportive Approach

The list below provides tools and approaches for tasks performed during supportive supervision.

Task: Help peer manage and reduce personal and work stress

Purpose: Build trust, support peer productivity and retention, improve client outcomes

Tools: Peer check-in format, self-care plans, reflective/active listening, linking relevant personal topics to client work

Suggested approach: Peers ultimately know what is best for them, particularly when it comes to their personal concerns. Your presence and listening, when offered regularly and within reasonable limits, helps peers recognize stressors, separate personal stress from work activities, and initiate plans for self-care.

Length of time: 3-10 minutes (longer if co-constructing a self-care plan)

Task: Ask peer about successes as well as challenges (Build on peer resiliency)

Purpose: Build trust, support peer self-esteem, encourage balanced perspective, support peer retention, reduce incidences of vicarious trauma for peers

Tools: Open-ended questions (i.e. What has been going well?)

Suggested Approach: Identify subtle successes and challenges in order to broaden peer's understanding of how he or she is helping clients.

Length of time: 5-8 minutes

Task: Encourage peer to present and explore work with one or more clients

Purpose: Monitor client care and improve client outcomes, support and training for peer

Tools: Open-ended questions, clarifying questions, inquiry into peer's perspective, case presentation format, presentation of client's care or adherence plan

Suggested Approach: Remember the peer's scope of work while the two of you come up with plans for client care. Identify places in which peer's expectations of self or client are too high or low, and how he or she may be overextending self, or avoiding difficult client work.

Length of time: 10-20 minutes

Task: Help peer identify feelings that are affecting his or her responses to a client

Purpose: Help peer manage countertransference, reduce client drop-out rates, support peer retention

Tools: Identification and normalization of feelings, countertransference model

Suggested Approach: Verbally reflect peer's feelings, positive and negative alike. You do not have to analyze each feeling—you can merely note them. This demonstrates to peers that feelings are normal and taking them into consideration is one of many ways to examine how client work is going.

Length of time: 5-10 minutes (usually happens along with client discussion above)

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Task: When a peer feels overwhelmed with job duties or client needs, help with prioritization

Purpose: Improve client outcomes, support program management, support peer retention

Tools: Time management and organizational tools and tips, share your methods

Suggested Approach: Offer your help and normalize peer's need for help.

Length of time: 5-7 minutes (not normally necessary each meeting)

Task: Offer your suggestions in ways that reveal the way you are thinking about an issue

Purpose: Build trust, model to peer how to think critically and intuitively about work

Tools: Think "out loud"; state opinions, not facts; suggest, don't tell; use "I" statements and "we" statements

Suggested Approach: Ask permission to provide your input and thank peer for accepting it.

Length of time: 2-4 minutes (dispersed within meeting)

Task: Offer your constructive criticism/feedback in a transparent fashion

Purpose: Build trust, depersonalize criticism

Tools: Evaluation forms, lead with peer strengths and value to you and program, state your dilemma (transparency)

Suggested approach: Deliver feedback honestly and respectfully. Detail how problem adversely affects peer, the program, clients, co-workers, etc.

Length of time: 15-20 minutes when necessary

Task: Address work process issues (i.e. communication with colleagues) using a solution-focused approach

Purpose: Support solving problems rather than assigning blame

Tools: Identification of problem or unmet needs of peer, brainstorm strategies for resolution

Suggested Approach: Reflect on peer's feelings (i.e., frustration) in a non-judgmental way before moving on to problem solving.

Length of time: 5-10 minutes

Task: Express your confidence and appreciation for peer

Purpose: Build trust, support peer's self-esteem, encourage peer to take on new challenges, support peer retention

Tools: Note peer's strengths and efforts as soon as you notice them

Suggested Approach: Lead with what is going well.

Length of time: Throughout meeting

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Task: Monitor your internal and external responses to peer

Purpose: Maintain positive supervisor/peer relationship, support peer retention

Tools: Self-awareness activities, identification of supervisor's countertransference

Suggested Approach: Ensure that your responses to peer consistently communicate positive regard and respect for peer, even when offering criticism.

Length of time: Throughout meeting when necessary

Sample Supervisory Dialogues

The following sample dialogues illustrate how to put some of the approaches, methods, and tools previously discussed into practice. The first dialogue provides commentary on how/what/why the supervisor is responding in a particular manner, and what approach or tool he or she is using.

Supervisory Meeting: Emotionally Charged Check In/Client Mental Health Issue

Supervisor: Hi, how are you?

(Supervisor starts with a simple open-ended question.)

Peer: I am good today. The weekend was hard, because I'm still having to deal with my niece and the guy that keeps bothering her. He has threatened to kill her again, so I had to help her get a restraining order. It's just so hard. I need her to be independent of me, and when this stuff happens, of course I have to help her out (tears up).

(Supervisor nods head in sympathy)

Peer: It just makes me so mad he is doing this. I cannot for the life of me understand why she keeps listening to him. I hope this time she stays away from him. She says she is going to. Anyway, thanks for listening.

Supervisor: Of course. It sounds like you are trying to both help her and set your own boundaries. Hey, remember we have that handbook on domestic violence if you ever want to borrow it. (Supervisor offers reflective listening and also offers a resource for peer to initiate self-care.)

Peer: Oh right! I saw that. I will look at it.

Supervisor: Great. So what is going well this week with clients?

(Supervisor asks open-ended question to support peer's sense of resilience/self-esteem and balanced perspective.)

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Peer: Here is a success. I talked to my client, Roseanne. She is going to disclose her status publicly at the HIV conference. I know that she is going to inspire so many people. She is doing so well! (tears up)

Supervisor: Those seem like happy tears.

(Supervisor reflects feelings.)

Peer: Yes, they are. It is just so inspiring to work with some of these courageous women. I am thinking of Louise, Sondra, Becky, Pauline... (names other clients as well as other peers and staff)

Supervisor: And you!

(Supervisor takes opportunity to affirm peer.)

Peer: (Smiles) And me.

Supervisor: (Smiles back) I am so happy to hear this about Roseanne. How will you support her after she discloses?

(Supervisor offers open-ended question to help peer think about her plan for client support.)

Peer: Oh, I'll see when the conference session is over so I can call her.

Supervisor: That sounds like an excellent idea. On another note, how is everything at the clinic?

(Another open-ended question to shift to talking about other clients.)

Peer: Going fine. I am worried about my client, Gina. She has always been so flamboyant, but lately she has been saying some strange things, and she thinks people are out to get her.

Supervisor: That does sound disturbing. What do you think is going on?

(Supervisor affirms peers concerns and asks open-ended question to invite peer to explore her thoughts about the situation.)

Peer: Maybe it is HIV-related dementia? She has been taking meds for so long.

Supervisor: That is an interesting thought, I didn't think of it. That might be something to ask one of the doctors at the clinic. I wonder if it also might be a mental health issue. You sound worried about her. How are you doing with it?

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

(Supervisor affirms peer's perspective, and also adds her own thoughts and suggestions. She also reflects feelings and with an open-ended question invites peer to express difficult feelings in case she needs to do this in order to release stress.)

Peer: I just hate to see this happen to her. It is so sad. She is such a nice person. She really is. She has helped so many other people, too (tears up). It just doesn't seem fair.

Supervisor: It really does feel...perhaps this is too strong a word...but, tragic.

(Supervisor reflects feelings, and indicates that it is ultimately up to the peer to figure out how it feels for the peer.)

Peer: That is not too strong a word at all. It is tragic. Thank you for saying that.

Supervisor: Of course. It makes me sad too. You seem to be feeling a little better.

(Supervisor shares in the experience with the peer and reflects the change in peer's feelings.)

Peer: Yes. I'll be okay with it. I guess I can only do so much, though.

Supervisor: Absolutely. I am so glad you realize that. What do you think she needs most from you?

(Another open-ended question, this time to illicit peer's intuitive knowing.)

Peer: Just to listen to her and calm her down. Sometimes it is hard, but I can do it.

Supervisor: What works with her?

(Open-ended question to illicit peer's perspective on how to care for client. Also illustrates to peer that supervisor believes in peer's ability to assess the situation.)

Peer: I guess just sitting close to her and letting her know I am listening.

Supervisor: That sounds good. You are doing a great job with her. Let me know if it gets any harder. And, you may want to check in with the medical social worker to make sure that she knows about this client's fears about people wanting to get her.

(Supervisor affirms peer for her good work and indicates that she is open to talking to peer more about it at a later date. She also suggests another action for peer to take.)

Peer: Oh, I think the social worker knows, but I'll mention it.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: Great. It might be good to get her take on the issue. Anything else before we wrap up?

Peer: No. Thanks!

Supervisor: Thank you. Hey, you have a lot on your plate with your niece and a lot of heavy client stuff. I hope you'll find a way to do something nice for yourself this week.

(Supervisor highlights need for peer's ongoing self-care.)

Peer: Yeah, maybe I'll get one of those free massages at the center.

Supervisor: Sounds like a good plan.

Supervisory Meeting: Adherence Concern/Supervisor's and Peer's Countertransference

Supervisor: Hi, how are you?

Peer: (Big sigh and speaking with annoyance) I am okay. I am just so frustrated with my client, Suzanne. She will not take her medication. She says she is taking it, but her viral load has skyrocketed. She acts like she doesn't know why, but I am not stupid, and I know why.

Supervisor: Why are you so angry with her?

(Supervisor immediately realizes her voice has an edge. She wonders to herself what is going on and realizes she is feeling impatient with the peer. She takes a deep breath and refocuses on what peer is trying to communicate.)

Peer: I don't know. I guess I am feeling tired of her lying to me.

Supervisor: (Changes her tone) Oh, I see. It can be frustrating when someone seems to think they need to hide the truth from you. Is that possibly how you are feeling?

Peer: Yes, come to think of it, I don't feel trusted. I have done so much for her. And I haven't done anything to make her feel like I can't be trusted. What am I supposed to do?

Supervisor: This really is a hard situation for you to be in with her. As matter of fact, it might be hard for any of us. What is it like for you when someone doesn't seem to trust you?

Peer: (Thinks for a moment) You know, I guess I hate it. Sometimes my boyfriend doesn't trust me and that drives me crazy. I get pretty upset.

Supervisor: So when this client acts like this, it may bring up similar feelings?

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Peer: I hadn't thought about that. I think I get more angry at my boyfriend. But you might be on to something.

Supervisor: Maybe, and maybe not. Again, it would be hard for a lot of people to be on the receiving end of this lack of trust. I know I'd find it challenging. It must be hard to conceal your frustration when this client acts this way.

Peer: Yes it is... Oh, is this countertransference?

Supervisor: Could be. What do you imagine is going on for her around the medication? I bet you are worried.

Peer: (Quiet for a moment) She probably just doesn't want to take those horse pills. The truth is, I have missed some doses lately, too. (becomes quiet and teary) I know I'm supposed to have it all together, but it is so hard to take them every single day of my life.

Supervisor: Sounds like you are being hard on yourself. Those meds can be really tough, and no one is expected to be perfect.

Peer: Yes, I guess so. But then there is the resistance problem.

Supervisor: Are you worried about yourself or your client?

Peer: Both of us, I guess. Well, I'll be able to manage, but I don't know about her.

Supervisor: What helps you get back on track?

Peer: Well, talking about it helps. I feel better right now.

Supervisor: I'm glad. What do you think would help your client?

Peer: I don't know. Talking about it?

Supervisor: Maybe you can share a little of your own struggle, of course, only if you feel comfortable sharing it with her.

Peer: Oh, I can do that. But without telling her everything about me.

Supervisor: No need to tell her everything. And, I know you'll remember she has to be the one who decides to change.

Peer: Right, right.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: Well, as you may have already guessed, this could be another part of your counter-transference with her. You can identify with her issue, and you get angry at her, like you get at yourself.

Peer: Oh my gosh. I really do. That is so unfair to her.

Supervisor: Okay, no need to be hard on yourself, here. It is normal for you to have feelings come up, and you are doing a good job today addressing them here. You are doing your job just fine.

Peer: (Sigh of relief) Okay, I think I can help her. (smiles)

Supervisor: You are doing a great job. Hey, are you getting support for yourself around the meds issue?

Peer: I am talking to you, the other peers, and my doctor knows.

Supervisor: Great, I'm glad to hear it. We need to wrap up. Anything else?

Peer: That is all for this week. I'll save another client issue for the peer meeting.

Supervisor: Oh good. See you then.

[Supervisory Meeting: Self-Care Plan/Client Crisis and Harm Reduction Approach](#)

Supervisor: Hello, How are you this week?

Peer: Fine. I had a good weekend. Got some rest.

Supervisor: Sounds good. We didn't have time to check in about your self-care plan last week. How is that going for you?

Peer: It is pretty good. It is hard to keep up with the water thing, but I am taking a walk twice a week for my work break.

Supervisor: Awesome! How do you like it?

Peer: I like it. It is easier when I can get someone to walk with me.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: Whatever it takes! What is hard about the water thing?

Peer: Well, I just don't like the taste of water and I'd rather drink soda!

Supervisor: Your goal was to drink two glasses per day. Is that working?

Peer: Yes, actually I am doing that.

Supervisor: Well then, you are meeting both of your goals.

Peer: (Smiles) Yes, I guess you are right. I have a client I need to talk to you about. Do you know who Shelley is? Well, she came in last week after she had been drinking. I could smell it. She came back after the support group was over and started saying to me that she "didn't want to be here anymore." I know that she has attempted suicide in the past so it worried me. I just don't know how to help her.

Supervisor: So let me get this straight. Shelley came to the support group last Wednesday and then left and came back?

Peer: Right.

Supervisor: I know you want to address how to help her, but first I want to check in about the suicidal comments. Do you remember more about what she actually said?

Peer: She just seemed really upset that she has HIV and said she was going to die, and she said she didn't want to be here anymore. She also said that she wouldn't tell me if she was going to try to kill herself because she knows that I'll tell someone. I just don't understand because she has never been upset like this before about the HIV.

Supervisor: When was she diagnosed? Recently, right?

Peer: She was diagnosed early last year. I guess that is pretty recent.

Supervisor: I wonder if she is starting to have more feelings come up about HIV.

Peer: Yeah, that could be. And, in the educational part of support group, we talked a lot about medication and side effects, so she might be reacting to that.

Supervisor: Oh, yes. That is a good point.

Peer: Maybe that is why she took a drink after the group.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: I wonder that, too. How did she leave that day?

Peer: Kind of upset.

Supervisor: Have you seen or talked to her since?

Peer: Yes, I tried to call her that evening and the next day. She never answered.

Supervisor: That was great that you tried twice. I assume you'll keep trying. Do you remember what to do if someone says suicidal things?

Peer: Yes. See if it is serious, like if they have a plan and they are going to do it, call 911 and you or the social worker.

Supervisor: Right on. How serious did you think she was?

Peer: Not very. And she didn't say she was going to do anything, really.

