Peer Linkage and Re-Engagement of HIV-Positive Women of Color
Contents
Background ........................................................................................................................................ 2
Pre-implementation activities ......................................................................................................... 3
Supervision activities ..................................................................................................................... 7
Intervention Implementation Activities ....................................................................................... 8
Maintenance and Integration Activities ....................................................................................... 13
Appendices: .................................................................................................................................. 14
  Appendix A: Logic Model ........................................................................................................ 14
  Appendix B: Staffing Plan and Job Descriptions ................................................................ 15
  Appendix C: 3 Year Work Plan ............................................................................................. 22
  Appendix D: Patient Care Plan .............................................................................................. 27
  Appendix E: Patient Contact Form ....................................................................................... 29
Background

The Peer Linkage and Re-engagement intervention is designed to utilize HIV-positive peers to:

- Link women of color (WoC) who have recently been diagnosed with HIV to HIV primary care; and
- Re-engage HIV-positive WoC who have fallen out of care (have not attended an HIV primary medical appointment in the prior 6 months) back into HIV primary care.

This is a short-term intervention in which peers will work intensively with eligible patients to achieve the following milestones within 4 months:

- attend 2 medical care visits with a primary care provider;
- complete 1 lab visit; and
- attend 1 visit with a case manager.

There are three main resources that will facilitate a successful implementation of this intervention. The Implementation and Technical Assistance Center (ITAC) at AIDS United, the Dissemination and Evaluation Center (DEC) at Boston University, and the Health Resources and Services Administration (HRSA) have collaborated to create the following:

1. Training Manual
2. Implementation Manual
3. Evaluation Protocol

This Implementation Manual is the road map for the implementation process. It follows the intervention’s logic model (Appendix A) and 3 year work plan (Appendix C). This manual complements the training provided by the ITAC, and is not meant to serve as a substitution for any training components provided by the ITAC. If your site feels as though it needs additional training on any of the content or activities addressed in this manual, contact the ITAC:

- Erin Nortrup
  enortrup@aidsunited.org
  (202) 408-4848, ext 259
- Marlene Clarke
  mclarke@aidsunited.org
  (202) 408-4848, ext 218
- Hannah Bryant
  hybrant@aidsunited.org
  (202) 408-4848, ext 261

All evaluation activities, protocols, and tools are included in the evaluation protocol. For all evaluation related questions or technical assistance needs, contact the DEC:

- Jane Fox
  janefox@bu.edu
  (617) 638-1937
- Alexis Marbach
  amarbach@bu.edu
  (617) 414-1411
Pre-implementation activities
The following are programmatic requirements that need to be addressed prior to implementation:

☑ Clinic administration will establish an internal champion for the peer program. This internal champion does not have an established list of activities, rather the champion will help the intervention team to gain the internal support and resources necessary to facilitate implementation. The intervention team, once hired, will provide ongoing programmatic updates to the internal champion (at intervals agreed upon by the intervention team and the champion). The internal champion may or may not be part of the intervention but must be on staff at the clinic and available to the intervention team.

☑ Clinic administration will hire peers (using the job description in Appendix B). In the Peer Linkage and Re-engagement Intervention peers are defined as HIV-positive individuals from the community who share characteristics and/or life experiences with the population that they serve, identify as women of color, are engaged in medical care and adherent to treatment, and are willing to openly share life experiences related to their HIV status. Program managers or supervisors will be proactive in recruiting appropriate candidates by:
  • Soliciting names of possible candidates from clinic providers, and other staff.
  • Generating emails, postings on websites, e-blasts on local clinic listservs.
  • Sending flyers or other materials to clinics, community-based organizations, AIDS service organizations, planning councils, etc.

☑ Clinic administration will provide clinic specific orientation and training to peers. 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. Sites will need to provide standard new-hire orientation as well as 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.

☑ Clinic administration will identify or hire an administrative peer supervisor and a clinical peer supervisor (using the job description in Appendix B). Effective peer supervision calls for a highly supportive supervisory style that borrows from mental health counseling, social work, and supervision. Peer programs across the nation have witnessed a high turnover rate among peers. In order to address this, the Peer Linkage and Re-engagement Intervention will implement two types of coordinated supervision that can positively affect retention rates among peers: administrative and clinical. Sites need to consider the implications of managing peers who are also clinic patients.

☑ Clinic administration will identify or hire a .50 FTE data manager (using the job description in Appendix B).

☑ Intervention team members (peers, administrative supervisor, clinical supervisor, and data manager) will participate in training provided by the ITAC.

☑ Intervention team members will participate in multi-site evaluation training provided by the DEC.
Intervention team members will conduct the following activities to ready program operations:

- Assess clinic space and secure space for intervention activities
- Plan for future Medicaid reimbursements (if applicable)
- Plan for obtaining billing codes for peer delivered services (if applicable).
- Obtain necessary technology (laptop, tablet, etc.) and secure internet capabilities at all locations where data could be entered.