Supervisor: I always think it is a good idea to ask direct questions about these things. My philosophy is that people feel taken seriously when we're direct with them about this stuff. And, I think they feel more cared about.

Peer: It is hard, because I don't want to suggest anything, or assume anything. But I hear what you are saying.

Supervisor: I hear what you are saying, too. It can be an awkward conversation. What about the drinking? Did you say anything?

Peer: I asked her if she took a drink and she said yes. She said that it helps her with her chronic pain. I told her that alcohol doesn't cure pain. She said she knew that and her doctor just prescribed medication.

Supervisor: I am glad you mentioned all that—a good example of being direct! You also may want to ask her if she knows whether it is okay to drink alcohol while taking the medication.

Peer: I'll write that down. I guess we can also ask her doctor or pharmacist.

Supervisor: Sounds good. Good work. I hope you will keep being direct with her like that. Tell me more about your concern with the drinking.

Peer: I don't think she drinks a whole lot. But I am not sure what to do about her coming in with it on her breath. Do I have to do something?

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: You do not have to as long as she is not acting unsafe or disturbing others. But I wonder how much it disturbs you.

Peer: I feel okay about it. She didn't seem drunk or anything.

Supervisor: Let me know if this continues with her, or gets worse. You may want to ask her if she wants help or needs a referral. As for helping her in general, what might she need from you right now?

Peer: Hmmm.... I guess she might need me to tell her more about HIV and the medication. I am not sure that she really knows how the disease and the meds works. And, we'll keep talking. Also, she is coming to support group and I see her there.

Supervisor: That all sounds like a good plan for her. How often do you see or talk to her outside support group?

Peer: Not so much.

Supervisor: This is someone who may need a little more contact, like a weekly check-in call and an occasional visit. What do you think?

Peer: I think that it would help. I'll start calling her on Mondays.

Supervisor: Sounds good. You are doing a really good job with her. There is a lot going on and you are juggling it well. You may want to check in with her social worker soon to touch base.

Peer: Yes, I'll do that when I am at the clinic.

Supervisory Meeting: Managing Boundary Concerns While Developing Peer Skills

Below is an example of how a supervisor might address a potential boundary issue between a peer and a client during a supervisory session. In this dialogue, the peer raises concerns that involve the peer personally and, with the help of some supervisory guidance, can begin to see the complexity of the relationships between peer colleagues as well as with clients. It is noteworthy to point out the opportunity that the supervisor has to help the peer not only reflect on his/her role in relation to the client, but also on Monique's position as a peer colleague.

Supervisor: Hello. How are you this week?

Peer: Good. I had a good weekend. Went out with some friends.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: Sounds like fun.

Peer: It was. (pause) I actually saw one of our clients, not mine, but Monique's. (pause) We happened to be at the same party.

Supervisor: Really. What was that like?

Peer: A little weird, but that client lives near me, so I see her sometimes on the street. This is the first time I saw her at a party.

Supervisor: You said, 'a little weird'. Want to say more about it?

Peer: Well, she was drinking and all over this guy I know. It was a little uncomfortable.

Supervisor: mmm (nods)

Peer: You know, I'm not working on the weekends and I don't have to be responsible for other people, especially when they're not my clients

Supervisor: True. You're not working on the weekends and you aren't responsible for others' behavior.

Peer: Right! But, I feel like I know something and it feels like she's watching me and wondering what I might say to this guy she's with. I know them; they're people I hang out with, and I know what they're doing and it makes me feel like I have to say something.

Supervisor: It's not your responsibility to stop somebody else's behavior, and sometimes we get information that puts us in a bind. It sounds like you're in a bind.

Peer: I am in a bind. I want to tell this guy that I know she's positive, cause I want to protect him; I want to tell her to stop drinking and think about what she's doing and I want to tell Monique what her client is up to.

Supervisor: You are really in a tough spot. What do you think the client is thinking?

Peer: I am sure she is wondering if I have said all that stuff that I wanted to. I didn't, but I am really frustrated and don't know what I will do when I see her again. I really want to tell Monique so she can deal with her client.

Supervisor: You have a lot of feelings about this.

Peer: I do, because she is a lot like I was, and she should be taking care of herself and care about others too.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

Supervisor: I understand that this is complicated for you because of your own experience, but it's not our job as peers and caregivers to tell others what to do. People have to make their own choices even if we don't agree with them.

Peer: I know. I realize that I can't say anything to the client or the guy I know, but what would happen if I talked to Monique about this client?

Supervisor: What do you think this would accomplish?

Peer: Monique would know what is going on with this client.

Supervisor: What makes you think this client hasn't shared information with Monique?

Peer: I didn't think of that.

Supervisor: By sharing this information with Monique, you might be hurting Monique's relationship with this client or your relationship with Monique.

Peer: What do you mean?

Supervisor: Well, Monique has an established relationship with this client and I imagine she is working hard with her, and if you tell Monique, it might be hard for Monique to work with her knowing that this client is possibly hiding something from her. Your relationship with Monique may be affected as well, because it might make Monique feel as if she is supposed to do something about her client's behavior, which we know is not the basis of a good peer-client relationship.

Peer: This is really tough for me and I am not sure I agree with you, but you're my supervisor, so I won't say anything, but I'm not happy about it.

Supervisor: I can hear that and it is ok to be frustrated and uncomfortable about the bind that this puts you in. Sharing your concerns in here with me might help you understand your feelings about it and might let this client figure this out her own way in her own time.

Peer: I may need to talk about this a lot.

Supervisor: That's fine with me.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: TASKS AND TOOLS

In this dialogue, notice how the supervisor asks questions and responds to the peer. The supervisor is able to help the peer realize that perhaps there are other options that can better support clients. Although, there is a difference of opinion, the supervisor acknowledges the peer and allows the peer to utilize supervision to express his or her concerns on an ongoing basis. This helps to ensure that the peer is being heard and supported while managing the clear expectations of maintaining the confidentiality of the client. This could have easily become a struggle or conflict between the peer and the supervisor, but by acknowledging the frustration of the peer, helping the peer reflect on Monique's role and offering the safe space of supervision, the meeting ended with a productive outcome.

This “Read More” section accompanies [Section 6.2, Supervising Peers: Supportive Supervision](#), part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.2 SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: STRUCTURED SUPERVISION

Structured Group Supervision

A four-phased model, 'Structured Group Supervision', gives an individual peer the opportunity to share and receive feedback from more than one person. The individual peer is able to experience uninterrupted group attention, and at the same time, it benefits all members of the group. The group supervision process can help build a shared identity among coworkers and can be facilitated by a leader without expertise in clinical supervision. It is, however, essential to the process that the facilitator preserves a safe, constructive environment for discussing difficulties in working with clients. Each phase requires 10 to 15 minutes of group time, and the facilitator is responsible for timekeeping and for monitoring the questioning and discussion.

PHASE ONE: Presentation and Request-for-Assistance Statement

The presenter describes a case, addressing the following questions:

- What are the facts?
- How did the situation arise?
- What specifically do I want help with in this case?

The information may be written up in advance if the group wishes. Following the presentation of the summary information, the presenter makes a specific request for assistance with the case. Specific requests may concern:

- Assessing or characterizing a client's needs
- Facilitating a client's progress
- Overcoming a perceived block
- Processing his or her emotional reaction to a client
- Developing specific counseling skills
- Working effectively in collaboration with colleagues or other staff members.

PHASE TWO: Questioning Period and Identification of Focus

Supervision group members question the presenter in order to obtain additional information and/or better understand and clarify issues involved in the request for assistance. This is done in round-robin fashion, with each group member asking one question in turn. If necessary the first member to ask questions begins the second round of questions, until the group feels it fully understands the focus of the request for assistance. The identification of focus will impact on the discussion in the next phase.

PHASE THREE: Feedback Statements and Discussion

During this phase the presenter is instructed to remain silent and listen without responding immediately to feedback. However, the presenter may take notes. After a brief pause, the facilitator asks the group members to make constructive suggestions, taking turns in round-robin fashion.

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: STRUCTURED SUPERVISION

These suggestions should be phrased as “I ...” statements. It may be preferable to talk about the presenter in the third person rather than addressing him/her directly. The facilitator does not engage in discussion, but needs to monitor the group process, discouraging judgmental comments and overly harsh criticism. If necessary, the facilitator may ask a member to rephrase his or her feedback so that it addresses the presenter’s request for assistance.

A pause period then follows (2-3 minutes) to give the presenter time to process the emergent material. The group should remain silent, perhaps reviewing and adding to notes, during the pause.

PHASE FOUR: Presenter’s responses

The presenter responds to the feedback with regard to which aspects were helpful, and is encouraged to say why the feedback and discussion was or was not beneficial. The facilitator may allow an open discussion period following the completion of the four phases, should time allow.



Sylvia Young (right) talks with two peer advocates at WORLD.

“The one piece of advice I would give to a peer supervisor is to have compassion for the peers who are doing this work because they are living with a life-threatening, chronic illness, and challenges will come up.”

Sylvia Young
Peer Supervisor
WORLD
Oakland, CA

SUPERVISING PEERS: SUPPORTIVE SUPERVISION

READ MORE: STRUCTURED SUPERVISION

Phase	Purpose	Presenter	Group	Facilitator
Presentation & request assistance (10 – 15 min)	<ul style="list-style-type: none"> • Provide group with info about case or problem • Identify specific nature of request for assistance 	<ul style="list-style-type: none"> • Present selected case • Request assistance in area of concern 	Take notes	<ul style="list-style-type: none"> • Ask presenter to begin • Ensure that only presenter speaks
Questions & focusing (10 – 15 min)	<ul style="list-style-type: none"> • Gather more information • Construct group understanding of case and specific request 	Answer questions	Ask clarifying questions, each person taking a turn as long as necessary	<ul style="list-style-type: none"> • Monitor time • Ensure that one person has the floor • Continue questions until no more questions
Feedback statements (10 – 15 min)	Provide suggestions and insights	Take notes	Give feedback, each person taking a turn	Monitor time
Pause period (2 – 3 min)	Give time to assimilate suggestions and insights	Review notes	Remain silent	Ask group to pause Monitor time
Presenter's response (10 – 15 min)	Identify benefits of suggestions and insights	Respond to suggestions and insights	Listen	<ul style="list-style-type: none"> • Monitor time • Ensure that only presenter has the floor
Optional discussion (10 – 15 min)	<ul style="list-style-type: none"> • Process the session • Identify benefits for group 	Free discussion	Free discussion	Monitor time One speaker at a time

Reference: Wilbur, M.P., Roberts-Wilbur, J., Morris, J. R., and Hart, G.M. (1991). Structured group supervision: theory and practice. *The Journal for Specialists in Group Work*, 16, 2, 91 – 100. Adapted by: Thulani Vazi, Psychosocial Wellness Coordinator, International Center for AIDS Care and Treatment Programs, Mailman School of Public Health, Columbia University

This “Read More” section accompanies [Section 6.2, Supervising Peers: Supportive Supervision](#), part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.3 SUPERVISING PEERS: CLINICAL SUPERVISION



Sylvia Young (left) with Anna Jackson, FCN
Consumer Task Force and Retreat Coordinator

I hope everyone understands the importance of mental health supervision. I need that support. This is hard work. I wouldn't be here anymore if I didn't have it.

Sylvia Young
Peer Advocate Program Manager
WORLD
Oakland, CA

Introduction

Although much of this guide is focused on developing peer programs that utilize an asset-based approach to program development by building programs from the resources that are readily available, it should be noted that while clinical supervision for peers is ideal, it may not be realistic, given budget constraints. It is important for programs to have an understanding of clinical supervision so that if resources permit, programs can invest in this level of support for their peers.

Some peer support programs are able to provide clinical supervision by a licensed clinical provider who may or may not be part of the organization. The following outlines a model and limited guide to providing clinical supervision for peers.

A clinical supervisor is defined as someone who is licensed by the state in which he or she practices clinical work and is in the position to provide guidance and direction to both clinical and nonclinical staff. In general, clinical supervisors have been in practice for at least five years.

Below is a comparison of clinical supervision for prelicensed practitioners versus clinical supervision for peers.

Clinical supervision for prelicensed practitioners:

- Provides individualized support and training.
- Allows for close monitoring of caseload.
- Assists supervisee in providing accurate diagnoses.
- Assists supervisee in forming a treatment plan.
- Helps supervisee manage feelings that arise about/towards clients (countertransference).
- Helps supervisee manage feelings that arise from the client about/toward the supervisee (transference).
- Teaches supervisee how to monitor therapist/client interpersonal dynamic and intervene therapeutically when difficult interactions arise.
- Supports supervisee in identifying and addressing work stress related to working with clients with significant life stressors.

SUPERVISING PEERS: CLINICAL SUPERVISION



Two peers at Christie's Place.

Supervision has been an ongoing issue for us. There are challenges of boundaries, there's countertransference. So we hired a clinician supervisor, an MFT with 20 years of clinical supervision experience. With her counseling background, she's able to provide a higher level of supervision and support to the peers.

Elizabeth Brosnan
Executive Director
Christie's Place, San Diego

- Helps supervisee maintain realistic expectations for self and clients.
- Helps supervisee identify and build on what works with clients.
- Ensures that supervisee works within scope of practice and makes appropriate referrals when necessary.
- Evaluates supervisee for eventual licensure.

Similarly, clinical supervision for peers:

- Provides individualized support and training.
- Allows for close monitoring of caseload.
- Can assist peer in forming client care plans.
- Helps peer manage feelings that arise about/towards clients.
- Supports peer in identifying and addressing work stress related to working with clients with significant life stressors.
- Helps peer identify and build on what works with clients.
- Helps peer maintain appropriate expectations for self and clients.
- Ensures that peer stays within scope of work and makes appropriate referrals when necessary.
- Can be used as a venue for supporting peer's professional development.

However, clinical supervision for peers:

- Does not diagnose clients.
- Does not treat clients, although they may come up with a plan for care and support.
- Rather than focusing on helping peers intervene once a difficult interpersonal dynamic arises, helps peers proactively navigate client relationships in which both flexibility and good boundaries are important. When a difficult dynamic arises, supportive supervisors help peers address difficulties in practical ways.
- Helps identify and address personal stress as well as work-related stress to a limited degree.
- Helps link personal experience and knowledge to peers' work with clients, but with a clear understanding of the boundaries and limits of the peer support provided (based on the peer role).

Clinical Case Consultation

Case consultation is the section of clinical supervision where peers present their client work in a clinical framework. In general, it can follow the case discussion framework below:

SUPERVISING PEERS: CLINICAL SUPERVISION

- Narrative description
 - Basic history or client story
- Current issue
 - Client questions/concerns
 - Supervisee questions/concerns
- Supervisee's thoughts/reactions
 - Transference
 - Countertransference
- Action planning
 - What is the plan to address:
 - Client needs
 - Supervisee needs

Although it is important that the peer not diagnose the client, clinical supervision can offer an opportunity for the peer to learn about mental health issues. In this way, peers may have a better understanding of their clients and the referrals they are offered and may be able to troubleshoot any obstacles for that client in seeking additional care.