Intervention team members will establish a regular meeting schedule between administrative and clinical supervisors and the peers.

Administrative and clinical supervisors will set up regularly scheduled meetings with peers to meet the goals described below for each level of supervision. It is recommended that a minimum of one hour of administrative supervision and one hour of 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.

Intervention team members will establish or strengthen working relationships with community partners to develop newly diagnosed patient lists and protocols to receive and provide community-based referrals.

- Intervention team members will define roles and responsibilities around communication to ensure open dialogue between peers, case managers, and clinical staff.
- Intervention team members will create and document protocols for internal and external referrals. This work will include connecting with any department of health supported staff or community agencies that specialize in patient outreach and identifying hard to reach individuals.

The internal champion will work with the clinic administration and the intervention staff to provide an overall orientation for all clinic staff members about the intervention to secure buy-in and cooperation. Regular updates will be provided to all clinic staff on the progress of the intervention.

Administrative and clinical supervisors will integrate peers into clinical team and case conferencing meetings.

Intervention team members will create effective feedback loops to engage peers in contributing to research meetings, social service coordination meetings, interdepartmental meetings, and strategic planning sessions.

Intervention team members will implement policies that address safety and boundary issues between peers and patients.

Clinic administration will provide hired and trained peers access to patient/patient information in the clinic EMR to both record their activities and review record for pertinent information prior to meetings with patient.
Intervention team members will work with the clinic administration and the internal champion to create daily “open” appointment times for peers to schedule patients for HIV medical appointments as needed.

The data manager in conjunction with clinic staff and the intervention team members will determine methods and create a protocol for identifying patients to be included on a monthly “out-of-care” list based on the following criteria.

Inclusion Criteria

- Age 18 or older; and
- HIV positive; and
- Identify as being female; and
- Women who identify as belonging to one or more of the following racial or ethnic categories: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latina, Native Hawaiian or Other Pacific Islander;
- Are receiving their HIV primary care at the clinic offering the peer intervention;
- AND at least one of the following criteria:
  - Are newly diagnosed; OR
  - Have never linked to care; OR
  - Have fallen out-of-care (i.e., have not attended clinic where they receive HIV primary care) for 6 months or more).

Exclusion Criteria

- Under age 18; or
- HIV negative; or
- Identify as being male;
- White, non-Hispanics of no other race or ethnicity; and
- Are currently linked to and retained in care at the clinic offering the peer intervention.

In addition to using EMR data, each clinic will develop a system within the health care team in which providers, case managers, or other staff look through their own caseloads and determine which of their patients meet the eligibility criteria. The data manager will be the point person for all team members and community partners to report to regarding patients who meet the eligibility criteria. Methods of identification will include: the review of clinic testing data to identify eligible patients who are newly diagnosed or have never linked to care (*if sites don’t offer testing but partner sites do, the data manager will reach out to partner agencies to identify patients who meet the eligibility criteria who would benefit from a peer linkage and re-engagement intervention); review of clinic appointment and EMR to identify eligible or have been out-of-care for six months or more; patient outreach (conducted by peers). Once eligible patients have been identified, intensive outreach to link patients will take place immediately. Outreach for this population requires regular communication with case managers; knowledge of the community,
resources, and partner agencies; and the time and commitment to get out of the office and into the community to find and meet with patients eligible for this intervention (“feet in the street”).

- Vetting of list at weekly clinical team meetings and using clinicians to assist in the identification of additional patients who may be eligible and/or patient with whom the clinician has concerns the patient is at high risk of dropping out of care or not linking into care due to comorbidities.
Supervision activities

Scheduled supervision from the administrative peer supervisor and the clinical peer supervisor is vital to the success of peer efforts with their patients, and is a key component to peer well-being and retention in their role at the clinic. The Peer Linkage and Re-engagement intervention requires, at a minimum, supervision meetings every other week between the administrative supervisor and the peer, and between the clinical supervisor and the peer. In addition, administrative and clinical supervisors, peers, and case managers will participate in weekly case conferencing meetings to provide an opportunity for peers and the clinical team to discuss pertinent patient issues.

The following activities are related to supervision:

☑️ The administrative supervisor will provide administrative supervision of peer(s) and the data manager every other week.

☑️ The clinical supervisor will provide clinical supervision of peer(s) every week.

☑️ The intervention team will hold weekly case conferencing meetings with clinical team, case managers, peers supervisors, and peers.
**Intervention Implementation Activities**

- Eligible clients identified in out of care list
- Administrative Supervisor assigns patient to peer
  * Peer offers intervention activities
  - Patient declines to participate
  - Patient agrees to participate
    - Peer asks patient if they want to participate in MSE
      - No
        - Patient is not enrolled in MSE
        - Peer and patient complete patient care plan
      - Yes
        - Data Manager enrolls in MSE
          - Patient meets with case manager to determine if the client is ready to be transferred to the standard of care
            - Yes
              - Has the patient attended 2 visits with her PCP, 1 visit with her case manager, and 1 lab work visit?
                - No
                  - Peer provides the patient in making and attending 2 visits with her PCP, 1 visit with her case manager, and 1 lab work visit
                    - Peer provides weekly check-ins with the patient
                      - *Peer provides practical and emotional support to help the patient meet the goals established in the care plan*
                - Yes
                  - Peer meets with case manager to transition the patient to the standard of care
                    - *Patient, peer, and case manager meet to transition the patient to the standard of care*
The following are implementation activities that occur at the patient level:

☑️ The data manager leads the process of developing an out-of-care list based on the protocol developed in the pre-implementation phase.

☑️ Administrative peer supervisor uses the out-of-care list to screen eligible patients.

☑️ Administrative peer supervisor assigns eligible patients to the peer.

☑️ The peer will make contact with his/her assigned patients via phone, an in person meeting, or email (if clinic permits email communication between the peer and the patient).
  - The peer will make 3 attempts per patient per month until the peer is able to make contact with the patient. If the peer is unable to make contact with the patient after 3 attempts, the patient will be put back on the out-of-care list and will be discussed at the at one of the future weekly case-conferencing meetings.
  - If after a second month of being on the out-of-care list, the peer is still unable to contact the patient, the patient will be place on a “hard to reach” list. This list will be made available to all clinic staff so that if a patient makes contact with a staff member other than the peer, that staff member can attempt to connect the patient and the peer.

☑️ When the peer and the patient are able to connect, the peer will explain the intervention including the role of the peer, the services provided by the peer, and the timeline of the intervention. The peer will clarify that after 4 months, the peer will work with the patient to decide if she should continue to work with the peer or work directly with her case manager and her clinical team (transitioning to the standard of care).

Conversation prompts:
  - Hi, my name is ______ and I am a peer. A peer is someone who is living with HIV and has learned to manage and control it.
  - I’ve been positive since ______ and have overcome many obstacles because I got the support that I needed to manage my HIV.
  - One of the things that helped me the most was learning about the disease and how to control it, and hearing how others were coping with their diagnosis and the things they did to overcome the stress, fear, and anxiety associated with being HIV-positive.
  - My role is to give you health information and be someone you can turn to for support for the next 4 months. Our goal together over the course of the next 4 months is to get you back in to:
    - Get your lab work done
    - See your doctor
    - See a/your case manager
  - But today, let’s talk about what your needs are and how I can help you address those.
  - Tell me about yourself. When did you receive your diagnosis and how have you been coping with the disease (medically, home life)? Who in your life knows about your HIV status? How would you describe your relationship with your family? What is your relationship with your friends like?
  - What do you know about HIV? Where did you get this information?
  - What particular questions do you have about HIV?
How have things been going since you last came in for an appointment or since you found out that you were HIV positive (depending on patient)? What are some of the reasons you haven’t come back in for an appointment with your primary care doctor?

Thanks for taking the time to meet with me today.

Let’s plan to meet again next week on____________.

The peer will explain the multi-site evaluation and ask the patient if they want to participate in the multi-site evaluation.

- If the patient wants to participate in the multi-site evaluation, the patient peer will make an appointment for the patient to meet with the data manager who will enroll them into the multi-site evaluation. The meeting with the data manager should ideally occur on that day. If this is not possible, the meeting between the data manager and the patient must occur within seven days from the initial meeting between the peer and the patient.
  - If the patient does want to participate in the multi-site evaluation, the data manager will consent the patient into the evaluation and administer the baseline survey (the data manager should refer to the evaluation protocol for specific instructions on administering the baseline survey).
  - The data manager will explain the process for withdrawing from the intervention and/or the evaluation:
    - If the patient chooses to withdraw from multi-site evaluation: The patient must tell a staff member. That staff member will inform the data manager and the administrative peer supervisor. The patient can still be enrolled in the intervention after discontinuing engagement in the multi-site evaluation.
    - If the patient chooses to withdraw from the intervention: The patient must tell a staff member and the staff member must then inform the administrative peer supervisor. The patient can still be enrolled in the multi-site evaluation even after discontinuing engagement in the intervention.
  - If the patient decides that she does not want to participate in the multi-site evaluation, the peer will explain her options for care (receiving the peer intervention, the standard of care, or another program offered at the clinic). The data manager will complete a form that asks why the patient declined to participate in the evaluation and document what care the patient does ultimately receive. Raw data on patients who decline to participate in the multi-site evaluation will not be submitted to the DEC (only aggregate data will be reviewed).

Once a patient has been consented into the evaluation and completed the baseline survey, the peer will set up an appointment to meet with the patient to assess patient barriers and needs, and develop a patient care plan (Appendix D). The patient care plan will guide all subsequent efforts made by the peer.

Depending on the need identified by the patient, the peers will conduct the following activities:

- Peers will support patients in scheduling:
  - 1 lab visit
  - 2 primary care visits
  - 1 case management appointment
• Peers will support patients in obtaining referrals for needed services (including transportation, housing, etc.). All referrals should be made in conjunction with or by the case manager, and will follow the protocol designed in the pre-implementation phase.