[Read More: The Coaching Model for Clinical Supervision](#) contains more information about the clinical supervision model.

► FOR MORE INFORMATION

Read More for Subsection 6.3

- The coaching model for supportive supervision
- Troubleshooting difficult cases and supporting peer efforts
- Recognizing and addressing countertransference
- Tasks and tools for developing a supportive approach
- Peer support groups and structured group supervision

Resources for Section 6

- Framework for supportive supervision case discussion (JRI)
- Framework for clinical case consultation tool (JRI)
- Administrative supervision tools (The Lotus Project)
- Supportive supervision tools (The Lotus Project)
- Supervision Tools (The PACT Project)
- Peer weekly staffing report (Project ARK)

Additional Supervision Subsections

- Supervising Peers: Introduction
- 6.1 Administrative Supervision
- 6.2 Supportive Supervision
- 6.3 Clinical Supervision

Further Reading

- Janine M. Bernard and Rodney K. Goodyear, *Fundamentals of Clinical Supervision* (2nd Edition).
- Marijane Fall and Jack Sutton, *Clinical Supervision: A Handbook for Practitioners*, University of Southern Maine.
- National AIA Resource Center "[Building Upon the Unique Strengths of Peer Workers](#)" *Newsletter of The National Abandoned Infants Assistance Resource Center*, Volume 11, No. 3, Fall 2002.
- Michael J. Austin, Karen M. Hopkins, *Supervision as Collaboration in the Human Services: Building a Learning Culture*, 2004. [Preview book](#).
- James M. Benschoff, "[Peer Consultation as a Form of Supervision](#)," *CYC online: Reading for Child and Youth Care Workers*, Issue 31, August 2001.

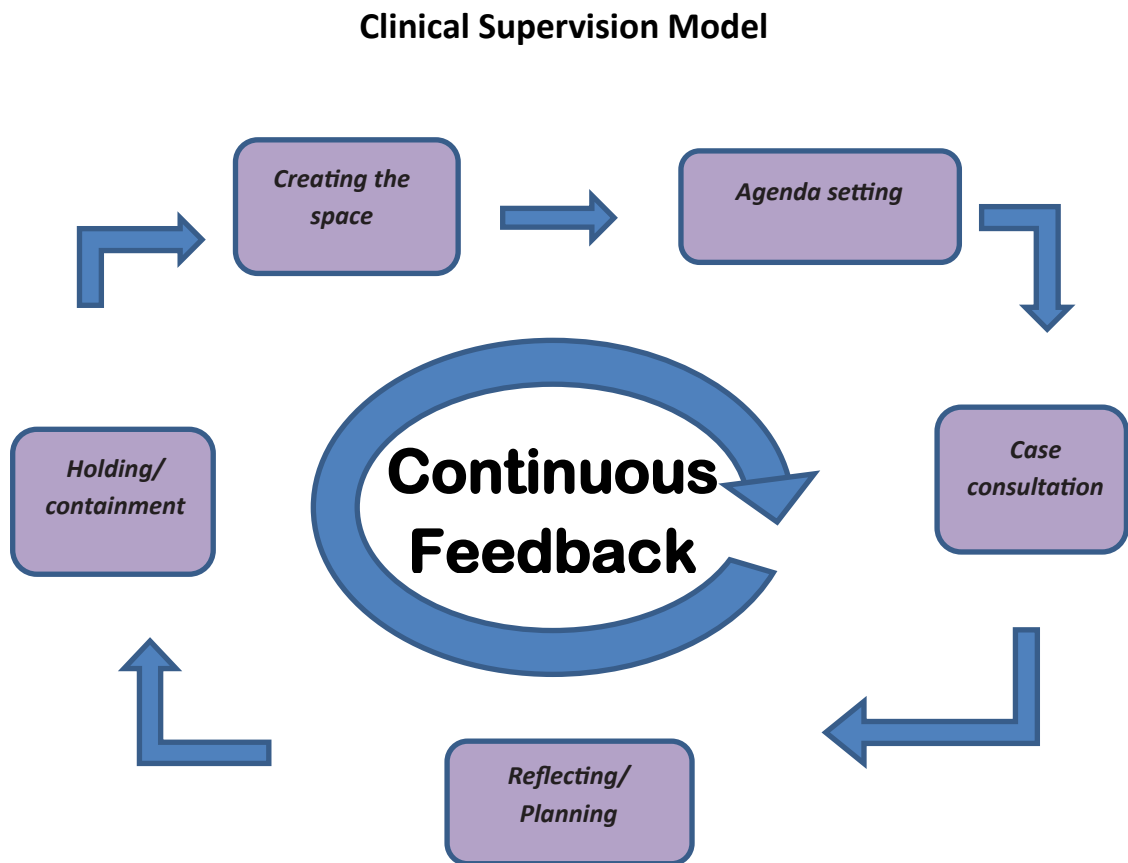
This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

6.3 SUPERVISING PEERS: CLINICAL SUPERVISION

READ MORE: COACHING MODEL

Coaching Model for Clinical Supervision

The coaching model below illustrates some key approaches to clinical supervision meetings with peers.



SUPERVISING PEERS: CLINICAL SUPERVISION

READ MORE: COACHING MODEL

Creating the Space

As a clinical supervisor, it is important to invite peers into a space that is designated as “protected,” allowing the peer to be vulnerable and share how work is affecting his or her personal life. In this way, the supervisor can learn what struggles the peer faces and reduce the possibility that the peer will act them out negatively toward the client (countertransference). In this space, the peer is able to talk openly about anxieties and concerns, knowing that the supportive supervisor will be empathic. Creating this space, however, does not rule out the necessity of “breaking” that space, meaning that in the event of a misuse of the peer-provider relationship, the supportive supervisor will need to break confidentiality (e.g., the same situation applies to breaking a boundary with a client - see [Read More: Tasks and Tools for Developing a Supportive Approach](#) for an example dialog which addresses a potential boundary issue.)

This is similar to the supportive supervision approach. However, clinical supervisors have the added skills to more deeply help the peer to reflect on why their work is affecting them in a particular way and to make the necessary clinical referrals to therapy or additional counseling if warranted.

Agenda Setting

It is important to set an agenda with the peer even if it is loosely articulated so that both the peer and supervisor know what will be discussed. The peer should be involved in the agenda setting since the primary role of supportive supervisor

is to give guidance to the peer in areas where the peer feels vulnerable or is requesting support. The supervisor can and should raise issues that may be challenging or difficult for the peer and where the peer may be reticent. However, these issues should be raised in a safe, nonjudgmental way so that the peer is able to explore his or her reactions and responses as they relate to clients and work. Some agenda items may be standardized and become part of each supervisory session such as:

- Client successes
- Client case consultation
- Resources
- Referrals to outside therapeutic or counseling providers

Clinical Case Consultation

Case consultation is the section of clinical supervision where peers present their client work in a clinical framework. In general, it can follow the case discussion framework below:

- Narrative description
 - Basic history or client story
- Current issue
 - Client questions/concerns
 - Supervisee questions/concerns
- Supervisee’s thoughts/reactions
 - Transference
 - Countertransference
- Action planning
 - What is the plan to address:
 - Client needs
 - Supervisee needs

SUPERVISING PEERS: CLINICAL SUPERVISION

READ MORE: COACHING MODEL

Reflecting and Planning

Allowing the peer to reflect upon his or her client work encourages exploration both in planning for client care and raising awareness of important issues that are affecting the peer. In this way, the peer has a place to reflect and learn and is freed up to engage with the client at the client's pace and readiness.

Holding/Containment

The term, 'holding or containment' refers to the environment in which the clinical supervisor uses themselves and the supervision time as mechanisms to give the peer opportunities to express how the work with the client affects them. There is potential for peers to experience unconscious triggers that may cause a reaction

that, when unaddressed, may create a response that may overstep a boundary with a client. These triggers are often due to the peer being in a similar situation (either due to HIV status, addiction history, mental health history or other physical health issue). 'Holding or Containment' is a metaphor for having the supervisor hold and contain, but in reality, help manage the feelings or reactions of the peer with issues that come up as a result of working with clients. These issues are held and contained as they are being worked through in clinical supervision. Having the opportunity to share openly feelings that may emerge in a safe space with a safe person reduces the likelihood that those unconscious triggers will result in breaking a boundary with the client. There are times when a clinical supervisor might refer a peer for additional therapeutic/outside counseling support, if necessary.

This "Read More" section accompanies Section 6.3, *Supervising Peers: Clinical Supervision*, part of the online toolkit, *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7. EVALUATING PEER PROGRAMS



“A goal without a plan is just a wish.”

Antoine de Saint-Exupery
(1900 – 1944)

Introduction

There are many reasons why evaluating a peer program is worth an organization's time, energy, and money. For example, an organization may want to know how effective peers are in enhancing retention of patients in HIV medical care, or what teaching strategies are most cost-effective in peer-led treatment adherence education support groups. The need may be as simple as learning if and how peers successfully meet client needs.

Often when a program attempts to answer these types of questions, it relies on anecdotal evidence and educated guesses from its staff. While staff members' input into program evaluation is important, it is best not to use it as the only evaluation tool. Staff members' impressions can be limited because they usually have a vested interest in program success, and because they provide partial views of program operations. As an alternative, evaluation questions are often best answered by using data from a variety of sources and using proven methods that are user-friendly, unbiased, and based on systematic principles.

This section provides an overview of how to document and measure the activities and results of a peer program. The information is intended for program directors or managers, clinical providers, and peers. It is appropriate for people who are relatively new to the field of evaluation and want to learn how to monitor progress towards meeting peer-related program objectives and goals (process evaluation). It also provides guidance on how to assess the impact HIV-positive peers have on HIV-positive clients receiving services and related outcomes, either at an organizational or systems level (outcomes evaluation). This section is not intended to replace the need for a trained evaluator for more advanced practices, but should equip program practitioners with the tools to conduct some basic evaluation activities to measure the effectiveness of a peer program.

The information in this section will position the organization to build upon existing systems using proven evaluation methods. Essential information will be provided in the text with links to more advanced information, examples of tools, and references as needed.

EVALUATING PEER PROGRAMS

TIP

Please note that your funder or other key stakeholders may have required evaluation guidelines. Any suggestions in this guide are not meant to replace what is required for your particular program. Be sure to check with your funding agency or project officer to get specific guidelines that fulfill your contract.

This section will help to answer the following questions:

- What do we want to measure with our peer programs? ([Subsection 7.1, Choosing the Outcomes to Measure](#))
- How do we design evaluation questions? ([Subsection 7.1, Choosing the Outcomes to Measure](#))
- What is a logic model and how can we apply it to peer programs? ([Subsection 7.2, Introduction to Logic Models](#))
- What data collection methods can we use to monitor and evaluate peer programs? ([Subsection 7.3, Data Collection](#))
- How can we analyze and use the results to shape program improvements, inform policy, and obtain future funding? ([Subsection 7.4, Analyzing and Disseminating Evaluation Results](#))
- What resources, including staff, do we need to implement an evaluation system? ([Subsection 7.5, Evaluation and Resource Planning](#))
- How can we ensure that the program evaluation safeguards patient confidentiality? ([Subsection 7.6, Protection of Human Subjects and Evaluation](#))
- Where can we go for additional resources and information? ([Program Resources](#) for [Section 7, Evaluating Peer Programs.](#))

Consider using this section to build upon what is already in place for evaluating program within the organization. If one is developing a new peer program, think about how existing monitoring systems within the organization can be adapted to track peer activities. Finding ways to integrate a peer program evaluation with overall agency evaluation is a best practice. This can save time and energy and prevent duplication of effort. Some of these systems may be labeled within an organization as Quality Improvement or Quality Assurance. See the [Read More: Differences Between Program Evaluation and Quality Assurance...](#) for distinctions between the two.

A first step is to contact the person(s) responsible for program activities and discuss how evaluating a peer program can be integrated into the current evaluations system for HIV services. For example, if a primary care clinic is currently monitoring the frequency of patient visits, then the peer program evaluation can compare number of visits by those patients with a peer and those without. Or if patient satisfaction surveys are conducted, one may want to include questions on that survey regarding interactions

EVALUATING PEER PROGRAMS

with peers. A user-friendly database tracking system that could incorporate peer program information may already exist. Staff may conduct chart audits for HIV-positive patients, and a peer program could utilize these audits to obtain information on clients participating in the program. Lastly, there may be resources to conduct a written questionnaire but the staff is unsure if the questions are unbiased and asked in an accurate way to capture the desired information and understand and measure the impact of the peer program.

The field of evaluation is based on scientific principles and practices that, when followed consistently, will prove useful and dependable. The selection of particular methods should represent the optimum balance between scientific rigor and practical feasibility, given the program's evaluation goals and real-world constraints.

► FOR MORE INFORMATION

Read More for Section 7

- Differences between program evaluation and quality assurance and improvement

Additional Evaluation Subsections

- 7 Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and resource planning
- 7.6 Human subjects protection and evaluation

Resources for Section 7

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7. EVALUATING PEER PROGRAMS

Differences Between Program Evaluation and Quality Assurance and Improvement

For many organizations, evaluation is already an essential component of your HIV program(s). Some organizations may call it quality management, some may call it quality improvement, and some are tracking numbers, demographics and services offered or accessed. All of these are a form of evaluating your program and each provides different data which can be used to revise and improve programs and services. In the literature, there are different terms that can be used to describe evaluation activities. There are a wide variety of evaluation designs including continuous quality improvement methods. The chart below describes the differences between program evaluation and continuous quality improvement.

Program evaluation may be seen as an extension of program quality assurance, quality management, or quality improvement activities.	
Differences between Program Evaluation and Quality Assurance and Improvement¹	
Program Evaluation	Quality Assurance/Improvement
1. Conducted independently of routine program activities	1. Conducted as part of routine program activities
2. Performed by program staff, dedicated evaluation staff, or consultants	2. Performed by program staff or internal evaluation staff
3. Designed to answer specific questions about program implementation, acceptability, effectiveness, and/or relevance.	3. Designed to ensure that program meets or exceeds quality standards and benchmarks in order to continuously improve service delivery
4. Addresses values and priorities of stakeholders (i.e., patients/clients, program staff, funders, community representatives affected by program activities)	4. Addresses professional standards and benchmarks

¹Patton, Utilization Focused Evaluation, 1997

There are numerous designs from which to choose to conduct program evaluation, with quantitative evaluation designs used more often than qualitative. (See [Section 7.3, Data Collection Methods](#) for a discussion of qualitative and quantitative methods.) Quantitative and qualitative evaluation designs are based on different paradigms. Although both designs are equipped to stand alone, they may be combined in what is referred to a **mixed methods** approach. The key to evaluating your program is a simple, user-friendly design. For more information on program evaluation, see [Additional Evaluation Resources and Websites](#) in Section 7 of the [Program Resources](#) for a list of publications and websites for further reading.