• Peers will offer accompaniment to internal and external appointments and assist with completion of paperwork for appointments, benefits, and referrals.

• Peers will assist with finding appropriate child care (when applicable).

• Peers will explain medical information that patients obtain from providers.

• Peers will provide appointment reminders for linkage or re-engagement appointments with the primary care provider and the case manager (Note: Sites should have a missed appointment procedure in place. For this intervention, when a patient misses an appointment, the Peer must be immediately notified. The Peer will work with the patient and the staff to reschedule the appointment).

• Peers will provide assistance with transportation related to linkage or re-engagement appointments and accessing social services.

☑ Peers will provide weekly patient check-ins by phone, in-person meetings, or text message, email, social media or other method of communication that is preferable for the patient and permissible by the policies of the clinic site. During the weekly patient check-in, peers will provide appointment reminders when appropriate.

  Peers will ask the following questions during their check-ins:
  • What services do you need? In particular:
    o Mental health?
    o Housing?
    o Substance use?
  • What referrals or appointments have been made for you, and which ones have you attended?
  • Would you like me to go with you to your medical or social services visit?
  • How can I help you connect with people/services you need?
  • How are things going for you in general?
  • Let’s schedule our next visit/check-in.

☑ Peers will provide coaching and trauma-informed emotional support to patients including supporting patients in navigating the clinic (or healthcare) system and community resources.

☑ Peers will work with the patient, case managers, peer supervisors, and clinical team to determine if a patient is ready to be transitioned to the standard of care. Patient completion of the Peer Linkage and Re-engagement for HIV-Positive Women of Color is a patient-driven process. The decision will be made collaboratively between the patient and peer.

Patients will be considered for transition into standard-of-care case management once the following requirements are met (within a 4 month period):

• Patient attendance at 2 visits with her PCP
• Patient attendance at 1 visit with her case manager
• Completion of lab work
• Agreement between patient, peer, case manager, and clinical team on patient transition to standard of care.
☑️ Peers will transition patients to the standard of care after they attend 2 visits with their PCP, 1 visit with their case manager, and 1 lab work visit within a four month period.

Peers will meet with the patient who have met the goals of the intervention to explain that the patient has completed the intervention with the peer and that she will continue to work with her case manager as the standard-of-care. The peer will notify the health care team when a patient has completed the intervention and is ready to be transitioned into standard-of-care case management. The peer will convene a meeting with case manager and patient. At this point the patient can ask any questions and schedule the next appointment with her case manager. This meeting will be documented in the encounter form under “transition,” and it will be noted that the patient has been officially transitioned to standard-of-care case management. Patients who have completed the intervention may later re-engage with their peer on an as-needed basis (these encounters will be documented in the encounter form).

Other Reasons for Patient Completion and Transition

- If, at any point, the patient is no longer willing to work to achieve the goals of the linkage and re-engagement intervention and no longer wishes to work with or be contacted by the peer, the patient and peer will agree to discontinue the intervention activities. The completion and transition policy will be executed at this time.
- If at any point, the patient relocates outside of the agency catchment area, the peer will follow agency protocol regarding case closure under these circumstances.
- If the patient, at any point, is terminated from all agency services, the peer will follow agency protocol regarding termination.
- If, at any point, the patient is unable to participate (i.e., long term incarceration, commitment to an institution, or death).
- If the patient is unresponsive to peer outreach and follow-up efforts and does not have contact with the peer for the remainder of the 4 month intervention.

The patient can re-engage with the peer in the following scenarios:

☑️ If a patient is unresponsive to peer outreach efforts and stops working towards completing the intervention goals, and later determines that she wants to re-engage with a peer.
   - The peer will complete a new patient care plan and “restart” the 4 month intervention time period.

☑️ If a patient completes the transition to the standard of care and then becomes eligible for the intervention again at a later time (patient falls out of care for 6 months or more), they will then be eligible for peer services.
   - If they agree to receive peer services, the peer will complete a new patient care plan and “restart” the 4 month intervention time period.
Maintenance and Integration Activities

The following activities will be conducted by the intervention team members in partnership with clinic administration and clinical team members:

- Continue to recruit, hire, and train peers.
- Provide ongoing professional development and mentorship to peers.
- Incorporate peer linkage and re-engagement work into the standard of care at the clinic.
- Train clinic staff who interact with patients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to be able to identify patients who may benefit from peer services, and train these staff members on how to connect these patients with the intervention.
- Add peer linkage and retention as a regular field in the EMR.
- Routinely assess patients to determine which patients could benefit from the peer linkage and retention intervention.
- Facilitate ongoing conversation among providers about patients that could benefit from the intervention.
- Continually engage peers in patient case conferencing.
### Appendices:
**Appendix A: Logic Model**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short Term Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long Term Outcomes</th>
</tr>
</thead>
</table>
| - Intervention staff  
- Peer  
- Administrative Peer Supervisor  
- Clinical Peer Supervisor  
- Data Manager  
- Community Health Centers  
- Community Partners  
- Clinic support  
- Electronic health record/RW service data collection and reporting system  
- Evaluation Support from the Dissemination and Evaluation (DWE) Team  
- Implementation Support from the Implementation Technical Assistance Team (ITAC). | - Pre-Implementation Training  
- For Intervention Staff  
- For Community Health Centers and Community Partners  
- Create monthly out-of-care lists  
- Conduct outreach to newly diagnosed patients and patients who have fallen out of care  
- Development of a care plan  
- Provide appointment reminders for linkage or re-engagement appointments  
- Provide assistance with transportation  
- Accompany patients to linkage or re-engagement appointments  
- Provide coaching to patients  
- Administrative and clinical peer supervision meetings  
- Documentation of services | - # eligible individuals identified  
- # outreach attempts made and types of outreach (phone, home visit)  
- # individuals who engage with peers  
- # care plans in place  
- # appointments made  
- # appointments attended  
- # patients who are transitioned into the standard of care  
- # weekly encounters with patients  
- # unsuccessful outreach attempts with patients  
- # clients requiring transportation  
- # patients need of social supports/ongoing care management (mental health, substance use disorder, dual diagnoses, Homeless, continued history of incarceration)  
- # referrals made  
- # referrals kept  
- # patients with care plan in place | - Increase in client:  
- Understanding of the importance of care  
- Adherence to ARV  
- Reduction in barriers to care  
- Reduction in patient need for services | - Patients are linked and re-engaged in care  
(attendance at 2 clinical, 1 case management, and 1 lab visit) | - Long term retention in care  
- Improvement in the following patient outcomes:  
  - HIV viral load suppression  
  - Quality of life  
  - Engagement in behavioral health treatment as needed (substance use disorder; mental health)  
- Increase in client satisfaction with care  
- Integration of the Peer Linkage and Re-engagement of HIV-Positive Women of Color intervention into the clinic |
# Appendix B: Staffing Plan and Job Descriptions

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
</tr>
</thead>
</table>
| **Peer**                     | - Conducting outreach to newly diagnosed patients and patients who have fallen out of care;  
                              | - Providing assistance in making a linkage or re-engagement appointment for HIV primary care and case management services;  
                              | - Providing appointment reminders for linkage or re-engagement appointments;  
                              | - Assisting with transportation related to linkage or re-engagement appointments;  
                              | - Accompanying patients to linkage or re-engagement appointments;  
                              | - Providing coaching and emotional support including supporting patients in navigating the clinic (or healthcare) system and community resources; and  
                              | - Documenting linkage and re-engagement activities on behalf of patients. |
| **Administrative Peer Supervisor** | - Working with the data manager, peers, clinical team, and partner agencies to identify newly diagnosed patients;  
                              | - Assigning and managing the peers’ caseloads;  
                              | - Providing guidance and support on a daily basis to the peers (programmatic and administrative);  
                              | - Providing administrative supervision every other week;  
                              | - Coordinating clinical supervision of the peers;  
                              | - Facilitating and supporting open communication between the peers, clinical peer supervisor, case managers, and the clinical team; and  
                              | - Coordinating and implementing fidelity monitoring of the peer intervention in collaboration with the data manager. |
| **Clinical Peer Supervisor**  | - Participating in case conferencing (as needed);  
                              | - Conducting 1 hour, clinical supervision meetings every other week and as requested with each peer |
| **Data Manager**              | - Creating monthly out-of-care lists to identify eligible patients (may need to work with other staff to create list);  
                              | - Consenting patients into the study;  
                              | - Collecting and submitting data required for multi-site evaluation;  
                              | - Coordinating the collection of patient surveys, encounter forms, basic chart data abstraction, and implementation measures, and reporting them to the Dissemination and Evaluation Center (DEC); and  
                              | - Providing quality assurance reports and updates to intervention team about study referrals, enrollment retention, etc. |
Peer Linkage and Re-engagement Intervention:
The Peer Linkage and Re-Engagement intervention is designed to best serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained HIV-positive WoC known as “peers” will link and re-engage patients in HIV primary care. The intervention is designed to link and re-engage patients by attending two medical appointments and one case management appointment in a 4 month period. Patients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of Position
Peers offer a unique personal perspective and can provide coaching and emotional support to patients who may need assistance in connecting to, and managing medical and case management appointments. In addition, peers who work closely with case managers and the clinical team can better provide individualized patient-centered services over a short time period to address immediate patient needs and build trust between the patient and the clinic team.

Key Responsibilities
1. Conduct outreach to newly diagnosed patients and patients who have fallen out of care.
2. Initiate contact with patients who have missed appointments.
3. Provide assistance in making a linkage or re-engagement appointment for HIV primary care and case management services.
4. When engaging and linking a patient to an initial health care appointment, accurately communicate verbally and in writing, the following information: the date, time, location, provider name, information about what to bring to the appointment and any other facility-specific information needed to have a successful appointment.
5. Discuss expectations with patients (what to expect from appointments, facilities, clinic staff, medical providers, etc.).
6. Provide appointment reminders for linkage or re-engagement appointments.
7. Assist with transportation related to linkage or re-engagement appointments.
8. Accompany patients to linkage or re-engagement appointments.
9. Establish and maintain strong working relationships with clinic staff and the clinical team.
10. Work in tandem with the case manager to reduce barriers to care.
11. Address health literacy needs of the patients to ensure patient understanding of medical advice.
12. Provide coaching and emotional support.
13. Document patient activities including maintaining accurate data on forms and in electronic database systems.
14. Work as part of the multi-disciplinary clinical team to provide tools and strategies using a patient-centered approach to support patients in taking their medications every day as prescribed.
15. Refer patients back to health care providers to discuss any issues (i.e., side effects) that may be affecting his or her ability to adhere to a treatment regimen.
Qualifications/Requirements

- A person who is currently engaged in HIV care (may be a patient from the clinic). Demonstrates a commitment to personal self-management of health conditions and treatment regimes.
- Representative of the intervention patient population (HIV-positive women of color).
- Demonstrated ability to work collaboratively in a team environment.
- Demonstrated computer literacy in Microsoft and web-based applications.
- Excellent verbal and written communication skills.
- Excellent interpersonal and organizational skills.
- Ability to be hired as an employee.
- Able to provide the time commensurate with case load and responsibilities.
- Shares their personal experience in a strategic, compassionate, and responsive manner and comfortably discloses status.

Preferred Skills

- Experience working in a medical, clinical, or social services environment (including documenting patient needs)
- Knowledge of community-based programs and providers
- Bilingual as needed to serve patient population
Administrative Peer Supervisor

Job Description

Description of the Peer Linkage and Re-engagement of HIV-Positive Women of Color Intervention:
The Peer Linkage and Re-Engagement intervention is designed to best serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained HIV-positive WoC known as “peers” will link and re-engage patients in HIV primary care. The intervention is designed to link and re-engage patients by attending two medical appointments and one case management appointment in a 4 month period. Patients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of Position
The purpose of the Administrative Peer Supervisor is to coordinate and support the administrative components of the intervention.

Key Responsibilities
1. Supervise the creation of a monthly eligible patient list, confer with clinical team to finalize monthly eligible patient list.
2. Ensure that up-to-date data from the electronic medical record system are provided to peers.
3. Assign eligible patients to peers.
4. Recruit, train, supervise, coach, and evaluate intervention team staff.
5. Provide administrative supervision to the peer.
6. Coordinate clinical supervision of the peers.
7. Facilitating and supporting open communication between the peers, clinical supervisor, case managers, and the clinical team.
8. Assist data manager with the implementation and monitoring of the evaluation plan, ensuring timely data collection.
9. Determine long-term strategic alliances with external partners and maintain program collaborative relationships.
10. Facilitate intervention team meetings and case conferencing meetings.

Qualifications/Requirements
- Bachelor’s level required, Masters preferred.
- 10 years working with people living with HIV/AIDS, patients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
- Minimum of 5 years of experience supervising staff.
- Minimum of 5 years of experience with budget, contract, and program management.
Clinical Peer Supervisor

Job Description

Description of the Peer Linkage and Re-engagement of HIV-Positive Women of Color Intervention:
The Peer Linkage and Re-Engagement intervention is designed to best serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained HIV-positive WoC known as “peers” will link and re-engage patients in HIV primary care. The intervention is designed to link and re-engage patients by attending two medical appointments and one case management appointment in a 4 month period. Patients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of the Position
The purpose of the Clinical Peer Supervisor is to coordinate and provide clinical support to the intervention staff.

Key Responsibilities
1. Participate in weekly case conferencing.
   Conducting 1 hour, clinical supervision meetings every other weekly and as requested with each peer

Qualifications/Requirements
- Licensed mental health clinician (e.g., licensed clinical social worker, psychologist, or psychiatrist).
- 2-4 years counseling or case management experience in assessing and managing the psychosocial needs of persons with HIV/AIDS.
- Experience in working with patients with complex and/or comorbid conditions, sexual and gender minorities, and communities of color.
- Knowledge of harm reduction philosophy, patient centered counseling, and motivational interviewing techniques.
- Excellent oral and written communication skills.
- Excellent interpersonal skills. Able to build relationships with individuals, groups, and organizations.
Data Manager

Job Description

Description of the Peer Linkage and Re-engagement of HIV-Positive Women of Color Intervention:
The Peer Linkage and Re-Engagement intervention is designed to best serve Women of Color (WoC) who are newly diagnosed with HIV or who have fallen out of HIV primary care. Trained HIV-positive WoC known as “peers” will link and re-engage patients in HIV primary care. The intervention is designed to link and re-engage patients by attending two medical appointments and one case management appointment in a 4 month period. Patients will be considered linked or re-engaged once they have completed all three appointments and have completed HIV lab work.