This “Read More” section accompanies [Section 7, Evaluating a Peer Program](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit

¹Patton, Michael Quinn. *Qualitative Research and Evaluation Methods*. 3rd edition. Sage Publications 2002.

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE



“We ask the same questions of patients before they start the program and repeat these tests every three months... I look at viral loads, engagement in care...the number of kept scheduled appointments and compare it against the number of urgent care visits the patient might have and what the urgent care appointments are for. Then we look at the number of contacts the patients have with their peer educators. We decided back in 2000 the things we needed to track: visit history, engagement in care, success with taking antiretrovirals.”

Rose Farnan
Infectious Disease Nurse Clinician
Truman Medical Center
Kansas City, MO

Identifying Outcomes

Often while implementing HIV programs or delivering a service, questions or needs may arise from staff, consumers, or other key stakeholders such as “There are so many patients with no-shows for medical appointments” or “Are the peer services helping newly diagnosed clients become connected to HIV services?” It may be difficult to translate these simple ideas to the formal language of program evaluation. This section will help to find ways to answer these questions and address program needs.

Outcomes are the foundation for subsequent planning and implementation activities of a peer program; therefore, it is important to develop them carefully. The organization may want to explore outcome issues with key stakeholders, such as an advisory committee, task force members, or local agency managers. Outcomes should reflect possible effects of the peer program on the participants.

Below are some useful evaluation definitions of frequently used evaluation terms:

Outcomes are the results or effects of the program that clients experience either during or after program participation. They can be defined as short-term, intermediate, or long-term.

- Short-term: occurring within 1 to 3 months of program activities
- Intermediate: occurring within 6 months to a year
- Long-term: manifesting over the duration of program activities

Client-level outcomes are the results or benefits for an individual client. For example, a client may have experienced an improvement in his or her mental health status or CD4 cell counts as a result of the peer program.

System-level outcomes are results that may be seen for all clients receiving peer services. For example, peers making reminder calls to HIV-positive clients may result in fewer no-show appointments.

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

▶ 5 KEY EVALUATION QUESTIONS

(from HRSA/HIV/AIDS Bureau)

- 1. Assessing Unmet Need:** “To what extent are Care Act programs identifying HIV-infected populations who are not in primary health care (not accessing available services)? To what extent are grantees identifying HIV-infected populations who are not remaining in primary health care and the reasons for this lack of continued service utilization?”
- 2. Removing Barriers to Care:** “Are grantees determining the specific reasons why individuals are not in care and removing barriers to their care? What are the providers doing to enroll and retain identified underserved populations in primary care?”
- 3. Optimizing Local Service Delivery Systems:** “Have CARE Act grantees identified the most effective combinations or models of integrated services that improve the use of primary health care, taking into account the characteristics of local health care delivery systems and affected populations?”
- 4. Providing Quality Care:** “To what extent are CARE Act grantees/providers providing quality care to clients as defined by Public Health Service and other care standards? Is the care having optimal effects on morbidity and mortality, and is it improving health-related quality of life?”
- 5. Adapting to Change:** “To what extent are CARE Act grantees adapting their service priorities and allocations to a changing and sometimes chaotic health delivery system and reimbursement environment?”

Outcome indicators or measures are observable, measurable data such as the number of referrals completed by clients, changes in CD4 cell counts, or number of HIV medical visits.

Below is a suggested list of steps to identify and generate a comprehensive list of potential outcomes and indicators from multiple stakeholders of a peer program. These steps include:

- Revisiting outcomes in planning discussions or start-up events with the funding agency and project officer.
- Reviewing existing materials such as program mission statements, work plans from grants or funding applications, literature reviews of peer support, and findings from local needs assessments.
- Talking with program staff and volunteers who are familiar with the peer program. They may have the best insight on aspects of the peer program that are of greatest value to its participants.
- Convening focus groups comprised of clients or peers. These individuals may be the project’s ultimate consumers. Their perspectives should be central when considering important program results.
- Reviewing client feedback about the program. These comments, suggestions, or complaints may give insight to goals that clients expected to achieve but were not able to reach.

Evaluation Questions

An evaluation attempts to answer specific questions about the results and effects of a program. These questions may relate to program structure, process, outputs, or outcomes. For example, an HIV clinic wishing to evaluate the effectiveness of its peer program might ask: How does the receipt of peer services affect client adherence to antiretroviral drug therapies?

To the left are five evaluation questions put forth by HRSA’s HIV/AIDS Bureau for understanding the effectiveness of HIV services. These are found in the guide *Outcomes Evaluation Technical Assistance Guide: Case Management Outcomes*. While this guide is designed for case managers, the information can be

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

► TIP

It is important to clarify the difference between the outcome and the outcome indicator. In the ABC Clinic example (See [Read More: The ABC Clinic's Peer Program](#)), one **outcome** is improved HIV medical outcomes. One **indicator** is the number and demographics of HIV-positive clients with at least 2 medical visits in the measurement year. This indicator can be compared at baseline and then after 12 months of the program or compared to clients who don't receive peer services. Medical appointment adherence can be measured by noting whether clients have had at least 2 HIV primary medical appointment in a 12-month period. This may be done via chart audit.

applied to peer programs. Not all of the questions may be relevant to every program, but they may provide guidance to an evaluation plan. For several of the questions, an example is provided below for how to evaluate and measure the effectiveness of a peer program in contributing to HIV services.

Evaluation Question #1: Assessing Unmet Need

“To what extent are CARE Act programs identifying HIV-infected populations who are not in primary health care? To what extent are grantees identifying HIV-infected populations who are not remaining in primary health care and the reasons for this lack of continued service utilization?”

“Are you able to identify and impact HIV-infected populations that are not remaining in primary health care and the reasons for loss to follow-up?”

Example: A peer program located at the ABC Clinic may want to measure how it connects underserved minority and vulnerable populations, either lost to follow-up or newly diagnosed, to care. (See the [Read More: The ABC Clinic's Peer Program](#) for a sample evaluation plan.)

Outcome indicators: To measure outreach and increased access to services for underserved populations, examples of outcome indicators include:

- Percent and demographics of individuals who are newly diagnosed or out-of-care for 6 months who accept peer services among those eligible
- Number of HIV-positive referrals to outreach peers from rapid HIV testing
- Number of HIV clients newly diagnosed through the peer programs with at least 2 case management appointments in 6 months' time
- Number and demographics of HIV-positive clients working with the peer program with at least 2 medical visits in the measurement year

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

Short-term outcomes may include:

- Larger proportion of newly diagnosed clients who have kept their first primary care appointment
- Newly diagnosed clients who access medical and support services within 6 months of diagnosis

An **intermediate outcome** may be:

- Within the target demographic group, a larger proportion of HIV-positive individuals who are engaged in care

Long-term outcomes may include:

- Increase in the number or percentage of HIV-positive patients with 2 or more HIV medical visits in a measurement year
- Increase in the number of clients with CD4 and viral load tests
- Improved HIV medical outcomes

Evaluation Question #2: Removing Barriers to Care

“Are grantees determining the specific reasons why individuals are not in care and removing barriers to their care? What are the providers doing to enroll and retain identified underserved populations in primary care?”

What are the number and types of support services provided by peers? Do peer services reduce barriers to care for clients? Barriers could include substance abuse, unstable housing, and/or experiences of HIV-related stigma.

Example: In a community-based organization (CBO), the outcomes and goals of a peer program may be slightly different. For example, case managers often have to struggle to meet all the needs of their clients. A peer program component

may help to facilitate the work of case managers in delivering support services to clients. (See [Read More: The Smith County Service Program](#) for a sample evaluation plan.)

Outcome indicators: To measure the effect of peers on increasing access to support services, a CBO may choose an outcome indicator such as:

- Number and types of peer services received by clients
- Number and demographics of HIV-positive clients referred and enrolled in HIV case management services

Intermediate outcomes may be:

- A greater proportion of clients are enrolled in peer-led support groups to address specific challenges to care such as substance use and stigma and disclosure issues
- A greater proportion of clients working with peers are connected with appropriate services to address needs, such as substance use treatment/counseling, housing and mental health
- A decrease in the number of missed case management appointments in a 6-month period

Longer-term outcomes may be:

- An increase in social service needs met by populations experiencing substance abuse, unstable housing and/or HIV-related experience of stigma
- Number of clients enrolled in peer support groups report improved comfort with disclosing status to family, friends, or health care providers

Evaluation Question #4: Providing Quality Care

“To what extent are CARE Act grantees/providers providing quality care to clients as defined by Public Health Service and other care standards? Is the care having optimal effects on morbidity and mortality, and is it improving health-related quality of life?”

EVALUATING PEER PROGRAMS: CHOOSING OUTCOMES FOR PEER PROGRAMS

“How do peers impact client satisfaction with health care services and overall quality of life?”

Example: Peers provide support and mentoring to HIV-positive clients on how to talk with their health care providers about treatment and managing life with HIV. This could be done through either peer-led support groups or one-on-one peer-client meetings. These measures provide the client perspective on quality of care and on how peers influence client satisfaction with care.

Outcome Indicator: The program may measure client satisfaction using a survey or questionnaire that asks clients to rate their experience with a program. In the [Program Resources](#) for Section 7 Evaluating Peer Programs there are sample surveys that could be adapted for peer programs. To measure if HIV peer services have an impact on overall client quality of life, a program could use validated instruments such as the Medical Outcomes Study Quality of Life[®] (<http://www.qualitymetric.com/WhatWeDo/GenericHealthSurveys/tabid/184/Default.aspx>) or the HIV/AIDS Targeted Quality of Life Instrument (<http://www.popcouncil.org/horizons/AIDSquest/summaries/sshatqol.html>).

Outcome indicators may be:

- Number of clients enrolled in support groups
- Number and type of peer-client encounters
- Number or percentage of clients of peers reporting a positive rating for health care services

A **long-term outcome** example may be:

- Improved health-related quality of life among clients receiving peer services

Next Steps

Once an organization has compiled its list of potential outcomes and indicators, the list must be reviewed and prioritized. There may be outcomes and indicators included in the list that are unimportant or off-target from the goals of the program.

Logic models can play a helpful role in organizing and refining this list. As you will see in the next section ([Section 7.2 Logic Models for Peer Programs](#)), logic models can be a useful tool for focusing evaluation activities and give a logical graphic representation to a peer program evaluation plan.

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

► FOR MORE INFORMATION

Read More for Subsection 7.1

- HRSA indicators
- Sample evaluation plan: A peer program in a clinic to improve retention...
- Sample evaluation plan: A peer program in a CBO to identify and engage HIV-positive clients...

Additional Evaluation Subsections

- 7 Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and resource planning
- 7.6 Protection of human subjects and evaluation

Resources for Section 7

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: HRSA INDICATORS

An example of how peer programs can contribute to achievement of HRSA's performance indicators

In 2008, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) began releasing recommended core clinical performance measures which may be used by all Ryan White-funded programs. These measures were developed to help and encourage programs to track and monitor the quality of the care and services provided to people living with HIV/AIDS (PLWHA) and are being released in phases to allow staged implementation. A complete list and description of these measures are provided at <http://hab.hrsa.gov/deliverhivaidscares/habperformmeasures.html>. Tools and technical assistance for implementing all the measures are also available at this site.

In addition, there are two measures for tracking and monitoring medical case management services and its impact on HIV primary care visits. While these measures were developed for Ryan White Grantees specifically, they can be adapted and applied to all clinic and community-based programs that provide HIV services. Peers who are trained and supervised appropriately can help HIV-positive clients receive essential medical and social support services and improve adherence to treatment. [Read More section B](#) and [Read More section C](#) provide examples of how a clinic or a community-based organization might incorporate and measure the contributions of peer programs into their existing program goals and work plans.

This “Read More” section accompanies [Section 7.1, Evaluating Peer Programs: Choosing the Outcomes to Measure](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: IMPROVE RETENTION IN CARE

The ABC Clinic’s Peer Program

The ABC Clinic located in a metropolitan area provides HIV medical and case management services to approximately 1000 HIV-positive patients annually. A recent chart audit revealed that only 50% of its HIV-positive patients had at least 2 medical visits in a 12-month period, and focus groups with case managers and HIV-positive patients reported a greater need for addressing HIV treatment concerns. As part of its quality management plan, the clinic has identified the goal of improving retention in care and treatment for its HIV-positive patients. At a recent meeting with other community area providers, the clinic decided to implement a peer program to improve the engagement in care of newly diagnosed and out-of-care persons with HIV, and enhance retention of current clinic patients in HIV medical care. The clinic plans to hire 3 outreach peers and 3 adherence peers to work with its case managers and other community programs to achieve these goals. Below is a potential work plan and key measures for the clinic to monitor and evaluate the peer program within its existing services.

Goal: Design and implement a peer program to improve retention in HIV medical care and receipt of support services.

Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.1 Link at least 60% of those newly diagnosed with HIV by the Counseling & Testing sites (C &T) to HIV primary care at the clinic within 90 days of receiving test results	<ul style="list-style-type: none"> • Outreach peers attend weekly Counseling & Testing sessions with C &T staff • Outreach peers make initial introduction and appt for case management services • Outreach peers inform C & T sites that referrals are completed 	<ul style="list-style-type: none"> • Outreach peers • Counseling & testing sites 	<ul style="list-style-type: none"> • Number/demographics and time to entry to care at the clinic • Number of HIV-positive referrals to outreach peers from rapid HIV testing • Number of HIV newly diagnosed with at least 2 case management appts in 6 months time 	Process: <ul style="list-style-type: none"> • Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Referrals logs 	Reduce unmet need for HIV care & services

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: IMPROVE RETENTION IN CARE

Goal: Design and implement a peer program to improve retention in HIV medical care and receipt of support services.					
Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.2 Link at least 60% of out-of-care clients from community partner sites to clinic services	<ul style="list-style-type: none"> • Outreach peers respond to referrals from other partner sites • Outreach peers link out-of-care clients to case managers at clinic and CBO partners 	<ul style="list-style-type: none"> • Outreach peers • Community partner sites 	<ul style="list-style-type: none"> • Number /demographics and time to entry to care at the clinic • Number of HIV-positive referrals to outreach peers from community partner sites • Number of HIV-positive clients with 2 case management appts. in 6 months' time 	Process: <ul style="list-style-type: none"> • Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Referrals logs 	Reduce unmet need for HIV care & services
1.3 Provide HIV primary care and social support services to 30 newly diagnosed persons living with HIV, 100 out-of-care clients and 1000 currently enrolled HIV-positive clients	<ul style="list-style-type: none"> • Adherence peers w/case managers develop care & treatment plan for HIV-positive clients • Adherence peers make follow up phone calls for HIV medical visits, lab tests and case management appts • Adherence peers accompany HIV-positive clients to HIV social and medical visits as requested 	<ul style="list-style-type: none"> • Adherence peers • Case managers at clinic and CBO partners • Clinic staff 	<ul style="list-style-type: none"> • Number/demographics of HIV-positive clients with care & treatment plan • Number/demographics of HIV-positive clients who achieve care & treatment plan goals • Number/type of services referred and used by HIV-positive clients • Number/demographics of HIV-positive clients with at least 2 medical visits in measurement year (both on ART and those not on ART) • Number/demographics of HIV-positive clients (both on ART and those not on ART) with at least 2 CD4 and viral load lab tests in measurement year 	<ul style="list-style-type: none"> • Chart audits • Client surveys- HIV Patient satisfaction survey • Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) • Case manager treatment plans completed 	<ul style="list-style-type: none"> • Reduce barriers to care • Increase in number of clients with undetectable viral loads • Increase in number of clients with 2 or more medical visits

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: IMPROVE RETENTION IN CARE

Goal: Design and implement a peer program to improve retention in HIV medical care and receipt of support services.

Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.4 Provide adherence education to at least 600 HIV-positive clients in the clinic	<ul style="list-style-type: none"> Adherence peers provide support to HIV-positive clients currently on ART Adherence peers assess HIV-positive clients readiness for ART 	<ul style="list-style-type: none"> Adherence peers Medical staff at clinic Case managers 	<ul style="list-style-type: none"> Number of HIV-positive clients receiving ART education adherence sessions Number of HIV-positive clients with ART assessments completed Knowledge, positive behavior and attitude regarding ART for HIV-positive clients receiving counseling sessions 	<ul style="list-style-type: none"> Peer contact forms (See Sample Forms for Documenting Peer Work in Section 7 of Program Resources.) Treatment adherence survey Focus groups Attendance lists 	Increase in number of clients with undetectable viral loads

This “Read More” section accompanies [Section 7, Evaluating Peer Programs](#), part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.1 EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: INCREASE ACCESS TO SERVICES

The Smith County Service Program (SCSP)

The Smith County Service Program (SCSP) is a community-based organization (CBO) whose mission is to provide outreach and support services for people at-risk or living with HIV/AIDS. The program provides outreach and prevention education services to people at risk for HIV, runs support groups, and has a case management program for people living with HIV. Most of its HIV-positive clients receive medical care at the local hospital or the community-based health center nearby which also performs HIV counseling and testing. Working with its clinic partners, the SCSP decided to develop a peer program using funds from the state department of health (Ryan White part B program) to help identify newly diagnosed HIV-positive persons and out-of-care persons and enhance their use of case management services and subsequently HIV medical care. Below is a potential work plan and measures for monitoring the quality and success of the SCSP peer program.

Goal: Increase HIV-positive clients' access to and engagement with support and medical services.					
Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.1 Provide at least 2000 outreach encounters to at-risk HIV-positive individuals targeting substance users, homeless persons, MSM, women, and communities of color	<ul style="list-style-type: none"> • Conduct at least 8 education and outreach activities at the agency and in the community per week. • Identify and build relationships with at least 8 other social service agencies (food agencies, housing organizations, substance treatment providers, etc) to outreach to at-risk populations. • Refer at-risk individuals to HIV counseling & testing at the clinic 	Prevention Education coordinator and outreach workers	<ul style="list-style-type: none"> • Number of prevention education activities • Number and demographics of outreach encounters • Number of partner agencies conducting monthly prevention/ education sessions • Number of referrals to counseling & testing at the clinic 	Process: <ul style="list-style-type: none"> • Encounter forms (see Sample forms for documenting peer work in Program Resources.) • Referral logs 	<ul style="list-style-type: none"> • Reduced unmet need

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: INCREASE ACCESS TO SERVICES

Goal: Increase HIV-positive clients' access to and engagement with support and medical services.					
Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.2 Provide at least monthly case management services to 100% of HIV-positive newly diagnosed or lost-to-follow up individuals referred from the clinic	Hold monthly meetings with clinic staff to identify newly diagnosed or lost-to-follow-up HIV-positive clients.	<ul style="list-style-type: none"> • HIV case management supervisor • Peer • Case manager • Clinic staff 	<ul style="list-style-type: none"> • Number/ demographics of HIV-positive clients referred and enrolled in HIV case management services • Number of HIV-positive clients with case management plans and service goals • Number/types of services provided 	<ul style="list-style-type: none"> • Case manager treatment plans completed 	<ul style="list-style-type: none"> • Reduced barriers to care for newly diagnosed & lost-to follow-up
1.3 Provide weekly support groups to 80% of HIV-positive clients	<ul style="list-style-type: none"> • Conduct at least 2 groups/week around HIV care and treatment adherence, positive living, resources, and other consumer-identified topics • Recruit HIV-positive clients into support groups 	<ul style="list-style-type: none"> • Peer leader • Staff support group leader • Program Manager 	<ul style="list-style-type: none"> • Number and topics of support groups • Number of HIV-positive clients who attend support groups 	<ul style="list-style-type: none"> • Client surveys (see HIV patient satisfaction survey in Program Resources.) • Focus groups • Attendance lists 	<ul style="list-style-type: none"> • Improvement in self-reported quality of life

EVALUATING PEER PROGRAMS: CHOOSING THE OUTCOMES TO MEASURE

READ MORE: INCREASE ACCESS TO SERVICES

Goal: Increase HIV-positive clients' access to and engagement with support and medical services.					
Objectives	Activities/Action Step	Person (s) responsible	Measures/Indicators	Evaluation Methods	Outcomes
1.4 Link 80% of HIV-positive clients into medical and social support services	<ul style="list-style-type: none"> • Conduct reminder and follow-up phone calls regarding medical and social service appts • Accompany HIV-positive clients to medical & social service appts 	<ul style="list-style-type: none"> • Peers • Case Managers • Clinic staff 	<ul style="list-style-type: none"> • Number of HIV-positive case-managed clients with at least 2 medical visits in measurement year • Number of clients with CD4 & VL tests 	<ul style="list-style-type: none"> • Chart audits • Client surveys • Peer Educator Encounter forms • Treatment plans completed 	<ul style="list-style-type: none"> • Increase in number of clients with 2 or more medical visits in a 12-month period • Increase in number of clients with CD4 & VL tests

This “Read More” section accompanies [Section 7.1, Evaluating Peer Programs: Choosing the Outcomes to Measure](#), part of the online toolkit [Building Blocks to Peer Program Success](#). For more information, visit http://peer.hdwg.org/program_dev

7.2 EVALUATING PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS



"It may be a model, Captain, but it's highly illogical."

www.FieldstoneAlliance.org

[Logic Models: What are they and why would anyone besides Mr. Spock care?](http://www.fieldstoneAlliance.org) on <http://www.fieldstoneAlliance.org>

Many public service programs rely on logic models for program planning. Logic models are particularly useful for focusing evaluation activities and identifying program indicators to be measured, because they present a systematic, graphic representation of program resources, activities, and outcomes, and articulate the intended links among these program components.

While the visual scheme of a logic model may vary, it will always contain the following core components:

Inputs are the resources necessary to undertake program activities. Inputs are primarily material and human resources; non-material factors that enhance a program's ability to fulfill its goals may also be included in resources. Examples of non-material inputs include public support for a program from a Ryan White Planning Council or consumer advisory board; long-standing referral networks that facilitate case management; or a series of public presentations to build support for a new initiative.

Activities include the necessary steps of all phases of program implementation and the types of services provided. Hiring processes and the establishment of community partnerships are crucial activities in early phases of program development, as are providing adequate training and supervision of staff. Service-provision activities include conducting education and outreach, building relationships with social services agencies, referring at-risk individuals to HIV counseling and testing, and holding support groups on HIV care and treatment and positive living. Collecting data about program objectives, disseminating program results, and expanding the funding base are more significant activities during the evaluation phase of a mature program.

Outputs are the direct results of program activities, such as services delivered or tasks completed, which provide evidence of service delivery to the target audience as intended. Outputs may also be evidence of program development or structure, such as number of people hired, trained and supervised.

EVALUATING PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

Outcomes are specific, measurable changes that are linked to program activities and outputs. Such changes may occur in knowledge, skills, or behaviors of a program’s target population. Outcomes are often measured as:

- Short-term, occurring within 1 to 3 months of program activities.
- Intermediate, occurring within 6 months to a year.
- Long-term, manifesting over the duration of program activities.

Outcomes reflect a program’s objectives.

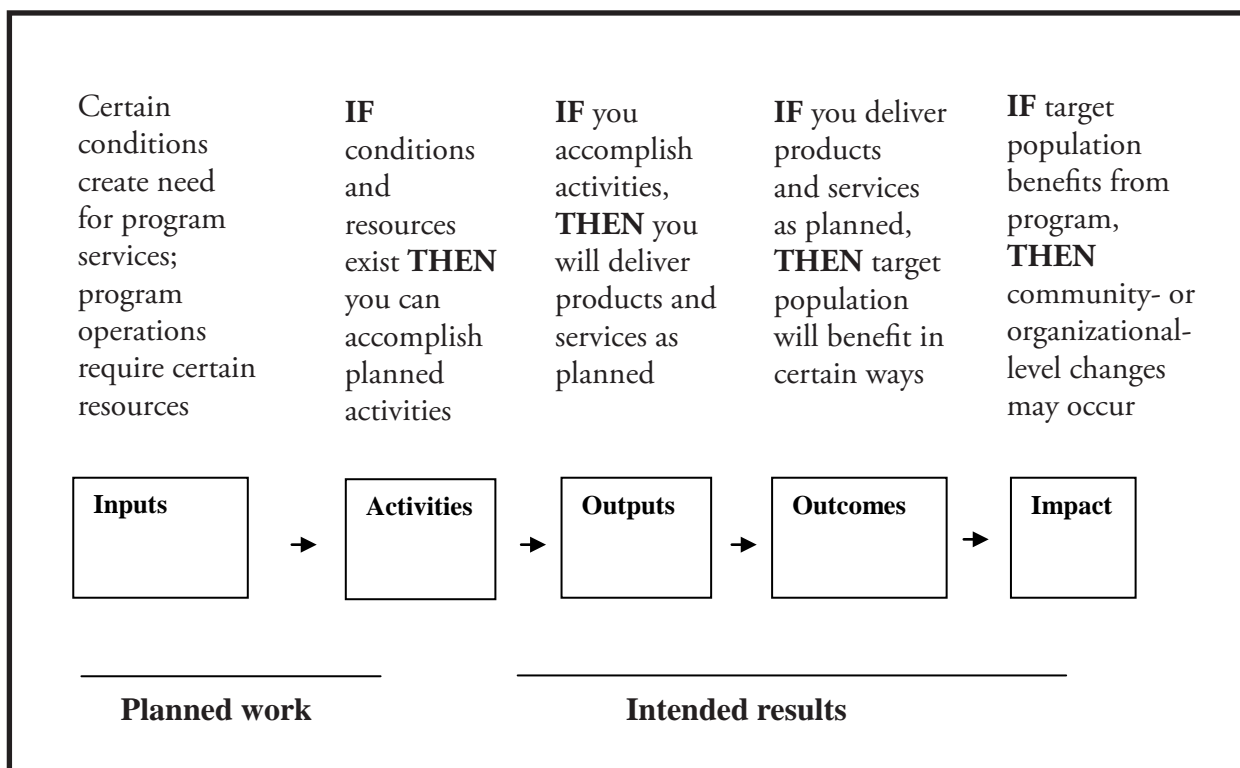
Impact is closely related to a program’s ultimate goal, and identifies broad-ranging, fundamental changes linked to program efforts. Impact is felt only after short- and long-term outcomes have

taken effect and may be dependent on factors beyond program outcomes or objectives.

The W.K. Kellogg Foundation describes the logic model as a series of “if – then” statements that map the intended road from program efforts to program results.

Process Evaluation and Logic Models

Creating a logic model helps inform and map out your program’s evaluation plan by more clearly defining the goals, outcomes, and indicators of your program. Logic models create a link between outcomes evaluation and process or implementation evaluation. Process or implementation evaluations are used to document and assess the intended links between components



The logic model is a series of “if-then” statements that map the intended road from program efforts to program results.

Adapted from W.K. Kellogg Foundation, *Logic Model Development Guide* (Battle Creek, MI, 2004), p. 3

EVALUATING PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

of the logic model, and to help refine the list of indicators created during the outcomes evaluation. Process or implementation evaluation uses the logic model to assess:

- How resources are invested in activities.
- How activities result in outputs.
- How outputs promote intended short- and long-term outcomes.

Information generated by process-evaluation efforts highlights where the intended links among program components are weak or broken.

Below is a sample logic model for a clinic who wanted to implement a peer program to improve client engagement in care and adherence to HIV treatment.

Logic Model of the Smith County Service Program

Inputs	Activities	Outputs	Initial Outcomes	Intermediate Outcomes	Long-term Outcomes
Program space and supplies	Build relationships w/ community partners	Effective community partnerships	Increased testing opportunities	Reduced barriers to testing & care	Reduction in unmet need
Prevention educators and outreach workers	Conduct outreach & community education activities	Prevention education activities	At-risk ind'ls receive HRT		
Clinic staff	Refer at-risk ind'ls for counseling & testing	Referrals made	At-risk ind'ls use program services	Increased proportion of HIV-positive ind'ls within target area engaged in care	Improved HIV medical outcomes
Case management team	Identify lost-to-follow-up clinic pts. for outreach efforts		Clients linked to case management		
	Provide case mgt for entry & re-entry into care	Follow-up services provided	At-risk ind'ls access medical & social services		
Peers	Facilitate support groups	Support groups held	Support group participants experience changes in knowledge & perceived social support	Support group participants experience changes in quality of life	Reduced experience of HIV-related stigma & discrimination
Evaluation team	Collect data related to program activities and outcomes	Program evaluation data collected	Program monitors activities	Program assesses outcomes toward stated outcomes or objectives	Evaluation of program success in meeting stated outcomes or program objectives

EVALUATION PEER PROGRAMS: INTRODUCTION TO LOGIC MODELS

► FOR MORE INFORMATION

Additional Evaluation Sections

- Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and Resource planning
- 7.6 Human subjects protection and evaluation

Resources

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.3 EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS



Two peers at Christie's Place

You can't just use quantitative data to evaluate the impact of peers. You have to use more qualitative data... It's not just about T cells, CD4 count, making it to your doctors' appointments on time. That's a big part of it, but what are the other quality-of-life measures we can look at to talk about the impact of this work on women who are positive?

Elizabeth Brosnan
Executive Director
Christie's Place
San Diego, CA

Getting Started: Monitoring and Documenting Peer Work

Documenting peer work with clients can help the program understand how peers are contributing to the success of HIV services. Integrating documentation of peer work with existing documentation processes can facilitate tracking and monitoring of peer work and program evaluation. Whether the current processes are paper charts or electronic medical records or databases, investigating the feasibility of peers documenting their work directly into those systems can save time and resources. It also increases the likelihood that the work peers do will be utilized by other members of the multidisciplinary team and helps to integrate the peers into the team. This can be a challenging process. Issues related to 'ownership' of the data in the record (electronic or paper) will have to be addressed, as will issues surrounding confidentiality, HIPAA compliance and patient privacy. (See [Subsection 7.6, Protection of Human Subjects and Evaluation.](#)) Resolution of these challenges will depend upon many factors within the agency and program.