Purpose of the Position
The Data Manager is responsible for the overall coordination of the data collection and management for the Peer Linkage and Re-engagement intervention at the site level. The Data Manager will work with the Dissemination and Evaluation Center (DEC) at the Boston University School of Public Health to insure that data collection and management is consistent with the multi-site evaluation protocol.

Key Responsibilities
1. Work with the administrative supervisor and clinical team create monthly lists of potential eligible patients from internal clinic records.
2. Consent patients into the study and track and manage follow up interviews.
3. Implement data collection procedures developed by the DEC.
4. Coordinate the collection of:
   a. Patient surveys
   b. Encounter forms
   c. Basic chart data abstraction
   d. Implementation measures
   e. Monthly eligible patient list
5. Review and monitor quality of the incoming data collection forms to ensure data are complete and consistent.
6. Ensure that all data collection and management activities are performed with the utmost attention to participant confidentiality, as well as HIPAA and IRB requirements.
7. Serve as a liaison between the DEC and clinic for all data collection and reporting.
8. Communicate problems with data collection and management to the DEC.
9. Participate in technical assistance and training sessions conducted by the DEC.

Qualifications/Requirements
- Knowledge of fundamental concepts of collecting and processing research data.
- Ability to communicate clearly and concisely, both verbally and in writing.
- Understanding of HIPAA and IRB requirements for health care research.
- Ability to manage competing priorities; willing and able to work flexible hours.
- Ability to work in a team as well as independently and to establish and maintain cooperative, supportive relationships with project staff.
- Experience with MS Office software (e.g. Access, Excel) is strongly preferred.
- Familiarity with basic computer programming and statistical software packages (SAS, Stata, SPSS) is preferred.
- Bachelor’s degree required
## Appendix C: 3 Year Work Plan

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Stage: Pre-implementation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess internal clinic and external systems</td>
<td>Establish internal peer champion for the peer program</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess clinic space and secure space for intervention activities</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan for possible future Medicaid reimbursements for peer delivered services (if applicable)</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan for obtaining billing codes for peer delivered services (if applicable)</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess current documentation in and reading of the EMR system, determine how to improve documentation and comprehension if necessary</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish or strengthen relationships with community referral networks. Create MOU for referrals of patients who need more intensive services (with an agreed upon timeline for referral appointments).</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obtain any necessary technology (laptop, tablet, etc.) and secure internet capabilities at all locations where data could be entered</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide peers with access to the EMR system</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess current HR policies related to hiring peers, and make necessary changes to facilitate hiring staff for intervention</td>
<td>Clinic administration, human resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
<td>Project Staff Responsible</td>
<td>Post-notice of award</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>---------------------------</td>
<td>---------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Hire or identify intervention team members</td>
<td>Hire or identify intervention team members (peers, administrative peer supervisor, clinical peer supervisor, and data manager)</td>
<td>Clinic administration</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete trainings provided by the ITAC</td>
<td>ITAC, Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complete trainings provided by the DEC</td>
<td>DEC, Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide training to intervention staff</td>
<td>Complete trainings provided by the ITAC</td>
<td>ITAC, intervention team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop, review, implement protocols and materials</td>
<td>Protocol to create the protocol for developing the “out-of-care” list</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protocol for accepting and making internal referrals</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protocols for accepting and making external referrals</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review the patient care plan and the acuity tool</td>
<td>Intervention team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protocol to transition patients to the standard of care</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prepare patient education materials</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review consent forms, HIPAA, intake forms, patient care plans and make any necessary updates</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare for evaluation</td>
<td>Complete human subjects training</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obtain IRB approval</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish communication timing and methods, and mechanisms for staff integration</td>
<td>Establish regular meetings for the intervention team</td>
<td>Intervention team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Define roles and responsibilities around communication</td>
<td>Intervention team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish weekly, individual administrative supervision meetings</td>
<td>Administrative supervisor, peers</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish monthly, individual clinical supervision meetings</td>
<td>Clinical supervisor, peers</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
<td>Project Staff Responsible</td>
<td>Post-notice of award</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>---------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Identify eligible patients</td>
<td>Establish regular case-conferencing meetings</td>
<td>Intervention team, clinical team</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish regular meeting schedule with ITAC</td>
<td>Intervention team, ITAC</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish regular meeting schedule with the DEC</td>
<td>Intervention team, DEC</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify eligible patients</td>
<td>Create monthly out-of-care list following protocol established in pre-implementation</td>
<td>Data manager</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review list with clinical team</td>
<td>Intervention team, clinical team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assign patients to peers</td>
<td>Administrative supervisor</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Initiate contact with eligible patients</td>
<td>Contact eligible patients</td>
<td>Patient navigator</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consent patients into the study and conduct baseline survey</td>
<td>Data manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiate intervention</td>
<td>Assess patient barriers, needs, and acuity</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop patient care plan with the patient</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss roles, responsibilities, and expectations with patient</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provide patient support</td>
<td>Connect patients to appropriate medical and social services</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accompany patients to appointments (as requested/needed)</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide appointment reminders</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct weekly patient check-ins</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arrange for transportation for patients to and from medical and social service appointments</td>
<td>Peer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
<td>Project Staff Responsible</td>
<td>Post-notice of award</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Assist with medication and adherence support</td>
<td>Peer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Explain information a patient receives from her medical provider</td>
<td>Peer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Monitor patient care plan, and make adjustments as necessary</td>
<td>Peer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Provide coaching and trauma-informed emotional support</td>
<td>Peer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Transition</td>
<td>Transition patients to the standard of care</td>
<td>Peer, clinical team, case manager</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Supervision</td>
<td>Conduct administrative supervision meetings every other week</td>
<td>Administrative supervisor, peer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Conduct clinical supervision meetings every other week</td>
<td>Clinical supervisor, peer</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Participate in weekly case conferencing</td>
<td>Intervention team, clinical team</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Integrate intervention into the clinic setting</td>
<td>Continue to recruit, hire, and train peers</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Provide ongoing professional development and mentorship to peers</td>
<td>Clinic administration, intervention team</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Incorporate peer linkage into the standard of care at the clinic</td>
<td>Clinic administration, intervention team</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Goal</td>
<td>Action Steps</td>
<td>Project Staff Responsible</td>
<td>Post-notice of award</td>
<td>Year 1</td>
<td>Year 2</td>
<td>Year 3</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>Train clinic staff who interact with patients (i.e. front desk staff, appointment scheduling staff, billing staff, etc.) to be able to identify patients who may benefit from peer services, and train these staff members on how to connect these patients to the peer services.</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Routinely assess patients to determine which patients would benefit from peer services and facilitate continuous conversation among providers about patients that could benefit from peer services</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue to engage peers in case conferencing.</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Add peer linkage and retention as a regular field in the EMR.</td>
<td>Clinic administration, intervention team</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Evaluation**

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Action Steps</th>
<th>Project Staff Responsible</th>
<th>Post-notice of award</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track program outcomes and conduct quality assurance review</td>
<td>Follow DEC protocols for tracking process outcomes</td>
<td>Intervention team, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review and audit intervention encounter forms for quality</td>
<td>Data manager, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Conduct monthly data cleaning</td>
<td>Data manager, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Map each piece of chart collection to a location in the EMR</td>
<td>Data manager, DEC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
**Appendix D: Patient Care Plan**

Client Name:
Client Record Number:
Date Created

Section 1: Coordination of Care

1a. First PCP Visit Attendance:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCP</td>
<td></td>
<td>Completed?</td>
<td>Y/N/Other</td>
</tr>
<tr>
<td></td>
<td>Peer</td>
<td></td>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1b. Case management visit attendance:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCP</td>
<td></td>
<td>Completed?</td>
<td>Y/N/Other</td>
</tr>
<tr>
<td></td>
<td>Peer</td>
<td></td>
<td></td>
<td>Notes:</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1c: Second PCP visit attendance:
Date Resolved:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section 2: Patient identified goals
2a: Patient identified goal
Date Resolved:

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 2b. Patient identified goal

**Date Resolved:**

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Party</th>
<th>Target Date</th>
<th>Outcome</th>
<th>Outcome Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ PCP</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Peer</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Patient</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
<tr>
<td>□ Other:</td>
<td></td>
<td></td>
<td>Completed? Y/N/Other Notes:</td>
<td></td>
</tr>
</tbody>
</table>

### Appendix E: Patient Contact Form

Complete this form with the patient at the time of introducing the intervention and conducting informed consent in your office or at the first scheduled visit. Update every 4 months, with any major changes affecting the logistics for peer encounters. Note: Sites will need to add this to their current contact form that includes contact information, emergency contacts, etc. as well as their HIPAA and Confidentiality forms.

1. **What days and times are best for you to meet with me in person?**
   Check as many days as patient says he/she could meet, and fill in available times for each day checked.

<table>
<thead>
<tr>
<th>Day(s) of Week:</th>
<th>Time(s) of Day:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Monday</td>
<td></td>
</tr>
<tr>
<td>□ Tuesday</td>
<td></td>
</tr>
<tr>
<td>□ Wednesday</td>
<td></td>
</tr>
<tr>
<td>□ Thursday</td>
<td></td>
</tr>
</tbody>
</table>
Where would you most like to meet? Note to Peer: Read choices:

- At home
- At another person’s home (Specify the home and relationship: )* 
- Patient’s PCP clinic within the Care Coordination Program
- Other location (Specify: )* 

2. For reasons of confidentiality, how would you like me to identify myself, when calling you or visiting you? (For example, should I go by my first name, say I am a “friend,” or say they “work with so-and-so?”)

3. Would you like to communicate by text?