If documentation of peer work cannot be integrated into the existing process, then developing simple tools for peers is important. The design of these tools and the data collected will depend upon the work peers are doing and the outcome measures for the program. For example, peers who help with support groups may want to keep attendance or sign-in sheets to document the number of persons, their gender, and the topic discussed. Peers who work individually with clients may want to use a contact sheet that can be filed to document the activities the peer did with the clients, any referrals that were made, and the length of time spent on the activity. For peers who are working with clients around treatment adherence, maintaining logs or sheets that describe their work and the progress made with a client is another valuable data-collection tool. This information can then be collected on a monthly or quarterly basis to describe the type of work peers are doing with clients and identify areas that could be improved. The [Program Resources](#) for Section 7 Evaluating Peer Programs provides data collection tools.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Data collection is an important aspect of peer program evaluation. Inaccurate data collection can impact the validity of the results of the project. Encouraging and training peers to consistently and accurately document their work with clients aids in the data-collection process. As peers work with clients, details of their work can be logged, either quantitatively or qualitatively, and this data can be monitored and compiled later on for analysis.

Data-Collection Methods: Qualitative vs. Quantitative

The first step is to decide the appropriate data collection method(s) for documenting and evaluating the peer program. Some methods assess how the peer program is contributing to overall HIV services at the agency. Other methods are more appropriate for identifying the impact of the program on peers and clients. Depending on the evaluation needs of the program, two types of data methods can be employed:

Qualitative Methods

Qualitative methods use scientific procedures to collect non-numerical, in-depth responses about what people think and how they feel. Qualitative data is often gathered during in-person interviews, written questionnaires, or observation. These methods often involve purposefully selecting participants from a larger population to examine a specific question. The participants are not randomly selected. This method can give outside audiences a real, personal understanding of the difference that the peer program makes in the lives of people. These methods provide valuable insight into attitudes, beliefs, motives and behaviors that can help to determine areas for quality improvement and program development. Qualitative data can be used as a formative process prior to collect quantitative data and to serve as a guide to direct

the evaluation process. Qualitative data can also be a stand alone method for program evaluation.

Examples of Qualitative Methods

Case Studies are detailed studies that document and present information on a particular participant or small group and frequently include the accounts of clients or peers themselves. The case study looks intensely at an individual or small participant pool, drawing conclusions only about that participant or group and only in that specific context. Emphasis is placed on exploration and description.

Advantages: Case studies fully depict the client's experience in the program process and results, and are a powerful means to portray the peer program to outsiders. For example, case studies may be useful for sharing and disseminating stories about how peers have helped clients with HIV medications.

Challenges: Case studies can be time consuming to collect, organize, and present. They represent a depth of information rather than a breadth of information.

Example: A program interviews a client of a peer to understand the client's experience with HIV care and treatment prior to working a peer, the motivation for seeking and working with a peer, and the impact the peer has had on the client's knowledge, attitudes and practices about HIV care and treatment.

Focus Groups are small groups (usually 6 to 10 members) brought together for guided discussions of a particular subject. The session usually lasts for 1 to 2 hours. A facilitator guides the group through a discussion that probes attitudes about client services. The discussion is loosely structured to allow for an open, in-depth examination of the thoughts and feelings of the clients. The facilitator is typically given a list of objectives or an anticipated outline to help guide the discussion. He or she will generally have only a few specific questions prepared prior to the focus group,

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS



“Typically, for a new person, I give out a survey so I know a little bit about how much they know about the disease. We do that every three months so we can see what they have learned that they didn't know before.”

Fred Glick
Peer Educator
Truman Medical Center,
Kansas City, MO

and these questions will serve to initiate open-ended discussions. Typically, a note taker is also present to record information by hand or with a tape recorder.

Advantages: Focus groups are a quick and reliable way to collect shared attitudes and feelings. They can be an efficient way to get a range and depth of information in a short amount of time and allow you to convey key information about the peer program.

Challenges: Information collected during focus groups can be difficult to analyze. A good facilitator is required to keep the group on track and for safety/closure. Also, participants of focus groups can be swayed by the comments made by other participants during the discussion, and therefore, data collected from focus groups may be more biased than interviews

Example: An agency that is just starting to design a peer program, invites and convenes a focus groups of 6-8 HIV-positive clients to learn about the strengths and challenges of peer programs and to collect ideas for peer roles that can help to improve the quality and efficiency of services.

Alternatively, a program may want to conduct a focus group with clients to identify successes and challenges in working with peers. The [Program Resources](#) for [Section 7, Evaluating Peer Programs](#) contain [Focus Group Guidelines](#) from the Kansas City Free Health Clinic and a [Peer Focus Group Guide](#) from the Massachusetts Department of Public Health.

Key Informant Interviews are in-depth interviews with people who have direct, personal experience with the program, such as peers or clients of peers. Many CARE Act grantees and planning groups use key informant interviews to obtain feedback on the adequacy of HIV services, gaps in care, and service barriers faced by different populations.

Advantages: Key informant interviews provide a full range and depth of information as well as help to develop a relationship with the interviewee. Additionally, follow-up questions can be included to clarify responses or to obtain additional details. Compared to focus groups, key informant interviews may yield more accurate information from participants, because interviews are typically

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

conducted one-on-one and in private, confidential settings. As a result, participants may be more willing to share their perceptions, knowledge and opinions.

Challenges: In-person key informant interviews can be time consuming and costly. It can be difficult to analyze and compare responses across interviews, and the potential exists for the interviewer to bias the information collected with his or her own perceptions or opinions.

Example: A program uses key informant interviews with clients to assess the role a peer played in a client's adherence to HIV care and treatment. The [Program Resources](#) for [Section 7, Evaluating Peer Programs](#) provides an [Example of a Qualitative Study Design and Interview Guide](#).

Quantitative Methods

Quantitative methods use scientific procedures to obtain counts, percentages, and other forms of measurement data that can be subject to descriptive analysis or more rigorous statistical analysis. Quantitative data is often collected through closed-ended questions that require participants to count how many times an event has occurred or to rate their satisfaction using a numerical scale. These methods can gather data on a large, random sample of participants. This allows the data to be generalized to larger populations. However, quantitative methods often cannot collect in-depth, descriptive details on knowledge, attitudes, and beliefs of participants.

Examples of Quantitative Methods

Medical Record Reviews can be used to collect specific, predetermined data from medical / service records. Usually a pre-coded, medical record abstraction form is used to aid the review. This method is useful when a program wants to identify the impact of a peer program that works

with clients around adherence to treatment or staying engaged in medical care. This program could examine the medical records of clients of peers every 6 months and see how many medical visits and CD4 and HIV RNA tests they have had since working with peers. This may be an appropriate method for clinic-based peer services. For peers in a community-based setting, obtaining client medical records requires additional work and must ensure that appropriate client consents are in place. For more information, refer to [Subsection 7.6, Human Subjects Protection and Evaluation](#).

Advantages: Medical record reviews allow for comprehensive and historical information collection. In addition, the review does not interrupt the program or clients' routine by requiring them to answer questions. The systematic methodology of this data collection technique helps to avoid biases in the data collection process.

Challenges: Medical record reviews can be time-consuming and often information is incomplete. Sometimes it can be difficult to read medical records, and trained personnel may be needed to perform abstractions.

Example: At the Kansas City Free Health Clinic, 25-30 patient charts are randomly selected each month. The evaluation team reviews the charts and documents whether the client is in compliance with a specific indicator for engaging in medical care. Charts are examined to see if a client on ARV has had a primary care visit and a viral load and CD4 test in the past 4 months. This information is entered into a spreadsheet and submitted to the Manager or Director of the clinic department for quality management.

Written Questionnaires are documents containing a set of predetermined questions and other types of items (e.g., demographic information) designed to solicit information appropriate for analysis. Surveys often collect information on demographics and how many times services are used.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Advantages: Data retrieved from questionnaires can be compared much more easily across a large number of participants than data collected from interviews. Responses can be obtained in numerical form which makes statistical analysis possible. Most people are familiar with completing questionnaires, but skill is needed to design a good questionnaire that will result in reliable responses and ultimately provide valid results.

Challenges: Individuals are often not accustomed to communicating information through a questionnaire. Additionally, the questionnaire must be written at a literacy level that every respondent can understand and needs to be provided in the native language of the respondents.

Example: The [Program Resources](#) for Section 7 Evaluating Peer Programs provide an [HIV Patient Satisfaction Survey](#) for assessing client satisfaction with HIV services.

Face-to-Face questionnaires/Telephone

questionnaires are structured conversations between two or more people (the interviewer and the interviewee(s)) where closed-ended questions are asked. Open-ended questions may be asked as well.

Advantages: Follow-up questions can be included in face-to-face and telephone questionnaires to clarify responses or to obtain additional details. Literacy may not be as great an issue as with a written questionnaire. Importantly, data from individual responses can easily be used to generate group-level summary statistics.

Challenges: Interviewers should be trained in appropriate, non-biased interviewing skills. In addition to training interviewers, designing an interview tool can be time-intensive. Sufficient time should be given to survey methodology.

Example: The [Program Resources](#) for Section 7, [Evaluating Peer Programs](#) provide an [HIV Treatment and Adherence Survey](#) that can be given to clients of peers who are involved in HIV treatment support groups or individual counseling sessions. These surveys may be administered quarterly or semiannually.

Management Information Systems (MIS) are the processes in place to systematically collect and assess data to assist with program quality improvement. For example, questionnaires and forms can be used to document the work completed by a peer with a client. The information can then be entered into an electronic database to track the services each client receives. Periodic reports (monthly or quarterly) on the data are run and submitted to a manager/director who may use the data to distinguish the types of activities conducted by peers, make adjustments to peer workloads, and detect gaps and additional service needs. In some places, peers may enter their work with clients directly into the client's electronic record or chart. In other cases, to protect confidentiality of the client, the data collected by the peer is entered into a separate database and then later linked with other client information.

Advantages: Utilizing a MIS system can help facilitate program quality monitoring and management. A MIS helps to process and assess the peer work and isolate areas for improvements.

Challenges: Peers will need to be trained to document their work and will require supervision to ensure the data is collected and submitted in a timely fashion. Maintaining a MIS may be time consuming and costly for peers and staff.

Example: The example in the box below describes one clinic's MIS for its peer program on treatment adherence.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

► MANAGEMENT INFORMATION SYSTEMS (MIS) EXAMPLE

In a multidisciplinary, clinic-based ART-adherence-support program, peers actively reach out to their caseload of about 15 clients each in order to engage clients in care, help them identify and resolve barriers to becoming adherent, and help them build long-term adherence skills. Peers work collaboratively with the program case manager and health educator. Peers use a contact form to document all aspects of their work with clients in a user-friendly format. Refer to the [Sample Forms for Documenting Peer Work](#) in the [Program Resources](#) for Section 7 Evaluating Peer Programs for an example of a peer contact form.

- Date of contact
- Client code and peer code (using codes instead of names enables the system to merge peer-entered information with the larger database of client information while maintaining confidentiality)
- Type of contact
- Location of contact
- Life stressors addressed
- Referrals made
- Adherence questions addressed

Peers complete the form as soon as possible following each contact. The program coordinator reviews the contact forms weekly for completeness and discusses issues documented in the 'notes' section during bi-weekly individual peer supervision sessions.

The program's funding source requires that it report the number of peer-client contacts each month, along with other client indicators such as the number of HIV primary care and case management appointments kept, the most recent CD4 and HIV RNA measures, and any new diagnoses. Peer-client contacts are abstracted from peer contact forms each month and entered into the clinic's electronic information reporting system according to client ID. Monthly reports of patient-level program data are generated through the electronic system and submitted to the funder in accordance with funding requirements. Peer-client contacts become part of the client's chart and are reviewed by clinic staff as part of quality assurance and quality improvement efforts.

In addition to required reporting, the program evaluation team has determined to answer several program-specific evaluation questions and has identified corresponding indicators, collected from the peer contact form, that the program will track. The evaluation questions and indicators are:

Evaluation Questions	Evaluation Indicators
Do peers successfully reach program clients?	Ratio of successful contacts to attempted contacts
Do peer services address potential barriers to adherence?	Life stressors addressed
Do peers contribute to comprehensive service provision?	Referrals to program, hospital, and outside service providers
Do peers address adherence behavior in their interactions with clients?	Adherence questions addressed

The program case manager and health educator are responsible for entering evaluation indicators into a program evaluation database every week. The program coordinator generates reports summarizing the indicators every month and presents them to the evaluation team at monthly evaluation meetings. The evaluation team presents results at annual meetings with the program's stakeholders and advisors.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

Anonymity and Confidentiality

During data collection, an individual's identity must be protected in order to prevent unintended risks or harm to the individual. Two techniques that are used to protect an individual's identity are anonymity and confidentiality.

Anonymity

A survey or questionnaire is anonymous when the survey administrator or evaluator cannot identify a survey respondent based on his or her responses to survey questions. For example, a mailed survey can be considered anonymous if the survey does not ask for personally identifying information, such as respondent name, and if it is sent without any personally identifying information on the survey or envelope. Anonymity makes it difficult to follow up with respondents who did not complete the survey, since there is no process to identify who has returned the survey/questionnaire. However, anonymity allows the respondents to feel more comfortable answering the survey, and in turn, provide more honest and accurate information.

Confidentiality

A confidential survey/questionnaire collects personally identifying information, but this information is not shared with anyone outside of the peer program. In other words, information

from confidential surveys is presented anonymously, but not collected anonymously. For example, a respondent's response to missing their medication can be made public, but the individual respondent information remains private. This type of information is reported as aggregate data, or group data, but not by individual.

To ensure confidentiality, a number of procedures can be followed. First, individuals administering protocols and/or who have access to identifying information should be trained in their ethical responsibilities. (Refer to [Subsection 7.6, Protection of Human Subjects and Evaluation](#) for more information on training.) Second, all names, addresses, and any other personally identifying information should be removed from the questionnaires and replaced with an identification number or code. A master identification list should be created linking the identification number or code to the names and only used as necessary. For example, the master identification list can be used to correct missing or questionable information, or to send a follow-up questionnaire. This allows you to track down individuals who have not yet completed the survey or who have left parts of the survey incomplete or ambiguous.

It is important to inform the individuals participating in any form of evaluation whether their information is confidential rather than anonymous.

EVALUATING PEER PROGRAMS: DATA COLLECTION METHODS

► FOR MORE INFORMATION

Additional Evaluation Subsections

- Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and Resource planning
- 7.6 Human subjects protection and evaluation

Resources for Section 7

(available at http://peer.hdwg.org/program_dev/resources)

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.4 EVALUATING PEER PROGRAMS: ANALYZING AND DISSEMINATING EVALUATION RESULTS

Due to our peer navigators' assistance with contacting our no-show clients, our no-show rate is stable at 29%, which is a 10% improvement. Making sure that the majority of our clients are in here and receiving health care on an ongoing basis--that's success to us.

Lucy Wells
Business Manager/Ryan White
Project Director
Boulevard Comprehensive Care
Center
Jacksonville, FL

Once an evaluation design has been chosen, a logic model developed, and data collection strategies and continuous quality control methods are in place, the program can begin to explore the meaning of the information. The plan for the use of the data influences the type of analysis. Data analysis also depends on available resources such as staff with expertise and software for analysis. Data analysis can be as simple or rigorous as necessary to meet the needs of the program. Many programs conduct data analysis for internal purposes (quality management and program improvement) and reporting to funders. Others are interested in disseminating the results through publications and presentations to share results with the broader community. It's important to have a clear understanding of the use of the data prior to data analysis.

Data Preparation: Coding and Cleaning

Before beginning analysis, it is important to prepare the data. For quantitative data, an important first step in this process is data coding. If statistical software is available, it is necessary to assign numeric values to each response. For example, a "Yes" response can be assigned the number "1" and a "No" response can be assigned the number "0." Assigning numbers to character responses will aid the data entry process and will allow the software to run frequency counts more easily and efficiently. The end product is a codebook that will be used for labeling and tracking variables.

For all software programs, it is important to thoroughly check the data to ensure that it's free of errors after it has been entered. This process is called **data cleaning**. Cleaning data is usually conducted by someone other than the person who entered the data and involves running frequencies to identify responses that seem out of the ordinary or missing data. In continuous quality improvement, cleaning data involves conducting a random audit by comparing information on the reporting form with the entered data.

If a program is analyzing qualitative data, data preparation involves organizing the documents for review or transcribing text from interviews and observations into a word-processing file.

EVALUATING PEER PROGRAMS: ANALYZING & DISSEMINATING EVALUATION RESULTS

Preliminary Data Analysis

Once the data has been properly entered and cleaned, the next step is to run preliminary analyses to gain understanding of the data and recognize any simple trends. For quantitative analysis, the program should begin with a descriptive analysis. Descriptive analyses involve calculating the mean, median, and variation in responses to determine the general trends in the data. In qualitative analysis, exploring the data involves reading through all the data to develop a general understanding of the database while recording initial thoughts in the margins of the transcript or field notes.

Unless the organization has invested in statistical software such as SPSS (<http://www.spss.com>) or SAS (<http://www.sas.com>), the program will be limited to conducting analyses by hand. For example, the Smith County program, described in [Read More C: Sample Evaluation Plan](#) found in [Subsection 7.1](#), tabulated frequencies of the number of community partner testing opportunities before the program started and compared them with the number of community partner testing opportunities at the end of the program period in order to measure the number of increased testing opportunities. Frequencies, or counting the number of recurring events, are the most common analytical tests of measurement. Frequencies will not reveal the cause for the number of recurring events, but instead will clearly provide information on how many times an event happens in a specific time period. Frequencies can be used to recognize trends in peer work, changes in clients' access to services, and other peer program outcomes.

Microsoft Excel can also be used to conduct preliminary data analyses. The program can be used to run frequencies, calculate means and medians, and create charts to visualize your data. Data

entered into Excel can be imported into both SPSS and SAS for further, more advanced analyses. For more information on how to import Excel spreadsheets, visit the Help sections in SPSS or SAS or their websites at <http://www.spss.com/> and <http://www.sas.com/technologies/analytics/statistics/stat/>, respectively.

Advanced Data Analysis

Quantitative Data

With quantitative data, advanced analysis uses appropriate statistical tests to address the questions, objectives or hypotheses that were established early in the planning or design process of the peer program. Statistical tests might include generating cross-tabulations to compare two different variables or running t-tests to determine the statistical significance of responses between two time periods, such as pre- and post-test.

Qualitative Data

Qualitative analysis involves more steps than most quantitative analysis techniques. It begins with coding the data, dividing the text into small units, and assigning a label to each unit or piece of text. Code words are assigned to text segments and then recorded into broader themes.

For example, an excerpt from a client interview may contain the client's thoughts on keeping appointments and adhering to medication. These different paragraphs would be separated into smaller units by placing the text in separate files or index cards. Then, the paragraphs would be labeled separately under the code words "appointments" and "medication," and may ultimately be recorded under a broader theme entitled "Adherence to Care and Treatment."

EVALUATING PEER PROGRAMS: ANALYZING & DISSEMINATING EVALUATION RESULTS

Themes can then be grouped into larger dimensions or perspectives related or compared. The themes or larger perspectives are the findings or results that provide answers to the program's initial objectives or hypotheses. It is a good idea to use a trained evaluator to run the qualitative data analysis process.

Dissemination of Findings

Sharing and disseminating results is an important final step in program evaluation. Dissemination of the results with stakeholders can lead to new programs and policies or improve and change existing ones. Evaluation results can be disseminated outside the program at national, state, or local events through presentations, workshops or posters and through written methods such as publications, review articles, or via the World Wide Web. Program staff can use evaluation results internally to improve systems and practices. Deciding a dissemination strategy during the design of the evaluation plan can help to facilitate data analysis and dissemination.

One of the most effective ways to increase the utilization of data analysis findings is to present the findings in a way that are of direct practical use to the program stakeholders. Depending on the audience, a program may want to present only a

summary of the findings or provide a full report of the findings. In either situation, it is important to keep the presentation focused on the key findings. Ideally, the program should bring together evaluators with key program staff to determine what key findings they want to present. A joint meeting is an effective way to discuss the meaning of the data from the program staff perspective. This tandem team strategy also can be helpful for deciding appropriate recommendations to assure practicality while staying true to the data. Plan the written report to make it simple, attractive, and user-friendly. Often, the best way to communicate the results is through narratives that reference tables and charts. Whether the findings are based on quantitative or qualitative methodologies, the use of visual or verbal presentations to complement written reports is universally accepted.

Some of the valuable uses of evaluation findings include:

- To improve/enhance programs or create new ones.
- To report/validate program effectiveness to current or potential funders, grantors, etc.
- To effect policy changes.
- To share positive findings with others through oral presentations, professional journal articles, etc.

The [Communicating and Reporting Plan](#) in [Program Resources](#) for [Section 7, Evaluating Peer Programs](#) provides steps to developing a plan for disseminating the results of a peer program evaluation.

¹Norušis, M. J. and SPSS Inc. 2000. *The SPSS Guide to Data Analysis for Release 4*. Chicago: SPSS

EVALUATING PEER PROGRAMS: ANALYZING & DISSEMINATING EVALUATION RESULTS

► FOR MORE INFORMATION

Additional Evaluation Subsections

- Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and Resource planning
- 7.6 Human subjects protection and evaluation

Resources for Section 7

(available at http://peer.hdwg.org/program_dev/resources)

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.5 EVALUATING PEER PROGRAMS: EVALUATION AND RESOURCE PLANNING

Engaging peers in evaluating peer program effectiveness provides peer insight by accessing input from their role as both consumer and provider. By virtue of this distinct role, peer contributions at every point of program development ensure that programs and evaluation measures are well thought-out.

Laura Fizek
Associate Director
JRI Health-Center for Training &
Professional Development
Boston, MA

Being able to document, monitor, and evaluate the contributions of peer programs requires sufficient financial and human resources. The following are recommended guidelines for evaluation resources and planning:

Incorporate peer perspectives: Peers can be thought of as straddling the often disparate worlds of program staff and program clients. They share many experiences with a program's clients or target community, and at the same time understand the program's activities, objectives, and goals from a staff or 'insider' perspective. Thus peers can make a unique contribution at every stage of evaluation planning, implementation, and analysis. Peers may understand more clearly than staff which evaluation questions are meaningful to the population they serve. They may also be effective in getting frank feedback from community advisory boards and other community stakeholders about program evaluation. Peers can also provide insight into what data collection methods would be more acceptable to a particular population and how best to engage clients in the data collection effort. To the extent that they are representative of the population receiving program services, they can also pilot or 'test-drive' data collection instruments to ensure that they are comprehensible and culturally appropriate. With proper training and supervision, peers can also be engaged in data collection efforts. Finally, whether or not peers are involved in conducting the analysis of evaluation data, their perspective on the implications of the evaluation results for the community is invaluable. Peers can also suggest means of making the evaluation results known, such as local TV and radio programs, community events, and consumer-oriented publications, that program staff are not aware of.

Identify evaluation staff: It is recommended that 10% of the program budget be set aside for staff who will be responsible for program monitoring and evaluation, reporting key successes to the entire program or agency staff on a regular basis, and identifying areas for improvement for the program. It is recommended that evaluation staff not hold responsibilities related to the delivery of program services so as to remain objective and fair in reporting results and outcomes of the program.

EVALUATING PEER PROGRAMS: EVALUATION & RESOURCE PLANNING

Consultants: Another option is working with a consultant on a periodic basis to assist the staff with documenting and monitoring program progress. A consultant can be contracted at various time periods to work with staff on:

- Designing an evaluation of services,
- Training staff to collect data to monitor program activities, and
- Analyzing data collected by the agency to identify program challenges and progress towards performance indicators and program outcomes.

Travel: In some cases, a program may want to include travel or transportation costs for evaluation activities. For example, if a clinic or organization would like to implement client focus groups on a semiannual basis to assess program impact on treatment adherence, providing a stipend or travel reimbursement for participants is likely to enhance participation in the group. Additionally, peers may need to visit clients at their home or accompany clients to appointments, depending on their scope of work. Therefore, it may be necessary to reimburse the peer for transportation costs.

Communications: Having resources allocated for postage and phone communications can help a peer program document its activities. For example, an organization may want to provide the program with funds for sending out client satisfactions surveys to participants in support groups or conducting follow-up phone calls with clients to understand and document why a medical appointment was missed.

Training costs: If peers will be required to document their work, program supervisors and managers should set aside resources to train peers on how to document their activities with client, either electronically or on paper, so that the

data can later be entered by other staff members. In addition, a program may want to set aside some funds for future trainings on documentation.

Printing and duplication of forms: For programs that do not use electronic data systems or decide they do not want peers to enter their work directly into an electronic system, it may be necessary to print forms that peers and supervisors will use to track their work. An organization may want to consider printing forms in duplicate so that the peer and supervisor can keep one copy for their records and another can be entered as part of the client's official medical or program chart.

Equipment and software: Deciding how to store and analyze the data for the program is important. Even if the peers are tracking activities on paper, it is recommended that an organization use a software package such as MS Access or Excel to store data for ease of data management and analysis. For in-depth analysis, the organization may want to purchase software packages such as SPSS or SAS for quantitative data or Nvivo for qualitative data.

Supplies and materials: Depending on the evaluation plan, a program may want to allocate funds for purchasing notebooks, pens, pencils, and carrying cases for peers to use in the documentation of their work with clients. In addition, the program should consider purchasing supplies to support the facilitation of focus groups and client surveys. This may include purchasing food, drinks, reading materials, and things to entertain children. Creating incentives and reducing barriers to a client's participation in a study can help facilitate the data collection process.

EVALUATING PEER PROGRAMS: EVALUATION & RESOURCE PLANNING

► FOR MORE INFORMATION

Additional Evaluation Subsections

- 7 Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and resource planning
- 7.6 Human subjects protection and evaluation

Resources for Section 7

(available at http://peer.hdwg.org/program_dev/resources)

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

7.6 EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

► IRB RESOURCES ON THE WEB

The role of the Institutional Review Board (IRB) is to ensure that human subjects involved in research and evaluation activities are not placed at undue risk or coerced into participating.

http://www.hhs.gov/ohrp/archive/irb/irb_guidebook.htm : Use the IRB Guidebook, produced by the federal department of Health and Human Services (HHS), to become familiar with the issues and concepts that underlie IRB regulations.

<http://www.hhs.gov/ohrp/policy/faq/> : This website has a list of frequently asked questions that describes HHS/OHRP's thinking on quality improvement activities and human subjects research

<http://www.hhs.gov/ohrp/assurances/> : Use this HHS website to search for a local registered IRB or to consult a list of frequently asked questions about IRB registration

<http://phrp.nihtraining.com> : Use this National Institutes of Health online training to become certified in human subjects protection

The role of the HIPAA is to ensure patient confidentiality.

<ftp://ftp.hrsa.gov/hab/hipaa04.pdf> : Use this resource guide for HIV services providers to become familiar with the Privacy Rule as it pertains to CARE Act grantees.

A crucial step in developing a peer program is to secure necessary approval for all phases of program implementation, evaluation, data collection, and data analysis. Obtaining approval from an Institutional Review Board (IRB) may be necessary depending on the design of the evaluation, the type of data that is being collected and analyzed, how the results will be used, and who is participating in the evaluation. The purpose of an IRB is to ensure that human subjects who are involved in research and evaluation activities are not placed at undue risk and are participating in activities with informed consent and without coercion. This section describes the role of the IRB and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in the protection of human subjects and patient confidentiality.

Some evaluation activities may be considered quality improvement (QI). QI refers to measures to continuously monitor and improve the quality and efficiency of services by systematically assessing program components. QI is built into routine program activities, so that service providers and administrators are engaged in monitoring and improving progress toward program objectives and goals. QI typically involves the review of patient or client records and/or anonymous surveys.

All staff members, including peer workers, who are involved in the collection, storage, or analysis of QI data must be trained to understand and comply with all guidelines concerning patient/client confidentiality, the Health Insurance Portability and Accountability Act (HIPAA), and the protection of human subjects in research (see below).

Although QI shares many characteristics with research, the two endeavors are essentially distinct. QI initiatives generally examine internal processes and work to generate solutions to process-type problems, and often have a limited, internal audience. Another criterion of QI initiatives is that the majority of clients are likely to benefit from the knowledge gained, and the clients are not subjected to additional risks or burdens beyond general clinical practice. QI initiatives may not typically be seen as research. Helpful criteria have been proposed for differentiating **QI and research** (Reinhardt, 2003)

EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

The table below helps to outline these distinctions.

Institutional Review Board (IRB)

In the United States, IRBs are governed by Title 45 CFR (Code of Federal Regulations) Part 46. Legislation in the mid-1970's provided the guidelines for IRBs and defined their roles and responsibilities for the review of research activities subject to regulation by the federal Department of Health and Human Services (HHS). The Office for Human Research Protections in HHS regulates and oversees IRBs. For more information see: http://www.hhs.gov/ohrp/archive/irb/irb_guidebook.htm

To determine whether IRB regulations apply to an evaluation program, two questions need to be answered: 1) do the evaluation activities constitute

research; and 2) do the activities involve human subjects. Each term has a technical definition within OHRP. For example, research means “a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.”¹

Human subjects means “a living individual about whom an investigator (whether professional or student) conducting research obtains 1) data through intervention or interaction with the individual, or 2) identifiable private information.”¹

It is possible that some evaluation projects will require an IRB approval, while others may not. Likewise,

DIFFERENCE BETWEEN QI AND RESEARCH

Criteria	Quality Improvement	Research
Intervention	Accepted practice or treatment intervention not previously implemented	New, untried practice or treatment intervention
Risk	Absence of risk to participants	Presence of risk, however slight, to participants
Audience	Primary audience is the organization Information is applicable only to the organization	Primary audience is the scientific community and consumers Information is generalizable

¹<http://www.hhs.gov/ohrp/policy/engage08.html>

EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

► HIPAA RESOURCES ON THE WEB

The role of the HIPAA is to ensure patient confidentiality.

<ftp://ftp.hrsa.gov/hab/hipaa04.pdf>

Use this resource guide for HIV services providers to become familiar with the Privacy Rule as it pertains to CARE Act grantees.

<http://privacyruleandresearch.nih.gov/>

This HHS National Institutes of Health website provides HIPAA resources and educational materials.

some research projects will need IRB oversight while others may not. The best way to address the issue, again, is to contact an IRB representative and discuss the proposed project activities to determine if they meet the definitions of “research” and “human subjects.”

Where are IRBs and who serves on them?

Most colleges and universities maintain IRBs, since these institutions routinely implement research funded by federal agencies involving human subjects. IRBs can also be found in most state and county health offices, and within medical clinics and social service agencies. There also are private IRBs that charge a fee for the review process. IRBs have guidelines about the types of applications they will accept for review. For example, universities may not review an application if it does not involve any of their staff, faculty, or students. The composition of an IRB is outlined in federal regulations. An IRB must have at least five members—some with and some without research expertise. IRBs should also include men and women from diverse professional fields and there should be at least one scientist and one non-scientist. At least one non-scientist member is not affiliated with the organization. The goal is to have a diverse board that understands research as well as local community standards and conditions. To find a local IRB, visit the Department of Health and Human Services website at <http://www.hhs.gov/ohrp/assurances/>

Criteria for IRB approval of research

An IRB representative can help determine if the evaluation activities meet the criteria for IRB review. If an application to a local IRB is required, the board members will consider whether all of the following conditions are met in the proposed activities: 1) risks to subjects are minimized, 2) risks to subjects are reasonable in relation to anticipated benefits (to participants or society), 3) selection of subjects is equitable, 4) informed consent will be sought from each prospective subject or the subject’s legally authorized representative, 5) informed consent is appropriately

PROTECTING HUMAN SUBJECTS AND EVALUATION

documented, 6) the research plan provides for monitoring the data collection process to ensure the safety of participants, and 7) there are adequate provisions to protect subject privacy and maintain confidentiality of data collected.

Training in the Protection of Human Subjects

Regardless of whether evaluation efforts qualify as research, it may be helpful to have all parties that are involved in evaluation certified in human subjects protection. Check with a local IRB and ask about completing human subjects protection training. Most trainings, if not all, can be completed online. A curriculum offered by the National Institutes of Health (NIH) takes about 90-120 minutes to complete. It includes reading materials and a number of quiz questions. Successfully completing the quiz questions allows the participant to print a certificate documenting completion of the curriculum. The course can be found at: <http://phrp.nihtraining.com>

HIPAA Guidelines

In all aspects of evaluation, patient confidentiality must be maintained and the Health Insurance Portability and Accountability Act (HIPAA) guidelines need to be followed carefully. The HIPAA privacy rule covers all protected, personally identifying health information.

The HIPAA privacy rule covers **individually identified health information** which is any health information that can be used to identify an individual. **De-identified information** is not covered by the privacy rule.

There are 18 identifiers that must be removed from data (such as medical record data) in order for it to be considered de-identified. These include name, social security number, dates of service and medical record number, among others. The organization should review the HIPAA guidelines put out by HRSA at the following site: <ftp://ftp.hrsa.gov/hab/hipaa04.pdf>

This information will help determine if the program is in compliance with HIPAA regulations. It may also be necessary to also discuss this with a project officer.

EVALUATING PEER PROGRAMS: PROTECTION OF HUMAN SUBJECTS AND EVALUATION

► FOR MORE INFORMATION

Additional Evaluation Sections

- 7 Evaluating peer programs: Introduction
- 7.1 Choosing the outcomes to measure
- 7.2 Logic models for peer programs
- 7.3 Data collection methods
- 7.4 Analyzing and disseminating evaluation results
- 7.5 Evaluation and resource planning
- 7.6 Protection of human subjects and evaluation

Resources

(available at http://peer.hdwg.org/program_dev/resources)

- Sample forms for documenting peer work
- Logic Model Brainstorm (The Lotus Project)
- HIV primary care quality assurance program summary (Kansas City Free Health Clinic)
- Process evaluation plan (People to People)
- HIV patient satisfaction survey-English and Spanish (Kansas City Free Health Clinic)
- Treatment adherence survey (Kansas City Free Health Clinic)
- Communicating and reporting plan (Kansas City Free Health Clinic)
- Focus group guidelines (Kansas City Free Health Clinic)
- Peer focus group guide (Massachusetts Department of Public Health)
- Example of a qualitative study design and interview guide
- Additional evaluation resources and websites
- Validated evaluation instruments

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev

8. FUNDING SOURCES



Elizabeth Brosnan (standing, on right) with the Christie's Place staff.

“One of the major challenges that we are facing is the landscape of funding and the politics behind it for HIV services.”

Elizabeth Brosnan
Executive Director
Christie's Place
San Diego, CA

Securing Funding for Peer Programs

There are four main funding sources that a clinic or organization can approach for peer program support. The best strategy is to secure funding from more than one source to fully fund the program and establish a base of support that is diverse enough to provide program continuity—even if one of the funders discontinues the funding.

1. Community Planning Councils and Groups

Summary: Municipal or regional community planning groups conduct activities such as prioritizing and setting allocations for Ryan White funds, conducting needs assessments, and helping to meet gaps in services. Thus, they may have access to funding for peer programs through federal or state grants or subgrants, funneled through state and local departments of health. These groups/councils would make a good first step for an initial funding approach.

Advantages: Networking, interest, capacity, and track record are generally the criteria for funding, rather than formal grant applications. Therefore, funding might be easier to secure than, for example, funding from a federal grant or contract. Decisions are local and involve the major stakeholders in HIV prevention and care. Depending on the local group, funding might be made available immediately.

Disadvantages: Dollars for sub grants or subcontracts will likely be limited, may not fully fund a large peer program, and might not be sufficient to fund more than one clinic or organization in the local market. Availability and results will vary from municipality to municipality, and state to state, since the groups are local in nature, focus, and decision-making.

Resources: Contact the local community planning group or council. If a clinic or organization is not already involved with the local group, contact the local department of health to begin the discussion and to obtain an introduction to the group.

FUNDING SOURCES

2. Federal Funding

Summary: Depending on the size of the proposed peer program, competitive federal funding may be available to fund the project, either as a unique opportunity or as a part of a larger opportunity. HRSA and the CDC recognize and have funded peer programs in the past and may do so in the future.

Advantages: Under the right opportunity, significant dollars may be allocated to fully fund a substantial peer program.

Disadvantages: The application process will, as a rule, be more involved, longer, and technically more challenging than those for other funders. The reporting burden will also be greater, as will the accounting of funds and rules governing use of funds. Competitive funding opportunities are also time sensitive and subject to budgetary changes at the federal level.

Resources:

CDC Funding Opportunities:
<http://www.cdc.gov/grants/>

Office of Minority Health:
<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=1&lvlID=1> There are also links to other community grant opportunities off of this page.

HRSA Opportunities:
<http://www.hrsa.gov/grants/index.html>

General Federal Funding:
<http://www.grants.gov>

National Minority AIDS Council:
<http://nmac.org/> The NMAC is a governmental agency, but the website occasionally provides information about funding opportunities.

AIDS.gov:

<http://aids.gov/federal-resources/funding-opportunities/how-to-get-funding/> This provides a list of funding agencies and programs to explore. It's a good resource and starting point, but not a substitute for going to individual federal agencies for open opportunities.

Kaiser Family Foundation:

Go to the Kaiser Family Foundation website at <http://kff.org> and do a search on "U.S. Federal Funding for HIV/AIDS Fact Sheet" to find the latest information."

Many of these resources also have a page with community, foundation, or corporate grant opportunities as well, so they are good resources across the philanthropic sector.

3. Foundation Funding

Summary: There are many foundations, from local family foundations to large health care conversion foundations, with giving priorities that would fit well with peer programming. Any foundation that has one of the following giving priority areas of focus might be a good fit and would be a logical choice to contact for an initial conversation: HIV/AIDS; disease prevention; healthy communities; public health and welfare; health and/or human services; health literacy (an up-and-coming focus area); minority health; youth (if target population consists of this demographic in any significant way). Some foundations with a focus on nontraditional educational opportunities might also fit with aspects of a peer program. The sophistication levels of the foundations can vary widely, but there are numerous foundations, with presence in most markets, that would support this kind of programming.

FUNDING SOURCES

Advantages: Foundations with giving priorities that align with peer programs can provide a stable, long-term source of funding for a clinic/organization.

Unlike a federal grant opportunity, there is some room to maneuver within a priority area, and there is more freedom in program design and evaluation.

Disadvantages: The clinic or organization will likely need to devote substantial time researching foundation prospects and developing relationships with and proposals to the targeted foundation(s).

Resources:

For general foundation research, go to **Guidestar** at <http://www.guidestar.org> or **Foundation Center** at <http://foundationcenter.org/>. Both of these resources have subscription-based services, but a large volume of information is available free of charge (and there are ways to use the free system to get most of the information needed). Through both resources, foundations' 990s are available (and free), which essentially give a window to how much money the foundations have at their disposal, what organizations they've funded in the past, and what the giving priorities actually are. The Foundation Center also has grant writing tips and related information.

Local directories of grant makers: Most metropolitan areas have some sort of association of grant makers; for example, Chicago has the Donors Forum of Chicago, and St. Louis has the Gateway Center for Giving. These associations publish directories of foundations and other grant makers that are invaluable for prospect research. The directories allow sorting by topic/giving priorities, names, regions, etc. and are generally very reasonably priced. You can locate your regional association of grant makers at <http://www.givingforum.org/node/79>

National AIDS Fund: <http://www.aidsunited.org/>

The NAF generates resources for community responses to the HIV/AIDS epidemic and supports over 400 grassroots organizations annually to provide HIV services to underserved populations.

4. Corporate Funding

Summary: Similar to foundations and their giving priorities listed above, corporations offer ample opportunities for funding. In addition to searching by giving priority, clinics and organizations can also approach corporations whose business approach is in line with a peer program. For example, pharmaceutical companies, health-care-related companies, and corporations that have already supported HIV are reasonable choices to approach.

Advantages: Similar to foundations, corporations have varying levels of sophistication, and varying complexity in the application process. There can be flexibility with a corporate funder, and there is potential for a productive relationship and long-term source of funding. Corporate funders can be very generous and very committed.

Disadvantages: Many large corporations have a "What's in it for me?" component. In other words, many want a volunteer opportunity for their employees, or recognition via press releases, photo opportunities, naming rights, etc. Sometimes, even the most perfect fit and the most well-written proposal is not successful for reasons entirely out of the grant seeker's control. For example, corporate profits were low that quarter, or a corporate employee has already promised a large gift to another organization because he or she sits on that board.

Resources: Unfortunately, previous funding does not always predict future giving priorities. Some high-profile corporations that have supported HIV in

FUNDING SOURCES

► ADDITIONAL FUNDING RESOURCES

Other resources that can be useful in staying on top of funding opportunities include:

Philanthropy News Digest: You can get targeted email updates on funding trends and announcements.

Charity Channel: This is a subscription-based forum that offers funding announcements (as well as many other services).

Funders Concerned About AIDS: <http://www.fcaids.org>

This website, among other things, describes trends in giving to HIV/AIDS-related causes and issues alerts on new funding opportunities. They also list the top HIV/AIDS funders (foundations and corporations—look under publications).

Local United Way: United Way varies from market to market, but is still generally focused on human services. Even if there is no opportunity for funding directly from the United Way, they may know of resources or grant makers that would be interested in funding a peer program.

Local and State Departments of Health: Departments sometimes have discretionary funding that can be made available for projects they support.

Kaiser Family Foundation: <http://www.kff.org>

A private, nonprofit foundation focusing on major health care issues facing the U.S.

The Foundation Center offers “Cooperating Collections,” usually at libraries, nonprofit resource centers, or other agencies throughout the US. These collections host full-access databases, free fundraising information, and technical assistance. Locations can be found at <http://foundationcenter.org/collections/>

See [Grant websites and resources](#) in the [Resources](#) section for more ideas.

5. Other Fund-raising Ideas

Summary: In addition to grants and requests for restricted funds, clinics can and should consider including funding for peer programs as part of their unrestricted fund-raising activities. Examples of unrestricted fund-raising opportunities that can help support peer programs include:

- Direct mail programs
- Events
 - o Walks
 - o Trivia nights
 - o Silent auctions
 - o Breakfast/dinner events (many, many models to choose from, including “Benevon,” galas, young professional groups, etc.)
 - o Speaker series

FUNDING SOURCES

- Individual major gift fund-raising
- Planned giving (legacies and bequests)
- Online appeals, which can include:
 - Direct email solicitations
 - “Friends asking friends” and similar models
 - Facebook cause pages and other social media fundraising tools
- Third party fundraisers (that is, other people holding fundraisers or collecting donations on your behalf through events like car washes, penny drives, etc.)

Advantages: Offsetting the peer program’s expense budget with unrestricted revenue, generated through unrestricted requests for funding, communicates a commitment to the peer program to clinic donors, and allows the clinic some fiscal flexibility in supporting the program. It could be relatively easy to incorporate language about the peer program into existing fund-raising language, and into general information about the clinic or organization. Some of the models, such as “Friends asking friends,” walks and social media strategies,

can be great ways to engage a broad base of volunteers in fund-raising for the clinic, without having to be able to write large checks themselves. Many “Fund-Raising 101” resources are available online, at local universities, and through local nonprofits that serve as resources to other nonprofit organizations. There are also opportunities to partner with other agencies on some of these kinds of strategies to increase donations for and general awareness of both organizations.

Disadvantages: Pursuing this strategy assumes a baseline level of sophistication in fund-raising that a clinic or organization should have, or commit to gain—which often means committing financial resources as well. Event-driven fund-raising (such as walks, trivia nights, etc.) is extremely time-intensive, and an organization should have a good sense of how much staff time will be devoted to these efforts, and how much they can reasonably raise, before they commit to an event. Other strategies, such as direct mail, major gift fund-raising, and planned giving, require a minimum level of sophistication in data management and a donor pool with interest in and affinity to give to the organization.

Resources for Section 8 (available at http://peer.hdwg.org/program_dev/resources)

- [Grant websites and resources \(the Lotus Project\)](#)

This section is part of the online toolkit *Building Blocks to Peer Program Success*. For more information, visit http://peer.hdwg.org/program_dev